

The Reconfiguration of CPD for Social Care Practitioners in Ireland: An Activity Theory Approach

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ABSTRACT

Social care practitioners at the frontline require specific Continuous Professional Development (CPD). Many changes affecting practitioners have occurred in Irish society since the start of the 21st century, resulting in the need for new types of reflective CPD. Previous research has explored the social care profession, but with little research conducted specifically on the CPD training provided to practitioners in residential child care centres.

This thesis addresses this gap by providing an insight into the issue of CPD through the voices of practitioners. It is informed by Cultural Historical Activity Theory (CHAT), advanced by Engeström as a way to study learning phenomena within the complicated, ill-structured, and contradiction-laden world of adult professional life. Primary research was in the form of semi-structured interviews with 18 participants: 15 practitioners and three social care managers. A CHAT-informed intervention was conducted in the form of a sequence of change laboratories (CLs) in relation to Therapeutic Crisis Intervention (TCI) – a key technique adopted in state-funded residential care. A follow-up questionnaire study took place with six of the eight participants who took part in the TCI CLs. The outcomes of the CLs indicated that the CHAT approach could be adapted to a small-scale work setting; a follow-up survey was conducted with six participants who originally took part in a TCI intervention. Secondary research includes a comprehensive review of relevant literature in the field of contemporary social care and in that of CPD.

The findings reveal that practitioners do not have a competency-based training framework; some participants said they had not received their mandatory training. In the follow-up, questionnaire participants reported they had subsequently received additional CPD. While structured formal supervision is offered, most expressed disappointment with it and suggested external supervision. Team reflection was the norm as opposed to personal reflection, with practitioners citing work constraints, staff shortages and depleted resources as the barriers to non-participation. Above all, professionals identified a lack of communication between them and their senior, external management and trainers; they all called for a change in their professional CPD training. In light of the findings, recommendations and avenues for future research are discussed.

DECLARATION

I certify that this thesis which I now submit for examination for the award of Doctor of Philosophy is entirely my own work except where otherwise stated and that it has not been previously submitted to any other Institute or University.

I give permission to the library of the Institute of Technology, Sligo to lend or copy this thesis on request.

Signature _____ Date _____

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TABLE OF CONTENTS

Abstract	ii
Declaration	iii
Acknowledgements	iv
Table of Contents	v
Appendices	vii
List of Abbreviations	viii
List of Tables	ix
List of Figures	ix
Chapter One: Introductory chapter	1
1.0 Introduction	2
1.1 Changes in the social care sector	3
1.2 Researcher's Background	4
1.3 Changing field of Social Care Practice	5
1.4 Changes in nature of client group	7
1.5 Professionalisation of the workforce	9
1.6 Accountability/Risk culture	10
1.7 Interagency/Inter-professional collaborative working	11
Summary	13
1.8 CPD	14
Summary	16
1.9 Research issues/problem for CPD	17
1.9.1 Research Questions	18

1.10 Cultural Historical Activity Theory (CHAT)

19

1.11 Thesis Structure

20

Chapter Two: Changes impacting on the work of social care practitioners

23

2.0 Introduction

23

2.1 Changing Field of Social Care Practice

23

2.2 Changes in the nature of client group

35

2.3 Professionalisation of the Workforce

42

Summary

56

2.4 Accountability/Risk culture

81

2.5 Interagency/Inter-professional collaborative working

89

2.6 Conclusion

94

Chapter Three: Activity Theory - Theoretical Framework

96

3. Introduction

96

3.1 Overview of chapter

96

3.2 Commonly used approaches to Training

97

3.3 Overview of AT

99

3.4 Activity Theory (AT) explained

101

3.5 Three generations of activity theory

104

3.6 Contradictions

114

3.7 Development Work Research (DWR)

117

3.8 Knotworking

120

3.9 Co-configuration	121
3.10 Four Questions	125
3.11 Five Principles	125
3.12 Learning by Expanding	127
Summary	140
3.13 Health Care Project in Helsinki Finland	140
Summary	144

Chapter four: Research Methodology

	147
4. Introduction	147
4.1 Research Design	147
4.2 Theoretical perspective	152
4.3 Constructive/interpretive epistemology	157
4.4 Thesis Methodology	159
4.5 Inductive v deductive	161
4.6 Phenomenological research approach	162
4.7 Methods	167
4.8 Data Collection and Analysis	170
4.9 Residential Child Care Centres – The Research Sites	172
4.10 Pilot interviews	173
4.11 Sampling Techniques	174
4.12a Semi-structured Interview Participants	175

4.12b Questionnaire Participants – Follow-up study	175
4.13 Data Analysis	179
4.14 Researcher’s role in the process	182
4.15 Strategies used to ensure the quality of the research	183
4.16 Methodological Pointers	189
4.17 Power relationships in the study	192
4.18 Strengths and Limitations of the Study	193
4.19 Chapter summary	194

Chapter Five: Findings from the Semi-structured interviews

195 5.0 Introduction	195
5.1 Research Questions	196
5.2 Interview Findings	196
5.3 Themes	202
5.4 Chapter Summary	227

Chapter Six: Interpreting and Applying AT to the findings of the research

229	229
6.0 Introduction	229
6.1 Overview of chapter	229
6.2 Analysis	229
6.3 Initial Steps: Setting up the Change Laboratory (CL) in a Centre	232
6.3.1 Therapeutic Crisis Intervention (TCI)	232
6.4 The social process of change and learning in the Centre	235

Summary	251
6.5 Actions, Scripts and Activity Systems	255
Summary	262
6.6 Disturbances and Contradictions	263
6.7 Innovations and Visions	272
Summary	277
Chapter seven: Discussion of Findings	278
7.1 Introduction	278
Summary	283
7.2 Research Questions	284
7.3 Themes of Study	286
Summary	292
7.4 Where to now – reconfiguring CPD	293
Summary	301
7.5 Contradictions in the Centre	302
7.6 Looking to the future	323
Summary	338
7.7 Conclusion	338
7.7.1 Activity Theory (AT); the issue of power	343
7.7.2 The significance of this study	360
7.7.3 Personal perspective	366
7.7.4 Future research	369

7.7.5 Recommendations

369

References

371

Appendices

412

Appendix: 1 Bio Data Form

413

Appendix: 2 Pilot Interview Guide

414

Appendix: 3 Letter of Request to take part in Study

415

Appendix: 4 Revised Interview Questions

417

Appendix: 5 Consent Form

418

Appendix: 6a Letter of thanks to Social Care Manager and staff

419

Appendix: 6b Letter of thanks to Social Care Manager and staff

420

List of Peer reviewed publications

421

LIST OF ABBREVIATIONS

APA	American Psychological Association
ASTI	Association of Secondary Teachers in Ireland
ASIST	Applied Suicide Intervention Skills Training
AT	Activity Theory
CAMH	Child and Adolescent Mental Health
CCETSW	Central Council for Education and Training in Social Work
CFA	Child and Family Agency
CARI	Children at Risk in Ireland
CHAT	Cultural Historical Activity Theory
CL	Change Laboratory
CPD	Continuous Professional Development
DWR	Developmental Work Research
EAPN	European Anti Poverty Network
GP	General Practitioner
HETAC	Higher Education and Training Awards Council
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
ICMP	Individual Crisis Management Plan
IMF	International Monetary Fund
IQDA	Irish Qualitative Data Archive
JLO	Juvenile Liaison Officer
NAPDP	National Association of Principals and Deputy Principals
NFQ	National Framework Qualifications
NISCC	Northern Ireland Social Care Council
OMCYA	Office of the Minister Children Youth Affairs
P	Practitioner(s)
PM	Performance Management
PQ	Post-qualifying qualification
QQI	Quality and Qualifications Ireland
RAP	Response Ability Pathway
SCM	Social Care Manager
SER	Significant Event Report
SWM	Social Work Manager
TL	Team Leader
TM	Team Meeting
TNA	Training Needs Analysis

LIST OF TABLES

Table 2.1: HSE: Review of adequacy for HSE children and families services 2010	24
Table 2.2: Responses to how do you define CPD for yourself?	69
Table 3.1: Key people/ideas in three generations of AT	101
Table 4.1: Crotty's classification table	148
Table 4.2: Schema outlining the theoretical framework of the study	149
Table 4.3: Questions corresponding to the nodes of the triangle	158
Table 4.4: Differences between qualitative and quantitative research approach	160
Table 4.5 Summary of positivist and phenomenological paradigms	166
Table 4.6: Distinctions between phenomenological research and ethnography	167
Table 4.7: Activity Theory Methods	169
Table 4.8: Comparison of criteria for judging the quality of qualitative v quantitative research	183
Table 5.1: Gender Profiles	197
Table 5.2: Age	198
Table 5.3: Years of service	199
Table 5.4: Years of service practitioners/team leaders	199
Table 5.5: No of Social Care Manager	200
Table 5.6: Years of service managers	200
Table 5.7: Work locations	201
Table 5.8: Educational Qualifications	201
Table 5.9: Training offered	202

Table 5.10 Overarching and emergent themes of the study	226
Table 6.1: Change Laboratories/TCI intervention at the centre	235
Table 7.1: Main barriers to CPD participation	294

LIST OF FIGURES

Figure 2.1 Social work standards in relation to CPD	48
Figure 2.2 Ten Level Framework	67
Figure 3.1 Advantages and Disadvantages of AT	100
Figure 3.2 First generation AT model	102
Figure 3.3 Second generation AT model: the structure of a human activity system	103
Figure 3.4 Two interacting activity systems as minimal model for third generation AT	107
Figure 3.5 Activity systems of practitioners and the child	108
Figure 3.6 Activity System Model indicating area of contradiction	112
Figure 3.7 Contradictions explained	113
Figure 3.8 Prototypical layout of the Change Laboratory	116
Figure 3.9 Historical forms of work: co-configuration	118
Figure 3.10 Central features of co-configuration work	121
Figure 3.11 The model of expansive learning actions	129
Figure 3.12 Current examples of recently published work by Engeström and the CRADLE centre	133
Figure 3.13 Engeström summarises the answers of the theory of expansive learning to the fourth question—and to all four questions—of the matrix	140
Figure 4.1 Second generation activity theory model	153

Figure 6.1 Two interacting activity systems: minimum model for third generation AT	224
Figure 6.2 Centre and Management activity systems with TCI contradiction (object)	225
Figure 6.3 The model of expansive learning actions	225
Figure 6.4 The social process of change and learning in the centre	230
Figure 6.5 First two work actions in Engeström's researcher's study	251
Figure 6.5a. First two work actions in researcher's study	252
Figure 6.6 Third and fourth work actions in Engeström's researcher's study	253
Figure 6.7 Researcher's study: The DSW promising to call the Addiction Counsellor	254
Figure 6.8 Researcher's study: DSW deliberating and making a decision to ring the addiction counsellor	255
Figure 6.9 Contradictions in the activity system: Engeström's study	258
Figure 6.9a Contradictions in the residential child care centre	259
Figure 6.10 Care Calendar of a patient, presented by the Chief Rheumatologist	260
Figure 6.11 Care map of a patient, presented by the Chief Rheumatologist	261
Figure 6.12 A model of the Care Agreement practice	261
Figure 6.13 Events Calendar for Centres	263
Figure 6.14 Training map for practitioners	264
Figure 6.15 Centre training agreement practice	265
Figure 6.16 The basic Vygotskian view of concept formation	267
Figure 6.17 Engeström's study: vertical and horizontal movement: care agreement	268
Figure 6.18 Researcher's study: vertical and horizontal movement: Training Agreement	270
Figure 7.1 CPD questions for social workers	296

Figure 7.2: Algorithm for negotiated training agreement practice	300
Figure 7.3 Contradictions in children's health care in the Helsinki area	303
Figure 7.4 Contradictions in residential child care centres	304
Figure 7.5 Assessed needs v cost cutting	305
Figure 7.6. Tension between the systems.	307
Figure 7.7 Changing nature of the client group v changing role of practitioners	309
Figure 7.8 Practitioners knowledge v HSE knowledge	311
Figure 7.9 HIQA standards v practitioners' action plans	312
Figure 7.10 The need for workforce on site at all times v the need for highly performing workforce	313
Figure 7.11 Increased technology v lack of technology literacy	315
Figure 7.12 Reflection v time constraints	317
Figure 7.13 Benefits of supervision v practice of supervision	318
Figure 7.14 HSE Policy TCI restraint v Practitioners desisting from using TCI restraint	319
Figure 7.15 Four perspectives on power in organisations	348
Figure 7.16 The nature or power, as understood by the four perspectives	348

CHAPTER ONE

I feel that quality and standards are questionable. The kind of training that we get is of very poor quality, it's not good quality, very poor; relevance is sometimes questionable... say going to manual handling training, it's mandatory... what manual handling would we be doing in our work?
(Social Care Manager¹ aged 42, 18 years work experience in a residential child care centre²)

¹ Social Care Manager will be referred to a manager(s) throughout the thesis

² For confidentiality and to protect the anonymity of participants, names of centres or their location will not be disclosed

1.0 INTRODUCTION

Change is a recognised aspect of all professional life and Continuous Professional Development (CPD) [assists] professionals to cope with changing construction of what constitutes GOOD (capitals in original) professional conduct and practice at different levels: clinical, technical, academic and organisational (Halton, 2014a).

Social care practitioners³, particularly in small settings, find it hard to keep up with the changing world of residential child care. Services are provided in the form of units/bungalows situated (usually) in urban communities, comprising work teams of 8-10, including a centre manager. Practitioners work with children/young people placed at the centres, sometimes by gardaí, if after 5pm, but mostly by social workers. Service provision is modelled on a family home.

Until 2014 the Health Service Executive (HSE) had responsibility for social work and social care services targeted at children. A major change occurred in child and family services in January 2014 with the establishment of Tusla, the new Child and Family Agency⁴ (CFA) which has taken over responsibility for services. About 4,000 staff were transferred to the new agency which, for the first time in the State's history, will bring a dedicated focus, under one umbrella, to child protection, family support and alternative care services for children. The aim of Tusla is to ensure better communication between agencies, more standardised approaches to care and increased accountability (Department of Children and Youth Affairs, 2013). Its establishment offers a chance to do things right from the start and sets the scene for the future development of social care practice.

Within this context, we need a good understanding of how things are now in order to help shape the type of practice that Tusla engages in. This thesis is a contribution to understanding what is happening on the ground in the residential child care sector and in relation to CPD in particular. In order to provide a contextual understanding, the central topic of CPD is examined by outlining the following five key contextual dimensions of change in contemporary social care: the changing field of social care practice; changes in the nature of the client group; professionalisation of the workforce; emergence of greater accountability and a risk culture; and greater focus on interagency/inter-professional collaborative working.

As well as outlining the key themes of the study - explored in greater depth in chapter two - this introductory chapter orientates the study for the reader and

³ Social Care Practitioners will be abridged to practitioner(s) throughout the thesis

⁴ This thesis was researched and mostly written prior to the establishment of Tusla the Child and Family Agency (CFA)

provides an initial snapshot of the situation. It locates the study in context while exploring the complexity of some of the issues.

It introduces the research methodology, the central research question as well as five associated questions, operationalisation of terms and the theory used to frame the research. It ends with an outline of the structure of the remaining chapters.

1.1 CHANGES IN THE SOCIAL CARE SECTOR

Ireland has witnessed many social and economic changes over the past decade, from economic boom to recession to possible recovery. Despite the recent recession, the International Monetary Fund (IMF) placed Ireland in 13th place in its 2013 ranking of countries from richest to poorest based on Purchasing-Power-Parity (PPP) per capita (Global Finance, 2013). Helliwell et al (2013, p. 22) reported that Ireland was in 18th place, on the world happiness report for 2013. Despite this apparent wealth and apparent satisfaction/happiness, we know from listening to the media and even our own experience of life, that many social problems continue to affect families and children/young people, most especially since the collapse of the Celtic Tiger (2008-2013) and the onset of the economic recession. Some of these children/young people may end up in residential care.

For Howard (2012, p. 40) ‘residential care is messy, ambivalent, tempestuous, volatile and sometimes dangerous for children and staff’. The changing world of residential child care has been documented world-wide, for example, in England by Clough et al (2006) and Berridge et al (2010); in Scotland by Smith (2009); in the US by Holden et al (2009a; 2009b); in Northern Ireland by Gibson (2012); and in the Republic of Ireland by Howard (2012) and Share and Lalor (2009; 2013). In Ireland, especially over the past 25 years, there have been many changes in legislation/regulation that have impacted on the sector including, among others, the 1991 Child Care Act, Children First ([1999], 2011) and the 2001 Children Act. Partly as a result of these changes, practitioners working in centres are now engaging in more complex, challenging and demanding work.

In order to cope with these demands and as practitioners’ previous training/experience may not have adequately prepared/equipped them to respond to this new environment, they require continuous professional development (CPD) to enhance their practice. According to Halton et al (2014b, p. 1) ‘CPD is generally described in terms of an on-going process of education and development which continues throughout the professional’s career, and which includes both “formal” and “informal” elements’. Social workers⁵ an allied social profession, through the Irish Association of Social Workers (IASW, 2013a), have already developed their own CPD policy document.

⁵ Practitioners regularly liaise and work with social workers on different issues regarding the children/young people at the centres. While the work of the two professions is similar in some ways, in other ways it is very different. Because of the similarities, throughout this thesis, the work of social workers is sometimes referred to.

The field of social care practice is now developing its own approach (SCI, 2014). It is one of the 12 professions to be registered under the Health and Social Care Professionals Act 2005 to be implemented by the new registration body CORU (CORU, 2013). CPD has been identified as a key element of professional registration and all registrants have a duty to engage in CPD and to record CPD activities. CORU (2013b) has developed a framework for CPD, the *Standard and Requirements* document, to guide each Registration Board in setting its specific requirements. The CPD standard is contained in the *Code of Professional Conduct and Ethics* adopted by the Registration Board of that profession.

This thesis specifically investigates the issue of CPD training for practitioners working in residential child care centres, as their work has changed considerably over recent years. Field research for this study was conducted in the period November 2010-April 2011, before the most recent developments occurred in the area, but it does place the discussion in a contemporary context. The thesis explores how some of these changes have impacted on institutions, practitioners and children placed in residential care. CPD is a complex issue that reflects the changing field of social care practice in many ways.

1.2 RESEARCHER'S WORK BACKGROUND

I undertook a 12-week college work placement in a residential child care centre in 2005 and thereafter worked there periodically, covering annual/sick leave shift until securing a permanent part-time contract. Working in the centre afforded me the opportunity to see changes as they were occurring both in terms of the intake of clients and the work required to address their issues. I could see that experienced practitioners were having difficulties adjusting to the changes and, in my view; the agency was not providing the necessary CPD training to address these changes. The only relevant training provided was mandatory Therapeutic Crisis Intervention (TCI) and fire safety training.

I envisioned a new type of approach to CPD training whereby all practitioners would have their voice heard and where they would identify the type of relevant training that related to their changed work situation. I wanted to explore how relevant CPD training could be provided, so that practitioners could provide a better social care service. At the time I began reading for my study (2009/10) there was little mention of CPD, but since then CORU as well as others (Halton, 2014a; 2014b) have seen the need for it.

The most recent CPD study among the social care profession (October 2013) was conducted by Catherine Byrne, CPD officer for Social Care Ireland. In January 2014 she published the results of the online survey: *Report on findings of Social Care Workers' CPD needs assessment survey* (SCI, 2014). Her findings indicate that one third of respondents (n=552) claimed that organisational support had not improved their workforce; only 11 per cent had a Personal Development Plan

(PDP) to support CPD. CPD was often unplanned and unstructured and may not have always met practitioners' priority needs. Respondents said they engaged in a variety of CPD activities such as supervision, training, team meetings, policy development and reflective practice. Nevertheless most (80 per cent) appeared to view attendance at a training course as their CPD, rather than recognising the breadth of learning opportunities in which they are already engaged.

Also, 80 per cent of those in Byrne's study engaged in CPD activities, in their own personal time, not necessarily supported through their organisation. On this note, 63 per cent said cost was the main barrier to them engaging in CPD. Byrne suggests that while practitioners demonstrate their commitment to CPD, employers need to value and support practitioners in their professional development. Furthermore, 59 per cent stated they had 'poor' knowledge of CORU and registration, 13 per cent said they had good knowledge and 28 per cent said they had average knowledge of it.

Byrne (2014) found that further training/education is most desired by practitioners in mental health, challenging behaviour, stress management and alcohol/drugs. CPD needs were further clarified when respondents were asked to identify critical issues at work. These included challenging behaviour, self-harm and suicide ideation. Based on these findings, Byrne identified recommendations and addressed the development of a CPD framework, CPD needs of practitioners and a guide to planning for CPD for 2014/15.

The following section outlines the five themes that help to structure the discussion in the chapters that follow, starting with the changing field of social care practice.

1.3 CHANGING FIELD OF SOCIAL CARE PRACTICE

Many of the changes in the field of social care practice stem from de-institutionalisation. This is a global trend but has its particular expression in Ireland where, traditionally, residential care was provided by the religious orders. De-institutionalisation involved the removal of children/young people from institutional care (in large hospital-like settings) to care in the community: in houses/bungalows/units/centres. Residential child care institutions had been relatively homogeneous with everyone located in one building. This made it easier to provide CPD training, such as it was. One suspects there was little formal CPD at that point, more an apprenticeship-type model. Since de-institutionalisation professions have become more diverse and more expert at providing ongoing CPD training to update skills of the different groups working in the field.

Kennedy (1996, p. 270) shows that child care provision in Ireland had its roots in the 19th century Poor Law, which originated in Britain but was applied here also. At that time the only provision for children in need of care was the workhouse. O'Sullivan and O'Donnell (2012) indicate that these were not a suitable way to deal with children in need of care, so institutions such as industrial schools and

reformatories were set up, first in Britain and, afterwards, in Ireland. These institutions were big and thousands of children were sent to them; they were popular. The decline in religious vocations, a re-structuring of Irish social policy and the realisation of past cases of abuse and ill treatment has led to a gradual replacement of the religious with lay residential child care staff within new types of institutions (Howard, 2003).

The *Kennedy Report* (1970) had a huge impact on thinking about child care. The smaller 'group homes' (centres) that it recommended gradually replaced the old institutions with a greater emphasis on the provision of foster care in the community (Kennedy, 1996, p. 271). As new centres were established, they came under the remit of the Health Service Executive (HSE) which maintains the care of all children under the banner of the Department of Children and Youth Affairs. The HSE also funds voluntary agencies such as Barnardos and Brothers of Charity to run centres. As the HSE became increasingly involved in these services, they had to make changes in response to key studies, reports and recommendations. Within this context many of the larger institutions closed and more geographically dispersed ones opened up. Based on the social model, this intervention aimed to integrate children in communities. It sought to give them a sense of belonging, utilising normalisation, in a family environment with fully trained professional staff, as opposed to being cooped up behind high walls in a regimented institution.

Because of the complex needs of children/young people in care, it is crucial that there is good quality interagency/inter-professional work undertaken between the professionals caring for them. Such an approach can enhance practice both for staff and for children but as yet, in Ireland, has not reached its full potential; de-institutionalisation has not overly enhanced this process. While various professional groups can be working together, such as social workers and practitioners liaising on children's cases, they continue to mainly work separately in their own teams. It could be argued that a 'silo mentality' exists. Despite having email correspondence, different professionals may have minimal face-to-face communication with each other or with colleagues in other teams; they may thus miss out on vital nuances both from verbal and non-verbal communication.

De-institutionalisation poses challenges for CPD as there are many diverse small groups working in large agencies such as the HSE and Tusla. It can be difficult to organise training that is relevant to each group. It is also important that everyone's voice is heard (Munro, 2011) because the sharing of views gives a more holistic perspective on how to deal with the issues of concern and opens up all channels of communication. Proper communication within organisations/centres is crucial, most especially with the rapidly changing nature of the client group.

1.4 CHANGES IN NATURE OF CLIENT GROUP

Prior to the implementation of the recommendations of the *Kennedy report* (1970), children were predominantly placed in care if their parent(s) were unable to care for them due to poverty and/or having many children in their family or, sometimes, if a child was 'boisterous' (Doyle, 1989; Raftery and O'Sullivan, 1999). Current HSE policies also revolve around keeping families together and showing they are being supported in communities (Focus Ireland, 2009).

There are significant changes in relation to the nature of the client group now coming into care: children/young people have higher and more diverse needs and, as stated by Barnardos (2016), child abuse does occur and can take many forms including neglect, physical, emotional and sexual abuse. McCormack (2015) reports that 2014 figures from Children at Risk in Ireland (CARI) show that over 600 children were the victims or perpetrators of rape and sexual assault with some 'increasingly violent teen-on-teen' incidents linked to pornography.

Staff are also having to address bullying, a problem amongst children in care, as in the broader youth population. O'Neill and Dinh (2013) reveal that almost a quarter (23 per cent) of 9-16 year olds surveyed in Ireland experienced some form of bullying, online or offline. A study by the National Association of Principals and Deputy Principals (NAPDP, 2014) found that 16 per cent of students admit to being a victim of cyber-bullying – a 33 per cent increase on the 2013 figure, with an 80 per cent increase in students admitting to being the transgressors of cyber-bullying (NAPDP, 2014).

Some children are ill coming into care, others have mental health and behavioural problems and some habitually engage in risk taking behaviour (Buckley, 2013, p. 14). Some children in care say they are depressed; a report on Mental Health of Young People in Ireland (Cannon et al, 2013), showed that one third of young people experience a mental disorder by age 13. Griffin et al (2013), reporting from the National Registry of Deliberate Self Harm Ireland, state that 'a total of 960 children aged 10 to 17 years presented to Irish hospitals with self-harm injuries, an increase from 904 in 2011'. This phenomenon is also impacting on residential care. Williams and Gilligan (2011) examined how practitioners in centres cope with self-injury among young people. They found that 'some interviewees were traumatically affected by their experiences in managing incidents of self-injury and may require supportive supervision, critical incident debriefing and specialised training in order to reduce both the personal and professional effects of these incidents' (2011, p. 24).

Children in care mention suicide ideation; staff in one centre in this study remarked on a notable increase in the number of young girls who so present. The *National Independent Review Panel* (Buckley, 2013) found that in 2012 of the 23 children that died and who were known to HSE services, nine died by suicide.

Some children go missing: in 2012 106 children were reported missing while in care of the State (O'Shea, 2012). Among other issues presenting in children in care are symptoms of Attention Deficit/Hyperactive Disorder (ADHD); Obsessive Compulsive Disorder (OCD), anti-social/aggressive behaviour and problems relating to alcohol, drugs and stress (Connors, 2010; Kelpie 2011).

Children/young people placed in care can be from diverse ethnic, cultural and religious minority backgrounds; language barriers can be a challenge. Some children have been neglected, abandoned and/or abused, physically, emotionally or sexually. They may be extremely traumatised as a result of being abused; when stressed and frustrated they can act out and engage in aggressive behaviour. All of these issues are complex and are putting further pressure on agencies such as the HSE/Tusla and on practitioners who are trying to keep up with changes that are impacting on their work practice (McHugh and Meenan, 2009).

Some of the measures that the HSE and Tusla have taken to address such issues include sending children to the UK by funding special care for them. Positive Care Ireland (2013) is an example of a private company that has made it their business to care for children who cannot be cared for directly by the HSE or Tusla. Despite changes in the nature of the client group and the impact of heavy workloads, agencies remain limited in the range of care they can provide due to staffing, financial and resource constraints. Because of the diverse needs of children placed in care now, it can be argued that there is a greater need for supports such as psychology and psychiatric services. Also, practitioners need to have access to relevant services and supports to assist them in their work.

While practitioners are qualified with a range of skills, not having access to relevant services can cause a level of frustration as they only have the tools to provide a basic service. At the same time, their job descriptions are lengthening and their roles are increasing, which can add to their stress which may also contribute to absenteeism from work; for example, Hough (2011a) reported that the Health Information and Quality Authority (HIQA) (2011) criticised the Gleann Alainn secure centre for children in Cork because more than one-third of the staff were agency staff and, in 2010, a total of 619 sick days were taken by the 28 members of staff. McDonald (2013) reported that the HSE as a whole was attempting to lower its €248m annual bill arising from staff calling in sick.

Lack of adequate resources and services can impact on children/young people in care because if the ethos of care (to provide a safe secure and nourishing environment for children), is damaged then children's problems may not be addressed properly by staff. If a young person sees their case is not progressing, this may cause them to have negative experiences that may lead to their behaviour regressing and their becoming more aggressive and withdrawn. By displaying aggressive behaviour, the child may be trying to show their feelings of inadequacy: this sometimes manifests itself in crime. The voice of the child can

become lost when a focus is then placed on the aggressive/criminal behaviour and the impact this has on others, rather than listening to the reasoning behind the child's behaviour (Garfat, 2003).

These limitations can reveal the inadequacy of the CPD training provided to practitioners. To compensate for such deficiencies some practitioners employ strategies such as sourcing free training from local professionals while others pay for courses themselves. As the client group has changed one would expect that CPD training would have adapted, given that there are new types of demands. Yet, practitioners are not professionally trained in how to address issues such as caring for children who are traumatised from being sexually abused or are themselves sexually abusing, apart from being able to consult the *Child Protection and Welfare Practice Handbook* (2011, pp. 23-43). Similarly, data collected by Mooney (2014, pp. 7-12) during interviews with child protection social work practitioners highlighted their unhappiness with the current practice surrounding retrospective referrals both by adults and children (children in residential centres can make retrospective disclosures to practitioners) citing that there is a much wider system level failure to meet the needs of adult survivors, current children and alleged abusers alike. In addition, practitioners who took part in this study as well as those in Byrne's study (2014, p. 25) have little means of addressing children's mental health issues and drug misuse or challenging behaviour, apart from knowledge acquired from TCI training, coupled with their own experiences. Thus, a lack of professional training can add to their stress and may cause burnout similar to that described by Redmond, et al (2012, 10) in relation to the social work profession.

1.5 PROFESSIONALISATION OF THE WORKFORCE

There is a clear link between professionalisation and CPD. CORU aims to register 12 professions and is advancing professionalisation with links to education standards through registration which, within a broad policy framework, is about ensuring quality provision of services to service users with links to accountability and evidenced-based practice. CPD reflects an acknowledgement of the increasing professionalisation of the sector and the importance of the role of practitioners as opposed to what Berridge and Brodie (1998, p. 135) described: residential care workers perceived as 'babysitters' or 'social workers in slippers'. Over the past 30 years, students intending to work in centres have availed of courses running in many educational institutions in Ireland. Applicants for a post in a centre must hold a minimum of a BA in applied social studies, while many have an honours degree and some have master degrees in social care. There is a contrast between such professionalising of the workforce and the type of burnout/stress outlined above. On the one hand practitioners are required to have qualifications prior to starting work but, on the other hand, they may not develop professionally as some of their CPD training has not always been relevant to their practice.

Williams and Lalor (2001, p. 78) highlight that many obstacles to professionalisation remain, including: issues of pay and status; education and training; State registration; and a multiplicity of job titles. Further education and training incorporated in their CPD will empower social care practitioners and enhance their professionalisation. The document: *Criteria and Standards of Proficiency Education and Training Programmes: Social Workers Registration Board* (CORU, 2013, e), lays out the criteria required by social workers and it is expected that similar criteria will be required when practitioners, like social workers, are registered with CORU and are working through their competency framework (CORU 2015h).

1.6 ACCOUNTABILITY/RISK CULTURE

Being a social care professional means being accountable; the *Code of Professional Conduct and Ethics for Social Workers* (Irish Statute Book, 2011, p 6) refers to a practitioner ‘demonstrating professional accountability and you must be prepared to explain and account for your actions and decisions’. It can be argued that regular relevant CPD can assist in helping the practitioner to achieve this; record keeping is another form of being accountable, for example. In *Better Outcomes Brighter Futures: The national policy framework for children & young people* (2014 – 2020, p.113) in conjunction with UN Convention on the Rights of the Child (p.120) they document the accountability measures to be put in place to ensure the rights, safety and welfare of all children. It can be argued that the ethos has changed from a focus on the quality of the work done with children to the quality of paper work (Smith 2009, p. 133; Howard 2012, p. 48). HIQA inspections and recommendations from the Commission to Inquire into Child Abuse: *Ryan report* (2009)⁶, and other reports, have contributed to the emergence of a strong discourse of risk and accountability.

Many reports have been published on the State’s handling of child abuse over the past two decades. O’Brien (2013) reports 29 inquiries with 550 recommendations made. As well as the *Ryan report* (2009), there was the *Roscommon abuse report*, (Gibbons 2010) detailing child abuse in State institutions in Ireland; the *Ferns Report* (2005), the *Murphy Report* (Department of Justice Equality and Law Reform, 2009), and the *Cloyne Report*⁷ (Department of Justice and Equality, 2011), all of which detail clerical child abuse. These have contributed to a strong discourse that emphasises the riskiness of residential settings.

⁶ <http://www.childabusecommission.ie/rt/ExecSummary.php>

⁷ For a list of findings: see *Cloyne report* in detail: http://www.justice.ie/jelr/cloyne_rpt/files/cloyne_rpt.pdf

In addition, the *Review of Adequacy for HSE children and family service* (HSE, 2011, p. 92) acknowledged an increasing awareness of deficits in the care being provided to vulnerable children and their families by the State. This has been highlighted in several critical reports that have drawn particular attention to poor governance and accountability arrangements resulting in inadequate performance management and inconsistent policy and practice. For example, in light of the Roscommon abuse case, Peyton (2012) conducted a pilot study to review practice and audit management of cases of neglect in Ireland. Findings included: that neglect cases including chronic neglect are prevalent within the caseloads of each local health organisation social work area; additional families where chronic neglect was a significant concern were identified by other disciplines who were frustrated by the thresholds for allocating cases to social workers; the involvement of senior management across disciplines is essential as the Review identified issues in the management of neglect within many disciplines, particularly Public Health Nursing, Paediatricians, Psychology and Child and Family Mental Health Services; findings demonstrate the need for action to resolve practice and governance issues at local (team and service level as well as general management) regional and national level; and there were limited opportunities for supervision, mentoring and support of professional managers (Peyton, 2012, p. 104).

In aiming to address these issues, HIQA regularly inspects centres, speaking to staff and residents. Practitioners need to be trained in how to be accountable and how to respond to HIQA when they visit, as the HIQA system can be complicated. Also practitioners need advice/training on how to properly address the recommendations made by HIQA. In addition, there are audits by HSE environmental health officers to check that all precautions are taken and recommendations adhered to. So, there is a lot of auditing going on: the emergence of a new culture of accountability.

1.7 INTERAGENCY/INTER-PROFESSIONAL WORKING

In the past when children were placed in institutions/reformatories, there was little emphasis on interagency/inter-professional work. Church and State were trusted by the public and care contained within the institutions. Now, given the scandals and resulting reports, there is a need to take on board the views of many different professionals. There are also specialist services that practitioners can consult if they require them for children in their care, albeit if they come within the remit of the budget and after enduring, in some cases, long waiting lists.

Practitioners are now better educated and trained in how to assess these services. When children were cared for in one institution, all professionals such as doctors/specialists were onsite and/or available if required. Currently, diverse groups of professionals work with children/young people in communities; this requires changes in how CPD is provided. Each group has its own CPD requirements but will also benefit from common CPD for interprofessional

working. If diverse professions come together from across agencies at a workshop or conference, they can provide mutual support and learn something new collaboratively. They can come to understand procedures: for example, how practitioners engage with children at the centre or develop a common working language. If only individual CPD is provided or if professionals are only trained in their own area, this may contribute to a silo mentality that may reduce efficiency and contribute to a failing work practice. There is a greater need now for interagency/inter-professional working as in some agencies staff teams work alone, apart from emailing colleagues. Practitioners who took part in this study had not yet developed the practice of engaging with other practitioners through social media such as Facebook/LinkedIn.

Research has shown the benefits of collaborative interagency work. Many government agencies in Ireland, the UK and the US, have called for staff to work together and ‘join-up’ for the performance of enhanced practice. For example, in Ireland, the *National Independent Review Panel* (Buckley, 2013) found that had there been interagency reviews, it would have assisted in the management of cases of deaths of children/young people (23) in care.

This report also found that there needs to be clear lines of communication between centres and external management, to combat poor cooperation and communication between State agencies. Other Irish reports that highlighted these issues include: *Towards 2016 Ten-Year Framework Social Partnership Agreement 2006-2015* (Government Publications Office, 2006); *Children First* (Department of Children and Youth Affairs 2011a, p.7. 2011b); *Review of adequacy for HSE children and family Services* (Department of Health and Children, 2011) and the *Report of the Independent Child Death Review Group* (Shannon and Gibbons, 2012). In the UK, Warmington et al (2004) and Edwards et al (2009) discussed interagency work in organisational contexts, while Rafferty and Colgan (2009) explored interagency work both in the UK and the US.

While interagency/inter-professional work is highly recommended it is problematic due to current staffing and financial constraints. For example, due to retirements and voluntary redundancies, frontline positions remain vacant, resulting in current staff possibly not having the experience in some cases, and certainly not having the time to meet with other agencies to the degree that interagency working requires. Nevertheless, practitioners need to utilise their relational agency. Edwards (2007, p. 1) explains that relational agency: ‘involves a capacity to offer support and to ask for support from others ... one’s ability to engage with the world is enhanced by doing so alongside others’. Interagency work should be a regular feature of practitioners’ work. At certain times, there is a need for professionals involved with children/young people to meet colleagues, such as to attend a child protection case conference. This is an excellent way for professionals to voice their opinion while sharing their knowledge, skills and

values. This can be maintained through regular interagency/inter-collaborative work amongst professionals caring for children/young people in centres.

Summary

From investigating the five themes it is clear that CPD needs to be continuously updated across the professions to up-skill all professionals both individually and working collaboratively in residential child care with vulnerable children/young people. Changes in the nature of social care practice, many stemming directly and indirectly from de-institutionalisation, have been a national trend. What has happened in Ireland reflects what has happened in a number of other countries, where vulnerable children have been moved from large institutions to centres in communities to be cared for by qualified practitioners. In Ireland, some centres are run by the HSE, others by voluntary agencies and funded by the HSE.

At the same time, the nature of the client group is changing, where children coming in to care now may have more acute problems due to impacts of social changes in society linked to addictions, mental health issues and abuse. These complex issues are putting further pressure on agencies and practitioners. Such changes, coupled with changes in social care practice itself, requires an increasingly professional workforce.

Pressures on practitioners are further compounded by the emergence and urgency of an accountability/risk culture discourse, whereby reports like *Ryan* (2009) and others, together with the monitoring work of HIQA, have put more pressure on agencies and practitioners to conform to legislation, rights and standards of practice. Despite these extra demands on their workload practitioners are getting on with their work but are not getting many of the extra supports they require.

Interagency/inter-professional work has been identified as crucial, but has not really evolved due to deficiencies in staff and other resources. For it to be fully effective practitioners need their voice to be heard by senior management. If they are not listened to and are not satisfied in their work, it may impact on their capacity to listen to the children, so the voice of the child may not be heard.

In moving towards identifying the central research question, by introducing and outlining the aforementioned five key themes, the researcher has:

1. Identified the key issues and dynamics of the contemporary social care sector
2. Identified the central role of CPD
3. It was clear that the research focus was to be CPD and how to reconfigure it
4. Identified key research questions to ask of interviewees
5. Suggested ways to answer the research questions

The next section briefly outlines key issues in relation to CPD; with a more extensive review of the relevant literature in chapter two: 2.3.2.

1.8 CPD

CORU (2014b) in its *Standards of Proficiency and Practice Placement Criteria* for social workers state that: all entrants to the register are required to ‘engage in evidence-informed practice, evaluate practice systematically, and participate in audit and review procedures’ (p. 12). With the aim of reconfiguring CPD training for practitioners this thesis, including the CPD review below, focuses on the key dimensions of evidence, practice and policy, linking evidence-based practice with delivery and implementation while policy holds all the learning together. These three are not always connected but should be.

There is a paucity of studies that specifically relate to CPD training for residential child care practitioners in the Republic of Ireland, apart from brief references to it in a paper by Williams and Lalor (2001). Moreover, aside from the following five studies, there has been limited research or findings elsewhere. After briefly outlining the main points from each study, the summary paragraph will highlight the findings with reference to the relationship between these studies, CPD my own study.

Milligan (2003) explored residential child care training issues in Scotland, in particular looking at the development of a BA/DipSW course to meet Central Council for Education and Training in Social Work requirements (CCETSW, 1995) via a 'particular pathway' in residential child care. He examined innovative features of the course, the first of its kind in the UK, and identified some of the perspectives informing the curriculum. He made brief comparisons with developments in the field of child and youth care elsewhere while focusing on the provision of practice learning opportunities.

In Australia residential child care training was examined by Ainsworth (1981, p. 234) who focused on the benefits for staff of knowing about the life space approach, citing that close and effective personal/professional relationships emerge in the course of everyday encounters, through being with another person in naturalistic situations. In describing the life space approach, Ainsworth noted that over the course of whatever shift arrangements may pertain, social pedagogues take ‘as the theatre for their work, the actual living situation as shared with and experienced by the child’ (or other client/service user). The idea of life space has become a central one in thinking on residential child care.

In the UK, ongoing training was assessed by Ward (1998) who delivers training courses and who was looking for ways to try to make them more interesting and focused by asking how can we help people to 'engage' fully with their professional training, and thereby help them to work with people - both service users and

colleagues - more effectively in their own practice. Also in the UK, Karban and Frost (1998) found that education can result in conflict with the organisation, particularly when students on placement question standards they are aware of and want to promote in centres.

In Northern Ireland training issues were discussed by Gibson et al (2004) and by Gibson (2012). Gibson et al (2004) describe and illustrate their approach to consultancy, development and training in residential child care. They draw on systems theory, systems thinking and the politics of child welfare to provide an analytic perspective that enables decision-making about the design of training and development interventions that promote good practice in this service setting. The theoretical perspective and intervention strategies are illustrated through case material. Gibson (2012) discusses the implications of the task still to be faced in Northern Ireland to truly professionalise residential child care, by asking such questions as: how is it possible to have one group of professionally qualified staff (field social workers) focus energy on keeping children away from another group of staff (residential social workers) with the same qualification?

In Wales, residential child care training was discussed by Colton (2002) who looks at how confidence in the public care system in the United Kingdom (UK) has been shaken by numerous and widespread scandals surrounding the abuse of children and young people, particularly those in residential child care institutions. His paper examines factors, associated with such abuse, including: failings in relation to staff recruitment, training, and supervision; ineffective management and systems of accountability; and the long-term policy failure to develop coherent and integrated systems of child welfare in the UK.

Crimmens (1998) investigated training for residential child care workers in Europe: comparing approaches in the Netherlands, Ireland and the UK. He examines differing approaches to the training of residential care workers in Europe, discussing similarities and differences. The study found marked improvements in the training of social care workers in the UK in recent years, where a social work approach is employed. Prior to this, 20 per cent of officers in charge of children's homes and 70 per cent of all residential child care workers possessed no relevant qualification (Utting, 1991).

In Europe, the model employed posits that residential child care is limited by contemporary definitions and structures that are too narrow in focus. This model is based on social pedagogy for which there is no exact English-language equivalent. It is a humanistic approach that places great emphasis on the importance of personality development, acquisition of social skills and competencies, education of feelings and emotions and the preparation for adult life in social, political and cultural terms. Crimmens (1998) noted that when comparing different training approaches it is evident that the UK standard of

training for residential child care workers was comparatively worse than European partners. For example, the Netherlands employs social pedagogues to work with young people and this requires a different set of training.

Crimmens (1998) highlighted that the care sector in Ireland was traditionally governed by the Catholic Church. In 1978 more than half of child care centres were operated by the religious orders. Ireland does not have a history of social pedagogy. Social care practice is encompassed in the professional practice programme that includes supervised practice placements. Crimmens (1998) found the training of and supply of accredited courses for social care to be a fairly recent development in Ireland, with reports suggesting that a large proportion of residential child care workers were still unqualified, though the levels of qualified staff in the Netherlands and Ireland were higher than in the UK.

Studies specifically in relation to CPD have been conducted by Halton in 2011 (cited in Halton, 2013, 2014b, pp. 39-71) with social workers, while the study by Byrne (2014, p. 25) centres on the CPD needs of Irish social care practitioners. Halton et al's book (2014) outlining CPD was published after the reading for the literature review for this study (2009/10) and field research (2010/11). The researcher agrees with the book's authors about the understandings of CPD and although the CPD study outlined in the book addressed social workers the findings from it were similar to that of Byrne (2014) and also to this study. This is outlined in more detail later on, for example, in section 7.2.1. and in table 7.1.

Summary

Being cognisant of evolution/change over time, we can see that the above studies span a 20-year timeframe. Common findings have emanated from these studies that will be discussed further in my study, such issues raised by Williams and Lalor (2001, pp. 83-86) in regard to pay and status; education/training; and registration. As in Milligan's (2003) study in Scotland, the need for basic education standards was previously highlighted in the Republic of Ireland in the *Kennedy Report* (1970). This initiated education and development training across Ireland and the need for CPD training courses in collaboration with agencies and third level colleges. Similar issues were highlighted in the reviews of CPD by Ward (1998) in the UK; by Crimmens (1998) in his comparative study of Ireland, UK and the Netherlands; and by Gibson et al (2004) in Northern Ireland.

A further finding from the above studies centred on the need for accountability and more interagency/inter-collaborative working, highlighted by scandals in the various countries. Colton (2002) reported that in Wales they investigated scandals and failures connected to the abuse of children. Ward (1998) in the UK examined how professionals can engage fully within their professional training by having more interagency/inter-collaborative working that can help them to work more effectively with service users and with colleagues, while Gibson et al (2004)

discussed the use of systems theory and thinking to develop and promote good practice in service settings. In the Republic of Ireland, scandals in centres were documented in the *Ryan report* (2009), which pointed to the need for clear accountability and more interagency/inter-collaborative working. The problem is that groups experience different CPD; a common collaborative/interagency CPD could benefit many professionals.

The relationship between these studies and CPD can be explored by comparing and contrasting how these other authors perceived CPD. For example, we saw that in 1981 Ainsworth was discussing the benefits for staff of knowing about the life space approach when working with children/families. CPD courses utilising approaches by Garfat, Fulcher, and Digney (2013) are now available, informing residential care staff about the therapeutic use of Daily Life Events (DLE) for working with children/families.

Recent CPD studies: Halton in 2011 with social workers, and Byrne in 2014 with social care practitioners reported similar findings. In parallel with this study, they highlighted the need for changes to include better education, qualifications and relevant CPD training; also needed to address issues described in the five key overarching themes of this study.

The above research has identified some of the key research issues/problems and point to issues that need to be looked at in my research. This thesis argues that they may be alleviated through the provision of relevant, consistent, practitioner-led CPD training and development. The most effective change has to incorporate a bottom-up as well as a top-down approach. Moreover, it can be argued that conducting CPD training properly and having a better trained workforce will be the key to resolving the aforementioned issues for practitioners. Relevance, content and methodology, as well as management and resourcing-reconfiguring, are issues cited in the research/issues problems to be addressed by the thesis.

1.9 RESEARCH ISSUES/PROBLEMS FOR CPD

Relevance

It can be argued that as a result of the changes in the nature of social care practice, it is practitioners themselves who know best the training they need. This was evident in the recent studies: Halton (2014b, pp. 39-71) and Byrne (2014, p. 25), cited specific practice issues that needed to be addressed. At present, agendas for CPD training sessions can be set somewhere else by people who do not know what is going on with vulnerable children/young people in centres; practitioners are thus not receiving relevant, consistent CPD training to meet their needs.

Content and methodology

Practitioners are witnessing the changing nature of the client group being placed in residential care, requiring them to need extra supports and relevant specialised CPD training. In order for this to happen, there needs to be a change in the content, methodology and delivery of CPD training; it has to be aligned with what is happening at the micro, agency and macro levels in the world of residential child care. If life is to be better for children it has to be better for practitioners, therefore agencies have to listen and co-operate with practitioners who are aware of the need to be more professional in their work practice. This will be strengthened by a competency-based framework specifically targeted to practitioners and standardisation/professionalisation, to be implemented for practitioners by CORU.

Management and resourcing-reconfiguring

As we have seen from the outlined research, if managers were to provide relevant CPD training to their staff, it would be a challenge as to where they would obtain and allocate resources such as money, time, and space to continue to provide it.

As mentioned above, practitioners regularly liaise with social workers through their work. Social workers and practitioners have on occasions said that now, due to work pressures and heavy caseloads, coupled with little support from their management, a work culture has developed where staff can feel worthless. In addition, due mainly to financial cutbacks, there is little relevant, consistent CPD training being provided to practitioners, with a consequent impact on children/young people in centres. The research outlined through the five key themes of this study, coupled with the national and international review of CPD, has shown that at present CPD in its present configuration is in some ways inadequate. Therefore CPD for practitioners needs to be reconfigured.

1.9.1 Research Questions

Central Question

How should the CPD training that social care practitioners receive, be reconfigured?

Associated research questions

1. How is the work in the social care sector in Ireland changing?
2. What type of CPD training is delivered to social care practitioners in Ireland?
3. What aspects of CPD training are most useful to meet the needs of social care practitioners?
4. How can CPD training be reconfigured to respond appropriately to changing

contexts and cultures of professional practice?

5. What has been the impact of relevant developments in CPD?

Operationalisation of the research questions comprised the following terms applicable to the social care field: CPD, social care, social care practitioners, residential care and reconfigure, defined in chapter four. Deriving from my own position as a practitioner in the sector, I recognise that CPD training encompasses a complex set of issues with regard to dynamic changes in the social care sector and for this reason a theory that involves practitioners themselves is needed. Cultural Historical Activity Theory (CHAT) is the theory chosen and adapted to theorise this study because, as we have seen even in this introductory chapter, the changes taking place are complex. Chapter three fully explains CHAT in terms of its principles, the questions it asks and the tools it uses in research interventions and how it helps to support this thesis in terms of research aims, objectives and research questions. A feature of CHAT is that it incorporates the practitioners themselves which can be good when responding to the complexity of CPD. While CHAT is fully explained in chapter three, a brief explanation follows.

1.10 CULTURAL HISTORICAL ACTIVITY THEORY (CHAT)

Cultural Historical Activity Theory (CHAT) is commonly shortened to activity theory (AT) (Engeström, 1987, 1999). Over the past 25 years, a consistent body of work has emerged through the work of researchers at the Centre for Research on Activity, Development, and Learning (CRADLE) at the University of Helsinki⁸ under the leadership of Professor Yrjö Engeström⁹

AT is an expansive, holistic theory, compatible with a team of people integrating and working together in trans-disciplinary teams. As well as addressing complexity, AT reflects on all the issues of concern for this thesis in that it encompasses a bottom-up as well as a top-down approach to learning and CPD while focusing on the relationships between the three dimensions alluded to above: evidence, practice and policy. Furthermore, AT incorporates a methodology called Developmental Work Research (DWR) which develops tools that can be described and applied to enhance the development, re-design and re-organisation of work (Engeström, 2005a). While Engeström and his team of professional researchers have conducted research in many fields, his studies on work re-organisation (1987, 1999a, 2000a, 2000b, 2001, 2006, 2007a, 2007b)¹⁰ resonate with this thesis as he is reconstructing problems/issues and explaining interventions that he conducted with practitioners in a health care setting in Helsinki. The problems there required similar attention to those of practitioners

⁸ http://www.helsinki.fi/cradle/foundation_letter.htm

⁹ <http://www.edu.helsinki.fi/activity/people/engestro/>

¹⁰ Throughout the thesis Engeström's work will be referred to as the 'Helsinki study'

and managers in this study, involving children/young people with complex issues being cared for by practitioners. CHAT was thus chosen as the theory to support the researcher to address the research aims, objectives and research questions

1.11 THESIS STRUCTURE

Chapter One

This chapter sets the scene of the study by introducing the reader to the changing world of residential child care practice by discussing and outlining the five key themes that relate to the analysis of the contemporary field of social care practice: changing field of social care practice; changes in the nature of the client group; professionalisation of the workforce; accountability/risk culture; and interagency/inter-professional/collaborative work.

Practitioners are finding it difficult to keep up with changes. There are financial constraints and interagency/inter-professional work is not working to its full potential. Analysis of the impact of the above changes on practitioners emphasises that their voice is not being heard; there are communication issues, staff say they are stressed and are finding it difficult to cope with the demands raised by numerous critical reports. A relevant methodology to address these issues – CHAT - is briefly outlined.

Chapter Two

This chapter examines in detail the changes that impact on the work of contemporary social care practitioners in Ireland. It explores the five themes in greater detail.

Theme one: ‘Changing field of social care practice’ begins by highlighting facts and figures pertaining to the residential child care profession in Ireland and there is a focus on what practitioners do. The theme addresses resilience in social care and highlights room for improvement. *Theme two:* ‘Changes in nature of client group’ discusses challenging times for practitioners due to complex and dynamic changes within the client/service user population. This theme also explores the personal and academic qualities now required by practitioners, to work in this profession. *Theme three:* ‘Professionalisation of the workforce’ highlights CPD, the educational qualifications needed to be a practitioner, competencies, lifelong learning, reflective practice and professional supervision. *Theme four:* ‘Accountability/risk culture’ examines ethics at work and discusses CORU and HIQA as well as professional standards required in centres. It also discusses bureaucracy and public attitudes to children in care. The *final theme:* Interagency/inter-professional/collaborative working explores communication, relational agency and technology.

Chapter Three

Chapter three explores Activity Theory (AT) by developing the argument alluded to very briefly in this chapter: that more expansive, holistic research approaches are required in the field of professional CPD training for practitioners/managers. The chapter argues that AT can meet this need; AT is described and a rationale for its use is given. It presents a history of AT and draws on the Helsinki health case study by Engeström. In this study, Engeström describes work re-design/re-organisation by incorporating Developmental Work Research (DWR) which includes Change Laboratories (CLs). Four questions and five principles are utilised in the CLs to address ‘contradictions/disturbances in activity systems’ and to describe and explain ‘knotworking’ and ‘co-configuration’. This action leads to expansive learning shown in Engeström’s cycle of learning. The chapter concludes with a synopsis of Engeström’s Helsinki study case and a discussion of how AT might be applied to the social care CPD case.

Chapter Four

This chapter outlines and justifies the qualitative research methodology approach adopted in the thesis. It refers to the research design and identifies and discusses constructivist ontology, epistemology, and the chosen theoretical perspective of interpretivism. This is an inductive, explorative, descriptive study that incorporates a cross-sectional design: this can be explained in that in her position as a practicing practitioner the researcher had some ideas about CPD. She was interested in a bottom-up approach; she saw gaps in the CPD provided, which she explored with interviewees using open-ended questions, in which they could describe their work situation, at three different research sites at one specific point in time i.e. November 2010-April 2011.

Issues of bias are discussed in sections 4.7.2; 4.11.2; 4.12.4; 4.13.2 (a) and 4.15.1. The researcher’s role in the research process is outlined in section 4.14. The following criteria for judging the soundness of qualitative research are discussed: credibility, transferability, dependability and confirmability. Strategies used by the researcher to address personal bias and prejudice are discussed in confirmability, section 4.15.4. Methodological pointers including access and ethics are referred to as well as the strengths and limitations of the study. Ethics is discussed in section 4.16.2; at the commencement of this study the research proposal was sent to two independent reviewers who did not request that further ethical approval be obtained for it at that time (2010/2011). The chapter also links the methodological approach to the AT and action research approaches utilised in the thesis: pp. 99,117, 139, 140, 142, 158 and 288.

Chapter Five

Chapter five presents the findings from the semi-structured interviews and follow-up questionnaire. It begins by outlining the central and associated research

questions before moving on to present the findings under the heading ‘personal profiles’ in which, among others, age, gender, years of service, work locations and educational qualifications are discussed. Findings under the five themes are then presented with the inclusion of interview excerpts. The chapter addresses the dearth that exists in professional CPD training literature and provides an insight into practitioners’ aspirations for future changes to CPD training.

Chapter Six

This chapter describes how activity theory (AT) was used as an intervention in this study. It begins with an analysis of centres before introducing and explaining how the TCI intervention was conducted in the change laboratories (CLs). It gives a step by step account of the interactions of practitioners and other professionals that culminated in an amendment of behavioural management policy.

Chapter Seven

Chapter seven presents a discussion of the findings from the study. It draws together the main conclusions and the researcher’s specific contribution. It asks ‘where to now – reconfiguring CPD’ and outlines the study findings in the context of the new CORU CPD policy framework. It discusses contradictions in the context of AT, encountered in the centres in detail. The chapter looks to the future by examining the challenges presented by de-institutionalisation; aggressive behaviour; professionalisation; accountability; and communication. It concludes with the researcher’s personal perspective and a vision for CPD for the future.

CHAPTER TWO - LITERATURE REVIEW

2.0 INTRODUCTION

While chapter one introduced the dominant themes of the research, this chapter explores and expands on changes encompassing these themes over the past decade, leading to the present situation and how this impacts on the work of social care practitioners. It looks in detail at competencies, an important part of the subsequent discussion and highlighted in theme three: professionalisation of the workforce. As was noted in chapter one, CORU has now come into existence and people are being registered under it. The chapter describes the work of practitioners in residential child care centres. The review of literature is illuminated with comments from the perspective of the researcher which have emerged from key experiences, as she works part-time as a practitioner in a centre. Research in this chapter draws on a range of sources, including from the following fields: the history of social care; residential child care work; historical reports; ethics; training; competencies; reflective practice; and supervision.

The aim of the review is to present a critical report of the relevant literature. It describes, summarises and clarifies this literature. It supports the theoretical basis for the research and helps to determine the nature of the study and provides an argument for conducting it. The review identifies and articulates relationships between the literature and this study. Also it provides the following (adapted from Boote and Beile, 2005, pp. 3-15):

- A context for the research
- Justifies the research
- Shows where the research fits into the existing body of knowledge
- Enables me to learn from previous theory on the subject
- Illustrates how the subject has been previously studied
- Outlines gaps in previous research by generating research questions for further research and discussion
- Shows how the work adds to an understanding and knowledge of the field of residential child care in Ireland.

2.1 CHANGING FIELD OF SOCIAL CARE PRACTICE

Chapter one argued that de-institutionalism was a major change that included the movement of children/young people from large institutions to bungalows/centres in communities. While this change has been ongoing in the field of social care practice, tensions remain about the nature of the job, skills and knowledge.

This section discusses these tensions through a brief description of social care and residential care in Ireland, before looking at the increasing salience of resilience, a concept that has been influential in social care and recently acknowledged in social care practice by practitioners in centres. It begins with a snapshot of numbers that encapsulates the residential child care profession in Ireland.

2.1.1 Snapshot of numbers in residential/social care

It is difficult to ascertain exactly how many practitioners work in residential child care in Ireland due to lack of registration, diversity of employers, variable qualifications and career paths. The *HSE National Service Plan* (2013b, p. 10), shows that 2,845 health and social care practitioners are employed with children and families. Lalor (2009) conducted an audit of social care student numbers and programme providers in Ireland, citing figures from the HSE of 3,405 practitioners working in the HSE/HSE funded agencies (excluding the private sector and agencies). This suggests a social care practice workforce of 3500±500.

De-institutionalisation has resulted in social care employment in residential child care centres being widely distributed across the whole country as evidenced by table 2.1 showing the number of children in care in December 2010.

Region	% of population 2006	No of children in care in 2010	% of children in care in 2010	Rate per 10,000 population	No. of children in care if distributed by population alone
Dublin Mid- Leinster	28.4%	1,557	26.1%	48.8	1,695
Dublin North East	23.3%	1,440	24.1%	55.1	1,388
South	27.4%	1,758	29.5%	57.2	1,632
West	21.0%	1,210	20.3%	51.4	1,250
National	100.0%	5,965	100.0%	53.1	5,965

Table 2.1: HSE: Review of adequacy for HSE children and families services 2010 (2012, p. 46).

Transition to centres from large industrial schools such as, amongst others, Artane Industrial School in Dublin, and Christian Brothers' school, Letterfrack, Co. Galway, appears to have happened in an ad hoc way (Kennefick 1998; Means et

al, 2008). Nevertheless, the distribution of services seems to reflect the population distribution quite well, probably better than (say) psychological or other support services. It suggests that most children in care are not located too far from their 'home' place - unlike the days when they would have been 'sent off' to the likes of Daingean or Letterfrack. While table 2.1 above gives statistics on children in care, for security and other reasons, it can be difficult to obtain current data on centres.

The Department of Health and Children: *Review of Adequacy report* (2011, p. 71) includes data on children's residential centres, based on data from HIQA's annual census. In 2011 there were 161 children's residential centres in Ireland, encompassing the statutory, voluntary and private sectors (ibid, 2011, p. 71). Darmody, et al (2013, p. 28), stated that:

There are over 6,000 children in care in Ireland; there has been an upward trend in recent years in the number of District Court orders permitting the HSE to take children into its care (from 5,727 at the end of 2010 to 6,282 in May 2012). Ninety per cent of children in care are in foster care (including family/relative foster care) and a minority lives in residential, high support, or secure care (p. 28).

This data suggest c.600 children in residential child care in about 160 centres, equating to about four children to a centre.

Increases in the number of children placed in care has been reported by O'Brien (2014) who notes a growing demand for foster and residential child care placements; the number of reports of children at risk received by social services increased 98 per cent in the previous seven years, while the number of children in the care system increased by a similar amount. Increased numbers of children in care combined with the economic recession impact on the work of practitioners. Their health/welfare at work may be impeded due to a lack of staff, resources and relevant training. This places constraints on them/their work, which can impact on the children/young people in their care.

There is evidence of reducing or inadequate resourcing. Among others, Smyth (2010), O'Brien (2010) and Buckley (RTE News, 2011) have discussed issues such as a lack of social workers (a contentious issue with different arguments, from time to time, from various sources, commenting on the lack/shortage despite the health service moratorium not affecting this profession; it may be an issue of turnover); the continuing reduction in many services; and inconsistencies, inequities and poor interagency communication within the health and social care systems. Riegel (2011) reported on expected increases in child protection referrals across Ireland and this has materialised: in 2011, there were 21,040 child welfare and protection reports received by social workers, this was an increase of more than 50 per cent since 2006 (ibid, 2011). There were increases in all child protection categories with reports for emotional abuse up by 60 per cent from

2,500 in 2010 to 4,011 in 2011 (State of the Nation's Children, 2012). Jones (2014b) reported that the HSE expected about 40,000 referrals to Tusla in 2014.

Despite increasing demand for services, Hunter (2011) reported on the intention of the HSE to immediately shed 6,000 more jobs. Hough (2011b) reported on possible cut-backs by the HSE to child and family support services. The HSE National Service Plan (2013a) stated that government policy on public service numbers required that, by end 2013, the health service was to achieve a workforce of 98,955 whole time equivalents (WTEs). From 2009-2013 there was a reduction of just over 10,000 WTEs in employment levels (ibid, 2013a).

The HSE claimed that while measures were to be implemented in a manner as to maximise the protection of frontline services, inevitably staff reductions of this magnitude impact on the level of services delivered (ibid, 2013a, p.9). In addition, the Irish Employment Monitor (2013) recorded a month-on-month decrease of 16 per cent in the number of new professional jobs available in July 2013; for the same period there was a 19 per cent decrease in the number of new professional job seekers in July 2013 (ibid, 2013), possibly reflecting the emigration trend.

Working in close contact with children/young people (who may be vulnerable) in residential centres requires staff ratios to be on a 2:1 basis, in line with accountability/risk factors, for staff safety as well as for that of the children. Staffing criteria are laid down by, among others: the National Standards for Residential Child Care Centres (2001); National Standards for Residential care for Young people (2004) and Children First: the National guidelines for the Protection and Welfare of Children (Department of Children and Youth Affairs [DCYA], 1999, updated in 2011a). Three staff are always on duty: two practitioners and the centre manager who usually works from 9-5, Monday to Friday. Shifts can begin either at 11am or 12 noon; the hour, for example from 12 noon until 1pm is always reserved for hand-over; duration of shifts is 25 hours with staff being paid an hourly rate for 18 hours: from 12 noon until 12 midnight and from 7am until 1pm the next day; they are paid a flat rate of €44 from 12 midnight until 7am. One to four children can be resident at any one time, including those on short-term placements or those availing of respite care.

It is arguable, in the researcher's opinion, that salaries on a par with similar professionals should be paid to practitioners partaking in this challenging work with vulnerable children/young people, (who sometimes can be violent), on a 25/7 basis. Williams and Lalor's (2001, p. 80) study found that the general feeling amongst practitioners they surveyed was that poor salary scales devalued the children in residential child care as it reflected the value placed on people employed to care for them. Salary scales for trainee practitioners is €24,325 at point 1 on the pay scale rising to €26,720 after three years (HSE, 2013a, p.22). Salary scales for a nurse after one year service is €27,221, for a garda €23,171 and for a primary school teacher €30,702 (Brennan, 2015). Practitioners are not paid

on college/work placements while recruit gardaí (Garda Síochána, 2009) and recruit prison officers (Irish Prison Service, 2008), are paid when they commence their courses and are given extra allowances. Despite this, there are a considerable number of people choosing this profession. Highlights from the 2011 census (CSO, 2012, pp. 75-76) show that there were 12,790 females and 6,033 males employed in the health and social care associated professions.

With an increase in the Irish population (4,239,848 in 2006 to 4,581,269 in 2011 (CSO, 2011a), more people will be needed to work in this profession. This means that practitioners, who are in work, albeit trying to cope with staff shortages and limited resources, will have no option but to endure a strict working regime to enable them to meet the needs of an ever increasing population, if the current policy of staffing reductions is maintained. Coupled with this is the emigration related 'brain drain', affecting staff knowledge and shortages.

Multiple social problems, fewer professional jobs available and a proposed reduction in HSE staffing levels means more challenging work for practitioners who are at work and a lack of staff and of resources to address the above issues; this is accentuated by the government moratorium on public service recruitment. This affects practitioners because although statutory requirements provide for high quality of care to be received by at-risk children, including those cared for in centres, the strict embargo on staffing numbers may have resulted in some problematic children receiving minimum care, attention and support in addressing their complex, diverse and unique challenging issues. While CPD can be part of the solution to the problem, it will not alone solve it; competently trained staff would be better equipped to address challenging problems but CPD cannot address the issue of a lack of staff resources.

While a lack of staff and resources was experienced in all three centres in this study, in two of them, agency staff were employed. While this happened occasionally in one centre, it happened on a daily basis in the other as third cover was needed for part of each day due to complex issues regarding one child. The researcher also acknowledges that there can be complex issues related to the use of agency staff, for example considerations of head count, pensions etc. It can be argued, both from a financial perspective and from that of experienced practitioners, that instead of continuously employing agency staff, Tusla would be better served financially if it employed these staff on a temporary contract basis or if the contract hours of the part-time staff in situ were increased. It was stated on RTE radio (7 July 2014) that funding to the Tusla was to be cut by €31m in 2014.

2.1.2 Social Care Ireland (SCI)

These changes need to be located within the historical development of social care practice, aspects of which were outlined in the previous chapter. Howard (2003) traces the history of contemporary Irish social care practice back to the 1970s. The Association of Workers with Children in Care (AWCC) was established in 1972

and made up mainly of religious. It emerged after the *Kennedy Report* (1970) when issues relating to children in care were in the public arena; the AWCC was influential throughout the 1970s in child/social care practice/policy (ibid, 2003, p. 2), and coincided with the development of the first formal training course for social care work in Kilkenny in 1971 (Focus Ireland, 1996). The Task Force on Child Care Services was established in 1974 following a Government decision to improve and extend services and to examine the administrative changes necessary to carry through reforms. Much of its final report in 1980 was taken up with alternative and residential child care (Howard, 2003, p. 3).

During the 1980s, the AWCC became the Irish Association of Care Workers (IACW) in view of the emergence of community services necessitating the involvement of child care workers; there was an active involvement in issues relating to registration and social care training. The association forged links with the then Regional Technical Colleges (RTCs); it held its inaugural annual conference in 1988 (ibid, 2003).

In April 1997 the Labour Court recommended the establishment of an Expert Review Group to examine and report on issues affecting ten professional groups in the health and social care sector including that of the grade of child care worker; thereafter referring to grades of staff as Social Care Professionals (*Joint Committee of Social Care Professionals, Final report, 2002, p. 2*). This committee, set up in the wake of a number of Labour Court recommendations that followed a period of industrial unrest in the social care sector, comprised representatives of the Department of Health and Children, social care employers and the IMPACT trade union. Part of the Joint Committee's task was to agree a definition of a social care practitioner so that the government and employers would be able to decide on what they did, what their status was vis-à-vis other occupations and, ultimately, how much to pay them (Share and Lalor, 2009, p. 8). The Joint Committee defined social care as:

The professional provision of care, protection, support, welfare and advocacy for vulnerable or dependent clients individually or in groups ... All interventions are based on established best practice and in-depth knowledge of life span development (ibid, 2009, p. 8).

According to Howard (2003), the 1990s brought scandals, inquiries and investigations and left the IACW battling to preserve the good name of its members, as public perceptions of what had gone wrong in some cases led to broad generalisations taking the place of fact. In the 1990s the association (while constrained by its voluntary status) provided support and advocacy locally and nationally to its members on issues relating to social care. It actively contributed to developments that led to the Children Act (2001) and was represented in the development of the National Standards for Children's Residential Centres. In 2002 the association established a permanent address and e-mail; in 2004, the

letter 'S' for 'Social' was introduced into the then title IACW (Irish Association of Care Workers (IASCW) (Howard, 2003).

As a representative body the IASCW was described in 2005 as 'fragmented, unrepresentative and relatively ineffective as an organisation' (Byrne and McHugh 2005, cited in Lalor and Share 2013, p. 50), though this may have since changed. The social care managers' organisation, now the Irish Association of Social Care Managers (IASCM), has been better organised and more reflective of its members' base. In the educational field, the representative body is the Irish Association of Social Care Educators (IASCE), has been active since 1998. In 2010, SCI was established as an umbrella body to incorporate the three representative bodies (Williams, 2011). It seeks to represent and develop the whole of the social care sector and has been active in the organisation of conferences; in working with CORU on the issue of registration; in making submissions to government; and in linking practitioners, students and educators (Lalor and Share, 2013, p. 50). SCI appointed a CPD officer in 2013 and produces an e-bulletin, available on its website.

To date, the most influential occupational groupings have probably been the major trade unions that represent social care practitioners (IMPACT and SIPTU). They have been successful in significantly enhancing the salaries and conditions of their members and in influencing major employers such as the HSE and some in the non-governmental sector to establish minimum standards of qualification, at degree level, for practitioners in some employment sectors. The State remains the strongest influence on the social care professionalisation project in Ireland. In November 2005 the most significant piece of legislation to date in relation to the professionalisation of social care practice, the Health and Social Care Professionals Act 2005, was signed into law. Statutory registration of social care practitioners may take place in 2016 (IMPACT, 2014). Professionals intending to work in centres will be required to have a qualification in social care practice.

2.1.3. What is Social Care Practice?

It is essential for practitioners in centres to engage in quality social care practice. Share and Lalor (2009, pp. 3-21) have sought to define and explore the domain of social care, drawing on widely-used definitions from policy and practice domains. They (2009, p.5) state that a basic definition of social care practice, agreed by IASCE, explains the following key terms discussed under the headings of: a profession, planning and delivery, quality care and other support services, individuals and groups, and with identified needs, that help to mark out the territory of social care practice. Starting with 'a profession' Share and Lalor explain that:

Social care practice is not just an ordinary job, nor is it something done on a voluntary or amateur basis ... The notion of 'professionalism' also implies that this is an occupation with some status and one that requires

access to a specific body of skills and knowledge (Share and Lalor, 2009, p. 6).

This ‘intent’ may not be reflected in practice: qualified practitioners employed as care assistants (as occurs mainly in the disability sector) as was the researcher’s experience¹¹, are not paid the social care rate of pay, despite having a four year honours degree in social care. Social care pay rates are applicable if practitioners are employed in residential child care centres, indicating that recognition of the status of the occupation varies by sector.

While exploring ‘planning and delivery’ the authors’ mention that:

Social care is not just about providing services, but also about devising and planning them, requiring staff to have the skills of providing hands-on care and support to people as well as the ability to identify what people require and the ability to be able to plan accordingly, preferably drawing on available evidence and policy guidance (Share and Lalor, 2009, p. 6).

Delivery and planning of services, especially in HSE settings, tends to be carried out by senior staff. Such staff may have worked in administration/elsewhere but may not have come up through the residential child care ranks. Parallels may be made with the recruitment of hospital management staff.

Once plans are decided, such managers usually hold meetings with either the principal social worker or social care manager to discuss them. They are then implemented with the assistance of practitioners, although prior consultation involving practitioners regarding issues/plans rarely takes place.

In discussing ‘quality care and other support services’, the authors state that:

Social care is about the provision of quality care, and also about providing other supports (Share and Lalor, 2009, p. 4)

The quality of care for children in care in Ireland has improved since 2010/11, as can be seen with regard to some issues discussed above by Smyth (2010), O’Brien (2010) and Buckley (RTE News, 2011). For example, most children (94 per cent) in 2012 were allocated a social worker, while 90 per cent had a written care plan in place (HSE, 2012b).

When emphasising ‘Individuals and groups’ Share and Lalor suggest that:

Social care can be either provided in a one-to-one situation but can also mean working with small or large groups of people (Share and Lalor, 2009, p. 6).

¹¹ Information is based on the researchers’ and some of her work-colleagues’ experiences

Practitioners tend to work in pairs in centres and, while seamless working is attempted and expected, sometimes it can be disrupted given that many additional professionals can be working at the same time with a child. Practitioners can experience complex group dynamics, in-groups and hierarchies that new recruits have to familiarise themselves with. Some recruits can find it difficult to ‘fit in’ coming immediately from college. Although older, more experienced practitioners may not have a theoretical background, they will have learned and accumulated tacit knowledge over time, therefore there is a sharing of new and old knowledge/learning, similar to newly professionalising groups.

In some cases new recruits experiencing difficulties at work may leave, which can account for high turnover of staff. In the *Someone to care* report (McEvaney et al, 2013, p. 178), young adults ‘repeatedly expressed their frustration when trying to build relationships because of the high turnover of staff in residential care centre’.

Colton and Roberts (2006, p. 14) explain that high staff turnover in children’s services is a key policy and practice issue on both sides of the Atlantic. The highest staff turnover in the children’s workforce in England was recorded in residential care, at 26 per cent per annum in the South East (Social Services Workforce Analysis, 2003), but figures may be different in Ireland where the workforce is more qualified and probably better paid. The financial cost of such turnover and the inevitable disruption in the care provided proved problematic, particularly for managers who cite rates higher than 15 per cent as unmanageable (Training Organisation for the Personal Social Services England, 2004).

Share and Lalor, in continuing the discussion of ‘with identified needs’, state that:

Traditionally the ‘client group’ of practitioners in Ireland has been children in the care of the State and voluntary organisations; now, practitioners may find work in diverse fields and with various groups across the birth to death spectrum, in the community (Share and Lalor, 2009, p. 6).

As practitioners find work across such diverse fields, it is incumbent on them to recognise the importance of forming positive relationships with those in their care. In acknowledging this need, some qualities listed by the Williams Committee (1967, p. 45) remain pertinent: knowledge of complex human personalities, energy and resourcefulness and capacity to take decisions when definite action is called for. These qualities can be capitalised on by encouraging independence in children/young people; looking at how to weigh the balance of risks; encouraging self-esteem that is so often damaged by being dependent on others for care; and protecting privacy (Rogers, 1990, p. 46).

While social care provision has improved over the past few years, so too has residential child care, a unique environment in which ‘practitioners take as the theatre for their work the actual living situations as shared with and experienced

by the child' (Ainsworth 1981, p. 234). Practitioners share the life-space, described as the therapeutic use of daily life events in residential settings (Clough 2000, p. 25; Murphy and Graham, 2002). Residential child care aims to provide a safe, nurturing environment for children who cannot live at home or in an alternative family at a particular time in their lives (Ferguson and O'Reilly, 2001). This work involves, not just knowing about what to do, but is also concerned with finding ways to put that knowledge into effect and to bring about desired ends (Clough, 2000, p. 28). Practitioners can get to know and understand children quite well even though they may be only in the centre for a short-term three to six month placement. Some people may describe this type of work as a vocation, as staff can be working with some very traumatised, damaged and un-integrated children/young people who may project their emotions onto staff.

Practitioners sometimes see worthwhile transformations resulting from their work; it can be beneficial to give children time and to listen attentively to them; this can boost their confidence and self-esteem. Individual attention may have been lacking in their lives up to this point. This work could be further enhanced if practitioners were given up-to-date relevant training in innovative ways to address children's problems. Through their own successes practitioners are given the impetus to continue doing this work as they can see the differences they can make in children's lives in a short time. Practitioners interviewed by Meenan (2002) about key skills and attributes for working with young people identified the need to be: non-judgemental; team member; good communicator (oral and written); good listener; problem-solving; patient – remaining calm in crisis; awareness of self; caring nature; assertive; open to learning new things; understanding; creative and imaginative; and have a sense of humour (cited in McHugh and Meenan, 2009, p. 296). The evidence above shows that social care practice is an evolving, complex concept requiring practitioners to have varied skills.

2.1.4 What do practitioners do?

Practitioners' work includes key working skills, doing life story work, and engaging in one-to-one work. They can also be involved in staff training and development (when available) and are expected to know about case management, use and interpretation of policy, report writing and formal recording. Team leaders and senior managers are involved in client contracting and supervision of staff, among other things. Anglin (1992) cited in Lalor and Share (2013, p. 16) shows direct service to clients and organisational activities where practitioners can be employed. Practitioners may be employed in the State (statutory) sector: in the HSE/Tusla; or in voluntary organisations such as Barnardos; or in private organisations, such as: Gateway, Freshstart, or Positive Care Ireland.

Emotion is at the centre of practitioners' work; sometimes they can be working with children of 12 years of age or younger, placed in care and struggling with many life changing issues in their lives. Practitioners aim to ease their discomforts

as well as helping/advocating (Bateman, 2000; Henderson and Pochin, 2001) for them or on their behalf while trying to give them a life on a par with their peers in the community. Individually, and in groups, practitioners use care programmes; assisting and providing access to the child's family/significant others; supervising access visits where necessary; and performing domestic duties such as cleaning and cooking and providing an appropriate role model for children (IMPACT, 1998, cited in Williams and Lalor, 2001, p. 6). Allowing for evidence of progress, it can be argued that there is still room for improvement.

2.1.5 Room for Improvement

The *Kennedy report* (1970) initiated improvement and changed how practice was done in residential child care centres in Ireland; it was influential in shaping the education and training that practitioners received; it instigated the education of practitioners in third level colleges. From then on educators and agencies worked together and their experiences culminated in evidence published in many other reports, including the *Ryan report* (2009) that documented malpractices of the past and made recommendations for changes for the future. Now, practitioners need extra supports as they work in increasingly intense environments. Despite considerable progress thus far, Shatter (2010) cited in Minahan (2010) claimed that 'the entire childcare protection service was dysfunctional', albeit that he was an opposition politician at the time. In effecting some change, the Children's Rights Referendum was passed in November 2012 (Sheahan, 2012). While advancing child protection, ultimately this will impact on practitioners' work as more children may be taken into care.

Despite improvements, including ideal or 'formal' definitions of social care, Williams and Lalor (2001) declared the public in general still do not really know what practitioners actually do. Interviewees in their study saw practitioners as 'minders' or 'baby-sitters' as some graduates found work in crèches, playgroups and private/public pre-schools. Moreover, the public often confused the role of practitioners with that of social workers; everyone appeared to know about the work of the latter occupation. In the Irish context, the role of the social worker is typically to manage the 'case', for example, by arranging the residential placement setting, co-ordinating case review meetings and negotiating the termination of placement (Share and Lalor, 2009, p. 11).

For Williams and Lalor (2001, p. 83) residential care, and social care in general, has had great difficulty in establishing a unified and recognised job title. Furthermore, while college can prepare students to work in residential child care, it can be argued it does not fully prepare them for the gamut of emotional challenges that they will encounter. It can be difficult for young students, mainly females (Williams and Lalor 2001, p. 23) coming straight from college. They may have had no experience of a residential care placement, prior to working in a centre with young people who are just slightly younger than themselves but who

come from disturbing, dysfunctional, family backgrounds. Yet such students have to try to understand these young people in order to effectively work with them.

Students will encounter other professionals at the centre, such as gardaí/social workers but may not fully understand their roles; what may be beneficial would be to have workshops prior to placements where students could meet/liaise with all possible professionals whom they would be likely to meet while on placement. Practitioners are tested in trying to address the needs of escalating numbers of challenging children/young people coming into care. Trying to strike the right balance between positivity and negativity is essential when dealing with issues of adversity. Unlike now, at the time of the larger institutions staff did not understand or recognise resilience in some of the children/young people in care.

2.1.6 Resilience in Social Care/Residential Care

Resilience has become a ‘hot topic’ in residential care, both for clients and staff. Practitioners as well as academics and professionals realise and acknowledge that children have learned to become stronger and resilient in trying to cope with their situations before being placed in care. Now, due to enhanced professional practices gained through college and in work experience, practitioners are more equipped to respond to resilience. For Gilligan (2005, p. 105):

Resilience is about doing better when bad things happen; children may only show resilience in certain parts of their lives; because some can do well, it prompts us to consider how other young people in care might be helped to do well and what carers and others can do to assist the process.

Practitioners can perform a critical role in child welfare as well as playing a major part in nurturing and promoting any potential for resilience-enhancing opportunities for young persons in their care. Anglin (2004, cited in Colton and Roberts, 2006) has argued that over the last 35 years the US and UK literature on residential care demonstrates ‘how the approach has survived’ (p. 173). In residential child care there can be risks to children of experiencing stigma because of the low social status often associated with being in care, and the risk of experiencing isolation, both from people who are close to them outside the care system and from normal social opportunities. Gilligan (2005, p. 105) suggests that resilience is enhanced not by some ‘high tech’ specialist practice but by attention to the fundamentals of good care: good relationships, purposeful engagement in valued tasks and in opportunities for enriching social and educational experiences.

Gilligan (1998, p.2) claims that:

The potential for encouraging resilience can only be fully realised through alert professional practice, imaginative engagement with potential ‘natural’ mentors, supportive agency policy, effective care planning

systems, and relevant training through professional supervision for social workers and practitioners.

Practitioners who work closely with children/young people can be adept at recognising that resilience is enhanced by successful coping with life's challenges while recognising that attempts to shield children completely from stresses can be damaging as well as futile (Rutter, 2000). Practitioners work on the principles of resilience by using practical applications while knowing that risk factors are cumulative – the presence of one increases the likelihood that more will emerge and transition points in children's lives can be both threats and opportunities. Where the cumulative chain of adversities can be broken, most children are able to recover from even severe exposure to adversities in early life (Newman, 2004).

In reinforcing the importance of resilience, Gaffney (2010) refers to a concept in psychology called flourishing: people who overcome difficult times are those who learn resilience and part of this is to get people to refocus their priorities. In addition to focusing on children's resilience, research by Fink-Samnick (2006) aimed at social workers but also pertinent to practitioners, found professionals need to be aware of the importance of a solid 'sense of self' to their emerging identities and in reinforcing their resilience be alert to their own self-care. As the above data implies, practitioners have come to appreciate that children have existing resilience; this has changed how practitioners work with them. Recognising resilience can promote growth and development needs both in the context of children/young people and staff, even in times of economic instability.

The research above indicates that many changes have occurred in social care and in residential child care practice, bringing it to its present position. While widely used definitions state the ideal position in practice, on the ground there are tensions and clashes between the ideal and reality on various issues such as resources, status and pay. Changes in practice have come into being partly in response to recent reports on child protection failings including inconsistency and fragmentation of service provision. Qualified practitioners work in a relatively isolated setting now in centres, in comparison to previously. In large institutions there was always someone to call on when things went wrong. Practitioners need extra supports because of caring for vulnerable children, some who may be more demanding and challenging.

2.2 CHANGES IN THE NATURE OF THE CLIENT GROUP

This section examines if children/young people in care are more challenging now despite the improvements that have taken place. Chapter one (1.4) outlined current challenges presented by children coming into care now and this chapter expands on that discussion. Topics of discussion include, why residential child care work can be challenging and personal qualities required to be a practitioner.

2.2.1 Challenging Times

There is little research that specifically profiles young people in residential care in Ireland. This area is not well documented in the Irish sector. Darmody et al. (2013, p. 28) point out that:

At present in Ireland – and in contrast to policy and practice in the case-study jurisdictions examined for the purposes of this study – there is a significant deficit in data relating specifically to children in care. This deficit is indicative of a wider shortfall in systematic, comprehensive data on children that has been a focus of concern, not only in Ireland, but also internationally.

Indications of the issues come from practitioner knowledge, and broader data about disadvantaged and marginalised young people in Ireland. Thus, chapter one outlined some challenges for practitioners working with children in care, such as abuse, bullying, self-harm/injury, suicide ideation and issues around alcohol and drugs, amongst others. Depression is another issue that practitioners have to deal with. Reilly (2012) reports that depression is on the increase; the depression support group *Aware* recorded a 29 per cent increase in calls from distressed people in 2011 with the agency's support services taking more than 370 calls a week. Frequently, practitioners experience children who appear to be depressed or think/say they are depressed, some presenting with classic symptoms of depression. Some children are cued to the symptoms of depression as a parent/family member may be treated for the condition. Practitioners are not trained in how to treat children with depression; this can make it difficult for practitioners to care for these children or to interpret their behaviour.

Another aspect of practitioners' work that is influenced by the economic recession is the consequences of deprivation in Ireland. The European Anti-Poverty Network (EAPN) Ireland, discussed CSO (2011b) figures published in Feb. 2013 that revealed rising levels of deprivation:

- 25 per cent of the population in deprivation (up by a half in 2 years)
- A third of children living in deprivation
- Twice as many people at work (15 per cent) in deprivation compared to 2009
- Lone parents and unemployed hardest hit

Hanan, Director of EAPN Ireland, commenting on these figures said:

These figures confirm what our members are telling us from their work on the ground. A series of policies and cuts have made life harder for people on low incomes, making it more difficult to move into reasonably paid work. It has been Government policy for years to 'poverty proof' all

policies, to make sure that they either reduce or at least don't increase poverty. In practice, this has not been applied to most of the policies which affect the day to day lives of people living with poverty, such as the Budget, the Finance Bill and employment strategies. We have the figures; we have the targets, now the Government, and the country, need to get serious about fighting poverty. These figures are shocking but not surprising (EAPN, 2013).

Stories of ordinary people at 'breaking point' after three years of austerity policies and up to six years of recession, are described in a report titled: *Now You See Us: The human stories behind poverty in Ireland*, published in 2014 by the Community Platform, an umbrella group of 30 national organisations working to combat inequality and poverty (Holland, 2014a).

In addition, while it is difficult to get official figures, but based on practitioner evidence, a high proportion of children in care are from low-income and/or one parent families. The following facts give a snap-shot of information on one parent/low-income families in Ireland:

- 1 in 4 families with children in Ireland is a one-parent family (Census, 2011)
- Almost 1 in 5 children (18.3 per cent) live in a one-parent family (Census, 2011)
- There are over 215,000 one-parent families in Ireland today – 25.8 per cent of all families with children (Census, 2011)
- People in lone parent households tend to have the lowest disposable income out of all households in the state (EU-SILC, 2010)
- Those living in lone parent households continue to experience the highest rates of deprivation with almost 69 per cent of individuals from these households experiencing one or more forms of deprivation (EU-SILC, 2010) (One Family, 2014).

Burke's (2011) report: *Eliminating Health Inequalities – a Matter of Life and Death* on health inequalities in Ireland states that:

Regressive budgetary measures over the last three years have had a disproportionate impact on low-income groups. These measures will contribute directly to higher levels of poverty and deprivation – and thus to increased health inequalities. Reducing the incomes of those who are already struggling to meet their basic needs has a direct impact on their health and wellbeing in the short and long term.

Holland (2014b) reports that the number of women experiencing multiple deprivations almost doubled between 2008 and 2011, from 321,000 to 600,000.

More women than men suffer deprivation. Among those most vulnerable to poverty are lone parents and their children. Over 60 per cent of lone parents in Ireland – both in the Republic and Northern Ireland - are at risk of poverty. This compares to an EU average of 50 per cent. Women are also disproportionately affected by low pay, being dominant in part-time and contract work and in such lower paid sectors as cleaning, child-minding and retail (ibid, 2014b).

Edwards (2014) reports that violence against women is also a problem; several agencies held a seminar in Dublin to mark the publication of Europe's biggest survey to date on violence against women. A total of 15 per cent of Irish women (223,495) had experienced physical or sexual violence by a partner but funding for rape crisis frontline services was cut by 16.5 per cent between 2009 and 2013, with further cuts confirmed for the future (ibid, 2014). Furthermore, Gartland (2014) reported that applications to the courts for protection from domestic violence had risen by almost 20 per cent, from 2011 to 2012: applications made under domestic violence legislation increased from 10,652 in 2011 to 12,655 in 2012. These trends may ultimately have an impact on the work of practitioners in that some of the children in these families may need to be placed in care (even though there is no evidence to specifically show this, but personal experience is showing this is what is happening) for their safety and welfare.

HIQA inspection reports have reported on work practice challenges: a HIQA inspection of a children's high support unit (2013b, p. 20) noted:

Inspectors found that staff were challenged to meet the complex needs of the children and young people in the unit and staff did not all have sufficient training, knowledge or skills to safely deliver the service as outlined in the statement of purpose (p.20). While some progress had been made since the July 2013 inspection there continued to be ongoing risks to children, young people and staff within the unit. There was a lack of confidence amongst the staff team in how to address children and young people's individual and group challenges during periods of disruptive behaviour.

A follow-up inspection of a centre in the HSE Mid Leinster area (HIQA: January 20th 2014) found that:

At the time of the previous themed inspection in April 2013, inspectors had significant concerns regarding the staff in the centre's ability to effectively manage the complex and sometimes unsafe behaviours of children and the lack of school placements ... The inspectors found that strategies used to manage children's behaviour continued to be ineffective as children living in the centre (new admissions since last inspection) continued to engage in unsafe and harmful behaviours on a regular basis.

The Children Acts Advisory Board (2009b, cited in *Youngballymun* 2010, p. 47), noted that carers in residential units have expressed concerns to inspectors about feeling overwhelmed by the challenging behaviour and complexity of needs of some children in their care. McEvaney et al (2013, p. 80) cite that ‘where children and young people have high levels of challenging behaviours, professionals noted they are harder to place in foster care and that residential homes are resisting taking them’.

McEvaney et al’s (2013) study also discussed challenges experienced by professionals in building trusting relationships with young people who have experienced trauma, often of a relational nature; the need to find ways to engage these young people so they can access the help they need; the struggle of working with those presenting with challenging behaviour, of seeing beyond the anti-social behaviour to the child who is still developing; and the additional training that is needed to be able to respond to such children in their time of need. Based on and in agreement with McEvaney’s study, residential child care work can be challenging for practitioners as children can be troublesome, leading to volatile environments with heightened tensions and constant argumentation.

2.2.2 Why Residential Child Care Work can be challenging

Practitioners work long hours partaking in many challenging situations on a regular basis. While this work can sometimes be rewarding, mostly it can be emotionally and physically challenging; it can involve working with some children that may have experienced multiple loss, rejection, deprivation, neglect and abuse. In many cases there can be a large gulf between desires, expectations and reality (Share and Lalor, 2009, p. 19) and trying to address issues for children/young people can leave practitioners psychologically exhausted after their shift, especially if they do not have proper answers to various issues.

Practitioners may have cause to be absent from work because of the risk of potential violence. Violence can be witnessed in centres including high support units, where children/young people (a) do not want to be in the first instance; (b) have been removed from their place of origin and their families; (c) are locked up for a good part of the day; (d) are distrustful and resentful of perceived authority figures; (e) are facing lengthy sentences (McHugh and Meenan, 2009, p. 291).

We earlier referred to HIQA’s (2011) criticism of overuse of agency staff in secure units for children with behavioural issues, such as Coovagh House in Limerick and Ballydowd in Dublin. Practitioners in these centres have been the subject of attacks by young people, which can lead to prolonged sick leave. It can be difficult for staff trying to cope with aggressive behaviour of children/young people. The report: *Growing up in Ireland* survey (ESRI, 2013) found that ‘young children who were brought up in families where parents were in some form of stress were more likely to display behavioural difficulties, which when displayed by children at three years were related to changes in the stress levels of their

parents since the children were nine months old' Some of these children may be already in care or come into care in the future.

Commenting on the report by Redmond et al (2012): *The Retention of Social Workers in the Health Service: An Evidence-Based Assessment*, Jeyes (cited in Holland, 2012) describes staff burnout as: 'chronic stress, containing elements of chronic exhaustion, depersonalisation and reduced feeling of personal accomplishment'. Although addressing and reporting on social workers, this report found burnout to be a particular problem among childcare workers. Humphreys (2013), reporting on stress and burnout amongst Irish workers in general, quotes Freeney, a specialist in the field, who states that: 'People are experiencing different types of stress as a result of the downturn in the Irish economy'. While she notes a lack of data on trends in work-related stress, she claims studies indicate that it affects more than 25 per cent of employees. A report for the Health and Safety Authority (HSA) put its cost to the economy at €200m a year (ibid, 2013).

Some practitioners have experienced violent outbursts that have been unpredictable, frequent or sporadic, depending on the residents in question. Woulfe (2008) discussed a violent incident involving a male care worker and three young people in a secure unit in Limerick. Lombard (2010) reported that one in five of all workers in Britain who have been signed off after work-related assaults are employed in social care. In addition, social care accounted for 19 per cent of all injuries involving assault in all sectors across the UK economy in 2009-10, according to the Health and Safety Executive, despite only representing 5 per cent of the country's workforce. The rate of major injuries to social care workers in Britain has more than doubled since 2001-2, with a 33 per cent increase in 2008-09, maintained in 2009-10 (Lombard, 2010).

The above reports support the premise that practitioners working with these vulnerable children/young people need adequate ongoing professional CPD training (which is just one part of a response to such issues, it will not of course solve them in itself) as this work is very stressful on many fronts (Smyth, 2010). Stressful work and needing to take sick leave from work regularly can contribute to other social problems. Due to the nature of the work, everyday demands of the job require practitioners to have certain qualities.

2.2.3 Personal/Academic Qualities required by Social Care Practitioners

Varied qualities are required by practitioners, such as: 'academic' qualities including a broad knowledge base in the field; the ability to work both independently and as part of a team, research skills and a problem-solving approach. From their thesis work practitioners may have developed research skills; from their work experience together with their learned theory, they may have acquired the knowledge to work on their own initiative by using a problem-solving approach. Practitioners are aware that there are key aspects of the work

that cannot be fully learned through the educative process in higher education institutions; the qualification is a base that needs to be further developed built on and maintained through CPD. After attending college for three/four years, most practitioners will have acquired some level of expertise to boost their work.

Certain personal attributes tend to characterise practitioners, such as reliability and trustworthiness, altruism, empathy and compassion and maturity. Practitioners must be open-minded and prepared to examine and perhaps even change their attitudes towards others (Share and Lalor, 2009, p. 14). In accepting these new challenges, practitioners will be open to learning new knowledge and skills that can be shared with their colleagues. Kennefick (2006, p. 213) states that the core task of social care is the act of one individual (the worker/practitioner) facilitating the development of another (the client/child), an act of support or help from one human being to another.

Because of the many needs of children/young people, practitioners need a variety of skills and a breadth of knowledge to perform the task effectively and professionally and ‘the principle tool of the practitioner is the self’. This statement captures the simplicity and complexity of the task (ibid, p. 213). The importance of the self is also referred to on p. 74 by Ginnott (1972, p. 47) and the use of self in social work has been discussed by Dempsey, Halton and Murphy (1997). With reference to self in residential child care work, this is discussed as follows by Holden (2009, p. S10):

The most valuable tool we have in therapeutic interventions with children and young people is ourselves ... We help young people to meet their basic needs and have countless opportunities to interact with young people in an open consistent and caring manner. Those of us who spend the most time with young people have the most influence on their behaviour and growth. It is very important to be aware of how our personal preferences and biases affect our interactions and interventions with young people. How we behave will affect how the young people in care will behave...

Effective care workers are aware of their goals, values, beliefs and self-talk –all of the components that make up self-awareness (Holden, 2007). Understanding our own feelings, strengths and limitations can help us manage our emotions in stressful situations such as crises ... We need to have the skill to self-regulate our own emotions if we are going to be able to successfully resolve potential crisis situations. Knowing personal triggers, possessing good observation and assessment skills, and showing flexibility to adapt to changing situations are critical skills ... therapeutic use of self in the role of care worker requires some introspection and reflection regarding our ability to handle situations similar to painful past experiences and willingness to get help if it seems that we cannot honestly say that the past is “finished”. Caring for challenging young people can be

very intense at times and can bring up painful memories. Life experiences do affect the way we work with young people and their families. Being emotionally competent and self-aware are keys to successful child and youth care work

The implications for training and ongoing professional development are far-reaching and complex; a dual focus approach is required: a focus on the actual work to be done – the task - and an equal focus on the person doing the work (O’Neill 2004, cited in Kennefick, 2006, p. 213). While the above research indicates that some advances have been made, still more work needs to be done to enhance professionalisation of the workforce by addressing the needs of practitioners.

2.3 PROFESSIONALISATION OF THE WORKFORCE

Aldridge and Evetts (2003, p. 555 cited in Share, 2013, p. 47) suggest that professionalism has become a way that both workers and their managers talk about work practices – a process that can have benefits, and drawbacks for each. They argue that above all ‘professional’ has entered the English language as a generic term that represents something ‘good’. While section 2.1 above examined the changing field of social care practice and section 2.2 explored if clients have become more challenging, this section assesses if *good* has happened to advance professionalisation in social care/residential care over the past decade through discussing educational qualifications, CPD, competencies and reflective practice.

In assessing the previous sections we saw the transition for children/young people from larger institutions to bungalows (centres) in communities. While there is a paucity of information available about centres, the snapshot of numbers in residential care uncovered figures showing an increase in the numbers of children being placed in care (Darmody et al, 2013). Another change in the field of social care practice is that SCI, the body that represents practitioners, has developed historically and continues to develop and promote good social care practice and the professionalisation of the workforce by coordinating courses and conferences.

Share and Lalor (2009) focused on professionalisation through an exploration of the key terms: ‘profession’; ‘planning and delivery’; ‘quality care and other support services’; ‘individual and groups’; and ‘with identified needs’. Having a thorough understanding of good social care practice is essential for practitioners whose diverse work can include working with children as young as 10 years of age who can be struggling with many life-changing problems. While professionalisation of the workforce has improved greatly since the inception of the *Kennedy report* (1970) there is still room for improvement because, as pointed out by Williams and Lalor (2001), ‘the public in general still did not know exactly what practitioners did’. Despite this, practitioners are continuing to professionally develop their practice and it can be argued, based on the explanations above about

resilience (p. 35) that practitioners are more attuned now to children's/young people's resilience as well as their own resilience in addressing complex situations.

It is incumbent on practitioners to work in a professional manner because, as we have seen, there are challenging times now in this profession because children/young people being placed in care can present with contentious issues. This type of work requires a certain type of person/practitioner who possesses certain personal qualities in addition to academic qualifications. Educational qualifications are at the forefront of professionalisation for practitioners.

2.3.1 Educational Qualifications

Educational qualifications are continuing to advance practitioners' professionalisation. Higher education institutions work with employers and prepare students for this type of work by teaching them relevant modules of interest that will give them knowledge and expertise to help them to address various experiences that they may encounter later on when they are at work. Giddens (1989, p. 746) identifies one definition, but not necessarily the only way of looking at professionalism, by suggesting that professionals are: 'occupants of jobs requiring high levels of educational qualifications, whose behaviour is subject to codes of conduct laid down by central bodies or professional associations'. In Ireland, the basic qualification for residential care practice work is the BA (Ordinary) degree in applied social studies/care practice, taught in institutes of technology or the social science degree taught in universities, together with relevant work experience. Recognised qualifications are detailed in Schedule 3 of the Health and Social Care Professionals Act 2005 (Irish Statute Book, 2013).

Many qualified practitioners go on to complete an Honours Degree (NQA Level 8) in the field, and an increasing number progress to postgraduate studies. Mature students (23+ years) are welcomed onto social care practice courses (Share and Lalor, 2009, p. 16). The Institute of Technology, Sligo is one example of a course that students can take; it is fairly typical, but courses can differ. Students are required to do two supervised work placements, one in year two and usually but not always a residential placement in year three. Students can take up placements in agencies all over Ireland as well as in the USA, South Africa, Sweden, Vietnam and elsewhere; subjects include, among many others, introductory sociology, children at risk and social psychology (IT Sligo, 2013).

These subjects are beneficial as the knowledge garnered from them equips students to deal with some of the issues and experiences they may encounter both on placements and afterwards while at work. This learning can give students a theoretical background into, amongst other things, how the law works, how people are integrated in society, how communities are formed and sustained as well as providing an understanding of problems encountered in centres while working with marginalised children/young people. It can be argued that most

practicing practitioners would agree with Williams and Lalor (2001, p. 18, citing the National Care Workers' Vocational Group) who affirm that professional qualifications should be seen as essential, not just as desirable, for all centre staff. In addition to educational qualifications professional knowledge and wisdom is developed through a combination of education and CPD.

2.3.2 Continuous Professional Development (CPD)

This section explores the key issues and trends surrounding CPD: the continuing education of professionals after completion of formal training and the underlying belief that professionals need to renew and enhance their knowledge, skills, attitudes and behaviours, throughout their professional life cycles (Halton, 2014). While the process of professionalisation has been ongoing and practitioners have been receiving a certain amount of CPD training, we have seen there is a contrast between the professionalisation agenda and what is happening on the ground in terms of CPD. This deficit has been identified in the earlier review of literature and is reflected as one of the key issues addressed by CORU (2013a).

The early years of this century have witnessed a change in Ireland from the notion of intermittent training for professionals to an acute emphasis on the concept of CPD. This is evident across the spectrum of professions, from pharmacists (Pharmaceutical Society Ireland, 2015); to engineers (Engineers Ireland, 2015); accountants (Chartered Accountants Ireland, 2015); teachers (Teaching Council Ireland, 2015); psychologists (Psychological Society of Ireland, 2015); solicitors (Law Society of Ireland, 2015); surgeons (Royal College of Surgeons, 2015); dentists (Irish Dental Association, 2015); nurses (Nurses and Midwifery Board of Ireland, 2015); social workers (Irish Association of Social Workers (IASW), 2015a); and finally to social care workers (SCI, 2015a), the focus of this thesis.

Professions such as doctors, nurses, dentists and pharmacists have been regulated for many years. Some professions with established CPD frameworks are now updating their policies such as the Irish Association for Counselling and Psychotherapy (IACP). In recognition of the importance of CPD; some colleges including University College Dublin (UCD, 2015) are providing programmes for their staff in how to develop CPD in their schools. Residential social care practitioners liaise regularly and work closely with social workers. Prior to the establishment of CORU, Ireland's first multi-professional health regulator, social workers were in the process of incorporating CPD into their practice and already had a CPD framework (IASW, 2013a; 2013b).

CORU is the umbrella body responsible for protecting the public by regulating health and social care professionals. It comprises Registration Boards and the overseeing Health and Social Care Professionals Council, established under the

Health and Social Care Professionals Act 2005 (as amended), to regulate the following designated professions (CORU, 2015a)¹²:

Register open (2015-16)

- Dietitians
- Occupational Therapists
- Radiographers and Radiation Therapists
- Social Workers
- Speech and Language Therapists

Still to be registered (as of 2016)

- Clinical Biochemists
- Medical Scientists
- Orthoptists
- Podiatrists
- Psychologists
- Social Care Workers
- Physiotherapists

As well as regulating the professions, CORU (2015) promotes CPD by providing public consultations and information for employers, stakeholders and professionals (CORU, 2013c, 2015b), CPD workshops, education, research and publications (CORU, 2015c). As chapter one and the two previous themes have shown, changes in the field of social care practice have been occurring both from an international as well as a national perspective for many years.

In preparation for the development of a CPD framework, CORU (2013d) undertook research with a selection of national and international regulatory agencies, primarily in the health sector, to show how evidence/data was collected to demonstrate that CPD changes were needed in these professions. They investigated case studies to provide some insight into the provision and regulation of CPD amongst the designated professions under the Health and Social Care Professionals Act 2005. The research was designed to inform the development of a uniform but flexible system of CPD designed to accommodate the diversity of health and social care professions under the remit of the Act (CORU, 2013d, p. 4). Case studies included the following:

1. CPD provision by healthcare and non-healthcare agencies with a regulatory function in Ireland, namely:
 - a. An Bord Altranais
 - b. Chartered Accountants Ireland
 - c. Medical Council
 - d. Pharmaceutical Society of Ireland
 - e. Royal Institute of Architects of Ireland

¹² The discussion of CORU and its activities, as well as other facts/figures/data discussed in this section relates to November 2015 when the latest information was available, at time of writing.

2. Regulatory bodies in international context such as:

- a. Australia
- b. Ontario, Canada
- c. South Africa
- d. United Kingdom

3. Table showing current CPD provision by professional bodies of 17 designated professions.

CORU explored: the protection of the public; the definition of CPD; recording of CPD; the range of CPD activities; the issue of compliance; CPD providers; supporting and enabling CPD; and models of CPD.

Following this review (2013d), CORU generated various models of CPD and in March 2013 launched a public consultation on a framework scheme for CPD with their document: *Framework for Registration Boards: Continuing Professional Development Standard and Requirements* (CORU, 2013b, p.8). CORU sees the development of the framework and engaging in CPD as very important as ‘active engagement in CPD is critical to ensuring that you continue to have up to date knowledge and skills to deliver a safe and effective service to service users’ (CORU, 2015i). Moreover, CPD is a wide-ranging concept that encompasses:

Academic and practice development and, equally importantly, informal learning and learning and development in the workplace and any development which contributes directly to improving the quality of care received by service users (SSSC, 2004, cited in Halton et al, 2014b, p. 2).

Like the IASW framework, CORU’s CPD framework contains a CPD portfolio that includes assessment of outcomes and records of CPD activities. Receiving or providing supervision is also recognised as a CPD activity. As mentioned above, social workers already had a CPD policy; being the first profession to be regulated by CORU. By exploring the pathway of social workers CPD in the following paragraphs, it gives an example of CORU in action and how a similar CPD plan could be used in the future by residential social care practitioners/managers, given their close working relationship with social workers.

Social Workers

The IASW launched its CPD policy in April 2009, in advance of the CORU Social Work Registration Board's CPD requirements, to facilitate social workers to record their professional development activities and have them validated by their professional body. Many social workers use the IASW policy and log to meet the CPD requirement of registration to keep clear and accurate records of CPD. Outlined in the policy are three types of CPD activities, listed below, that can be used by social workers and that could also be used as guidelines by social care practitioners/managers when planning and deciding on CPD activities.

- (1) Supervision
- (2) Skill development and gaining new knowledge and information
- (3) Contributing to professional knowledge and practice.

CPD requires a commitment by social workers to career-long learning as a means to keeping their knowledge and skills up to date, ensuring they work safely, legally and effectively. As reported on the IASW website (2015), in social work there has always been a commitment to high standards of professional practice. In particular social workers place a high value on the need to have access to supervision. As stated in their CPD policy, the IASW believes that to ensure on-going quality of practice, it is essential that social workers receive regular quality supervision. Social workers also know the importance of life-long learning and in order to ensure that the IASW can evidence their practice it is essential that they undertake and record this learning.

According to the IASW (2015) the majority of social workers undertake post qualification training and engage in research projects, journal clubs and peer reflection. Halton et al (2014b, p.71) cite Higham (2009) who tells us that a major component of CPD in the UK in relation to social work has been post-qualifying (PQ) awards. The IASW was aware that most social workers regularly engage in CPD activities but, prior to the development of the CPD policy, these had not been formally recognised. Statutory registration was enacted on May 31st 2011 as a means to ensuring professional social workers operate to a high standard of practice (IASW website: CPD Resources, 2015). Registered social workers sign a statutory declaration stating that they have read, understand and will meet standards set out in the Code of Professional Conduct and Ethics for Social Workers (Quinn, 2011; Irish Statute Book, 2013) Section 23 (Fig 2.1) of the Code sets out the standards in relation to CPD:

Section 23: Keeping your professional knowledge and skills up to date.

Social workers must:

- a) Make sure that their knowledge, skills and performance are of a high quality, are up to date and are relevant to your practice
- b) Maintain and develop their professional competence by undertaking relevant education and training to improve their knowledge and skills
- c) Keep up to date with relevant knowledge, research methods and techniques so that their service, research activities and conclusions will help and not harm others. For example, this can be done, by reading relevant literature, consulting with peers and taking part in continuing education activities
- d) Take part in continuing professional development (CPD)
- e) Keep clear and accurate records of CPD

Figure 2.1: Social work standards in relation to CPD

The IASW policy and log are under review so as to be aligned with the CORU CPD framework (IASW, 2015b). The IASW website provides all the information regarding registration and CPD updates for members while their CPD officer will continue to meet with teams and groups of social workers nationwide to provide seminars and Q&A sessions on CPD. IASW regularly liaises with CORU on behalf of its members and works together on a range of issues that includes the publication of the Standards and Requirements for CPD (IASW, 2015b). In summary the requirements are as follows:

1. A registrant must engage in a range of CPD activities on an on-going basis
2. A registrant must complete 60 CPD credits in each 24-month cycle
3. A registrant must demonstrate that their CPD activities are relevant to their professional role and mindful of current and future practice.

4. CPD is to be based on a self-directed review of their knowledge, skills, performance and professional qualities in the context of their professional practice.
5. A registrant must maintain an up to date CPD portfolio (CORU, 2015d). The CPD portfolio must include:
 - a. Description of current role and practice setting learning plan
 - b. Record of CPD activities
 - c. Reflections on a number of CPD activities
 - d. Evidence of undertaking CPD activities.
6. A registrant must, upon request from the SWRB, submit their CPD portfolio (which must be their own work and supported by evidence) for periodic audits of compliance with CPD standard and requirements. From 31st May 2015, the start of the 24 month audit cycle, social workers will need to fulfil these specific requirements, with the first audit occurring from 1 June 2017, and every 24 months following that (ibid, 2015).

CORU provides professional supervision information for IASW Members (CORU, 2015e). One of the core requirements is for social workers to have access to 20 hours of supervision from a qualified social worker within a 2-year cycle. IASW is aware that some social workers do not have access to supervision from a suitably qualified social worker and so need to seek supervision from outside their agency. Hence IASW offers guidance to supervisees (IASW, 2015c) seeking supervision/consultation and a list of supervisors available for supervision (IASW, 2015d).

The IASW CPD committee accredits courses relevant to the social work profession, but stresses that it is the individual social worker's responsibility to allocate CPD credits themselves (as stated in the CORU SWRB CPD Framework, CORU, 2015j) for new and enhanced learning resulting from attendance at the event. This is based on the principle that one hour of CPD learning activity is equal to one CPD credit. IASW provides new CPD opportunities in the form of mindfulness and meditation courses for its members (IASW, 2015e), a practice that could benefit other professionals including social care practitioners.

It is difficult to show evidence for the effectiveness of CPD and to identify all the outcomes of CPD, while CORU are saying we need to have it. CPD can be seen as bringing about change - change in practice but what about the resources to implement and maintain it and not only resources in terms of money but also issues around time to do CPD? Now a significant number of professions are implementing CPD; it is seen to be a good thing. So why is it so important and what are the key tensions/issues? It was acknowledged in chapter one that there was a paucity of studies that specifically related to CPD training for residential

child care practitioners in the Republic of Ireland and limited research findings elsewhere; we will revisit them now.

Studies

The studies, similar to the information pertaining to this study, spanned 20 years. They show that the meaning of CPD has been contested over time, geographically and across the professions. For example, the internationally themed studies from the Republic of Ireland, UK, Europe and Australia all looked at ways to improve CPD for residential child care professionals so that it would enhance professionalism and provide a better service for service users. One difference was that 20 years ago researchers talked about ‘training’ which was given/provided, now it is CPD, which involves the person themselves. Like CORU, these studies explored conceptual and practical ways to improve CPD.

The research identified common problems/issues that needed to be addressed. The CPD issues for social workers in Ireland (Halton 2011) were similar to those revealed by Byrne’s study (2014) with social care practitioners. While these studies have teased out the need for relevant CPD, as of yet there are no available studies showing the *effectiveness* of CPD for social care practitioners or indeed for social workers in Ireland. Interestingly, the following research studies, in relation to other social and health professions *have* evaluated CPD training. In the summary of this section, the main points/areas of contestation are discussed.

Studies on the Effectiveness of CPD

Eaton et al (2011) reviewed the mandatory CPD requirements of general dental council (GDC) registrants, in part to investigate the impact of CPD activity on individual practice and competence assurance. The overall aim of their literature review was to establish what evidence exists to demonstrate the range of likely positive and optimum impact of CPD upon the practice of dental professionals within the GDC. The review addressed questions related to: models of CPD, regulatory purposes of CPD, CPD participation and CPD performance.

Eaton et al’s (2011, p. 36) review produced few robust evidence-based answers to seven questions (listed below) posed by the GDC. The authors claim that this is perhaps unsurprising as numerous authors have commented on the difficulties of conducting robust research into educational outcomes (Bloom 2005, Marinopoulos et al. 2007, Schostak et al. 2010, Grant 2011). While this was not the purpose of this review the authors ask that they should be borne in mind when considering the conclusions, set out below, which address each of the seven questions posed by the GDC.

Models of CPD

Question 1: What are the least and most effective modes of CPD for the healthcare professions, and in particular dentistry?

Eaton et al (2011, p. 36) assert that it was evident from the literature that no studies of high quality existed to demonstrate the effectiveness of CPD, in terms of quality of care delivered, performance, professional standards, competence, public satisfaction or safety, or their longer-term effects on knowledge retention and application. Particular elements of individual CPD programmes were deemed to be effective. These include the benefits of sustained, repeated, or longer term CPD activities, involving an interactive method of delivery utilising multimedia, or combining techniques, for example, interactive education and academic detailing. The importance of planning, self-directed learning and reflective practice was highlighted, as were the perceived benefits of personal learning plans, in a process through which clinicians can be supported in the identification of their learning needs, to focus their selection of appropriate CPD (2011, p. 36).

Question 2: What are the least and most effective qualitative and quantitative measures of CPD activity for the healthcare professions, and in particular dentistry?

Overall, both the dental and non-dental literature demonstrated the difficulties in developing effective and evidence-based recommendations for quantitative or qualitative measures of CPD.

Regulatory purposes of CPD

Question 3: What are the regulatory benefits of CPD participation in dentistry?

The literature identified a range of potential regulatory benefits of participation in CPD, but did not demonstrate any direct associations with quality of care delivered, performance, professional standards, competence, public satisfaction or safety (p. 37).

Question 4: What are the regulatory processes of making CPD a mandatory requirement in healthcare professional regulation?

The peer-reviewed dental literature did not reveal any studies to demonstrate the regulatory purposes of making CPD a mandatory requirement in healthcare professional regulation. The GDC website (GDC 2011) reminds registrants that: ‘patients are right to expect that all members of the dental team are keeping their skills and knowledge up to date throughout their careers’.

CPD participation

Question 5: How do healthcare professionals, and in particular dental professionals, currently engage with, perceive and benefit from CPD; and does CPD have particular consequences for different groups and forms of practice in dentistry?

The concept of self-directed assessment of CPD needs, and reflection of any subsequent improvement or achievements, has been highlighted in a range of healthcare professional groups. For dentists especially, the benefits of the personal development plan have been highlighted. Factors motivating practitioners to undertake CPD, and barriers to CPD appear to be influenced by work-related factors such as environment, working patterns and employment status, all specific to each healthcare professional group, as well as individual perceptions of CPD.

CPD and Performance

Question 6: Is CPD participation a valid indicator of professional competence or performance? Based on what criteria?

Neither the dental nor the non-dental literature provided any information to demonstrate if CPD participation is a valid indicator of professional competence or performance. This is principally due to the challenges of assessing outcomes of CPD in terms of effectiveness and impact.

Question 7: Is there a link between participation in CPD activity and performance enhancement in the healthcare professions including dentistry, and how is that formed?

The dental literature did not address either of the two parts of this question. The medical literature suggested an association between undertaking CPD activities and enhancing performance. The benefits of targeting and management of CPD were highlighted, especially through the use of personal development plans and annual appraisals. In summary Eaton et al (2011) conclude that it is very difficult to measure the effectiveness of CPD for dental professionals.

Similar issues are discussed by Schostak et al (2010). As there had been little evaluation of the *effectiveness* of CPD they undertook a literature review and research project with the key aim to explore this. The review involved non-training doctors from staff grades to senior consultants, including those primarily involved in management, CPD provision and assessment; and institutional officials, across a range of specialties to determine their understanding of:

- Their own learning or the learning of other doctors within their organisations
- How this learning relates to conceptions of CPD, its provision and its uptake
- Effective CPD

The research was conducted by a team of clinicians and educators. In replying to the question “How do you define effective CPD for you yourself?” respondents replied in a variety of ways across a broad spectrum, as shown in the diverse range of responses in table 2.2.

The authors suggest that such diversity must be read as a strong indication, supported by the literature review (Schostak, 2009, p. 72), that CPD is personal and owned by the individual; and that the array of CPD opportunities listed suggests that CPD provision is flexible and meets people’s needs for the most part. They found that the assessment of CPD activities is another matter and deemed to be more inflexible than it could otherwise be.

Schostak et al (2010, p. 64) assert that is it possible to notice or develop a way of talking about workplace learning that might make it more visible, more learnable and hence easier to develop practices. They note the complexity of communication for consultants and comment that such skills are better assessed either by being observed in the clinical area or in a simulation. They suggest that instances of assessment might be built upon and extended to include these more difficult to record dimensions of learning. From these findings, it can be argued that what is needed here is a process such as an Activity Theory Change Laboratory (CL) (Engestrom, 2001) to discuss the contradictions and expand the professionals’ learning.

Joyce and Cowman’s (2007) study at the Royal College of Surgeons in Ireland, *Continuing Professional Development: investment or expectation?* explored the reason for nurses’ participation in post-registration education. The main finding was that the major reason for participating in post-registration education was to ‘obtain promotion to a higher grade/position’ (99%) and to ‘enable me extend my clinical role’ (98%) (p.1). The authors concluded that investment in nursing education should take into account the reasons for participation in CPD so as to focus efforts that improve planning for CPD long-term. They assert that the adoption of such a strategic approach by employers would ensure more precise targeting of scarce CPD resources and they further note that equally expectation without adequate investment is not realistic if the profession wants to move forward in this era of rapid change in the delivery of healthcare.

How do you define effective CPD for you yourself?		
Moving people on through a mixture of employing the tools of learning needs analysis and personal development plans	attendance at conferences	reading
of experiencing a dissemination of new concepts because text books are typically five years out of date	workshops	private study
“getting to know of developments within the NHS, particularly from a managerial point of view”	accumulation of credits	on-the-job learning
it involves clinical management; learning about people management skills; about knowing oneself and one’s limitations and attempting to address that	the giving of presentations	editing a journal
group-work	talking with colleagues	“corridor conversations”
meetings	ticking boxes	networking
“putting yourself next to people [so that] having recognised a weakness [...] you’ve put into place some ways of improving that”	“signing off”	
promoting evidence-based medicine	Learning to listen to the patient and knowing when to talk to the patient (child) or to the parents.	

Table 2.2 Responses to how do you define CPD for yourself?

A study by Penny (2005) noted that the Irish healthcare sector has seen radical new reforms being initiated in recent years. The author was aware that the opening of new schools and impending State Registration would place unprecedented attention on the provision of, and engagement in, CPD. The study showed that CPD was a valued and important concept, meeting a range of needs both clinical and managerial. A high percentage of respondents were in favour of mandatory CPD for registration. Managers availed of CPD opportunities similar to those that their staff engaged in. The study highlighted the absence of mentoring as a factor in CPD development for managers in Ireland and pointed to the availability of funding, time and increased staffing as key factors in the facilitation of CPD. The study indicated that CPD must be fostered and developed within all fields of Occupational Therapy, regardless of speciality and location. There was a need for it to be intrinsically motivated, and therapists should not rely on fulfilling statutory requirements as the sole reason to engage in CPD. Penny (2005, p. 2) posits that adequate resources such as funding, time, mentoring and increased staffing will go a long way towards the effective implementation of CPD activities. Penny also suggests that CPD activities should demonstrate value for money, address competency, improve service provision and complement organisational strategic goals.

A 2003 study by Cordingley et al reports on a review by asking: How does collaborative CPD for teachers of the 5-16 age range affect teaching and learning? This was unpacked into two interrelated sub-questions about *Whether* collaborative CPD for teachers of the 5-16 age range has an impact on teaching and learning? and if so *How* is this impact realised and manifested? The review offered detailed evidence that sustained and collaborative CPD was linked with a positive impact upon teachers' repertoire of teaching and learning strategies, their ability to match these to their students' needs, their self-esteem, confidence and their commitment to continuing learning and development. There was also evidence that such CPD was linked with a positive impact on student learning processes, motivation and outcomes. On this, the authors contend that:

This means that funding collaborative CPD that is sustained could be a powerful component of international, national, regional, local and school efforts to improve teaching, enhance learning and raise standards. Policy-makers at all levels may wish to consider reviewing their policies and resource strategies for CPD to explore whether sustained and collaborative CPD of the type illustrated by this review might increase their effectiveness (p. 8).

The positive findings about the links between collaborative and sustained CPD and increased teacher confidence, self-esteem, enthusiasm and commitment to continuing to learn about teaching, all address important issues related to teacher retention and recruitment. Finally, Cordingley, et al (2003, p. 10) suggest that:

Policy-makers at international, national, regional, local and school level should consider whether current CPD programmes and activities could make a greater contribution to recruitment and retention if they were organised on a collaborative and sustained basis’.

Summary

The five research studies involving dentists, teachers, occupational therapists, nurses and doctors/consultants from the UK and Ireland give a good indication that CORU have been successful in how they have conceptualised CPD for the professions they are currently regulating. It can be argued that one of the reasons that CORU has been successful in conceptualising CPD is that no other institutional player has come up with a strong model. CORU has just been established and potential critics will not contest it until they see what is happening, how it is being received and operating. Furthermore, CORU has been active in consultation with key stakeholders in order to inform decisions in relation to CPD: this is in marked contrast to how CPD (such as it was) in the social care sector was organised prior to the establishment of CORU's CPD function.

The main points/areas of contestation based on evidence from the five studies beginning with the most comprehensive study (Eaton et al, 2011, of dentists and other health professionals) demonstrated that engaging in CPD did not demonstrate any direct associations with quality of care delivered, performance, professional standards, competence, public satisfaction or safety (p. 37). Schostak et al (2010) indicate that CPD was personal and owned by the individual and meets people's needs. Joyce and Cowman's (2007) study found that virtually all respondents (99%) said the main reason they wanted to partake in CPD was to obtain promotion.

Penny's (2005) study indicated that adequate resources such as funding, time, mentoring and increased staffing was required for the effective implementation of CPD. Cordingley et al (2003) found positive outcomes linked to sustained and collaborative CPD for teachers. All these studies highlighted key trends such as time management, resources, evidencing theory, practice and learning. Findings suggested that there was benefit both to individual professionals, the organisations and service users from having regular sustained CPD where funding and resources were allocated to it. Moreover, the findings suggest that everyone has a different set of reasons to be involved in CPD.

In Ireland there can be differences regarding CPD between what Tusla/HSE want and provide, what the agencies/organisations want and provide and what individual professionals want. Participants may see CPD mainly in terms of their own personal benefit while professional associations claim it benefits the profession and the public. So, who ultimately gets to decide and on what basis

will it be decided to provide CPD? In an ideal world everyone would be accommodated with their choice of CPD.

Should the agency/organisation reflect and take the ideas of their professionals more seriously or should the agency/organisation say no 'we think you should do b, and c, CPD training'. This is where it becomes an issue. So should both be done or should there be a compromise to suit everyone? There are many different ways to look at this and it is a tension that underpins many of the issues surrounding CPD for social care professionals. Nevertheless, agencies seem to be ploughing ahead and providing CPD. It remains to be seen if this will continue in the future or could it be a trend that professionals will have to fund their own CPD by sourcing new learning in order to get their 60 credit points over each two year period so that their portfolio's are up to date in case of a random audit by CORU?

It can be argued that this will be a potential risk that professionals will have to take and, while practitioners may incur payment for CPD privately, they may be able to claim for payments against their tax. Also professionals will be required to pay an initial registration fee as well as annual registration fees thereafter. Will employers/agencies provide resources including time out to do CPD? Moreover, some practitioners including the researcher are holders of post-graduate masters degrees for the past five/six years and, although they have been working in residential care, both before and after obtaining their degrees they have not been rewarded financially or otherwise for same. On the other hand it was the case with teachers that the more qualified they were the more money they were paid. The Association of Secondary Teachers in Ireland (ASTI, undated) state that prior to 2012: 'teachers are paid allowances for certain academic qualifications achieved and in relation to the nature of their job and duties, for example, candidates with a Masters degree (1st or 2nd Class Hons) is awarded with €5,496'.

Models of CPD: Inputs v Outputs

The case studies in CORU (2013d, p.4) illuminate the two competing approaches. The input model usually involves the accumulation of a minimum number of hours annually or a certain number of hours over a longer period of time, with a minimum each year. A system of credits/points or Continuing Education Units (CEUs) operates in the same way. Credits/points or CEUs are awarded for different activities undertaken by the participant, usually 1 hour of input = 1 credit. A development of the credits system involves assigning credits to each type of activity with some activities counting for more credits than others. CORU observed from the case studies that the input model was often the preferred choice of professional bodies where the focus of CPD was on supporting personal and professional development and where participation in CPD generally operated on a voluntary, if recommended, basis (as indicated in results of survey of professional bodies). It was noted that the input model, in its simplest form, was relatively easy to understand, implement and monitor. Its main drawback was that it did not

measure what outcomes, for example, changes in behaviour or practice, may have resulted from the learning. The regulator thus has no way to know if competencies are being maintained or if the level of client safety and service is being improved.

The output model involved the individual professional self-assessing their practice and their personal and professional needs. The professional then develops a personal learning plan. Implementation of the learning plan is followed by reflection to identify what learning has taken place and the impact of the learning on practice. The general trend is towards a CPD model that has a number of stages, theoretically based on Kolb's Cycle of Experiential Learning. The stages generally include: planning – action – results – reflection - demonstration. An advantage of this system is that it is a systematic, self-directed system where the professional is actively involved at every stage.

A further advantage of the output model is that it sends a signal to the various stakeholders (patients, public, professionals and employers) that the registration body/profession takes the maintenance of competence and the development of knowledge, skills and competence Health and Social Care Professionals Council seriously. The output model easily accommodates the full range of learning styles and activities, formal, informal and incidental. On the other hand the measurement of outputs is a complex matter and places significant demands on regulatory bodies who try to operate it. It involves the development of valid audit procedures, the selection and training of peers in the audit process and the selection of appropriate numbers of professional portfolios for audit. The development of customised electronic systems is making the collection and measurement of evidence of continuing competence and professionalism more achievable and it is likely that developments will continue apace in the area.

CORU reflected on a 'third' or a 'hybrid' model that involves a combination of the input and output models. This model allows participants to engage in a self-directed assessment of needs followed by the development of a personal learning plan. The standard sets out the minimum number of credits required annually or over a longer period. The participant is required to reflect on the activities undertaken and to identify the impact of the learning activity on their practice and service. This hybrid model allows participants achieve a combination of structured and unstructured CPD inputs, measured in credits or hours in a given year, together with evidence to demonstrate achievement of outcomes to sustain professional competence (CORU, 2013d, p. 7). As mentioned above, it could be a work in progress and the need to combine criteria from all models to create the model most suited to CORU. CORU are already showing signs of a combining approach with regard to a top-down versus bottom-up approach to CPD.

Top-down v bottom-up approach to CPD

Unquestionably, CORU, Tusla, SCI and the IASW are all working together to provide the conceptual as well as the practical side of CPD training for

professionals. This is further facilitated by CORU in the content of CPD with them employing both a top-down and bottom-up approach. Formerly a mainly top-down approach was used for CPD, with the senior management of an organisation contacting a line manager requesting them to organise CPD for its professionals. This can be linked back to the individual/institutional tension alluded to earlier, regarding who decides on CPD.

In utilising a mixture of both approaches CORU has been organising regular information sessions for social workers, in preparation for registration and for other professions (including sessions currently for social care practitioners); also, they invite all professionals concerned and solicit submissions from them and from employers/stakeholders through public consultations. They provide feedback on proposals and, after final drafts, implement changes based on the views of the council and elected board members. In initiating and continuing to promote this approach, it can be argued that CORU paved the way for a new type of thinking for the professional concerning the collective versus the individual approach.

Collective v individual approach to CPD

Prior to CORU, it was likely that the management in organisations decided on relevant training that needed to be delivered to certain staff. Moreover, while CORU are laying down the guidelines they are introducing a work ethic that will require every professional to be in charge of their own learning and development. In agencies, they will have to decide if they are going to go with individuals' maintaining their own CPD portfolios or if they should consider a collective approach and conduct CPD in groups.

Do we have enough resources?

Of importance for every aspect of CPD is to ask ourselves: do we have enough resources? It is imperative that adequate resources are provided to manage CPD; it can be asked if resources will be continuously employed across all agencies or eventually will payment for CPD be carried by individual professionals?

While referring to social workers, but also applicable to social care practitioners, Halton et al (2014b, p. 36) comment on this by saying: 'while the importance of CPD for professional development in social work has been acknowledged in recent years, questions remain as to how this is to be funded and supported, particularly in the current economic climate'.

Over the past two years, the researcher has noted that in Tusla agencies CPD is widely available regardless of austerity concerns. However, there is evidence that the government are facing financial challenges with regard to immediate welfare provision and maintenance of Tusla services. For example, in May 2015 Tusla (2015a) published the *Integrated Performance and Activity Report, Quarter 1*, showing that for the period March 2015 year to date (YTD), Residential Services

was over budget by €0.554m owing to the increased number of children in private placements. Residential Services has indicated that there is considerable pressure emerging for additional places to be provided and it is expected that this will result in increased spend in this area. In addition spend on agency staff was over budget by €0.277m at the end of March YTD (ibid, 2015, p. 46).

Moreover, Baker and Rogers (2015) reported that the Government has been warned that it faces ‘a crisis a year’ unless it starts ploughing additional funds into the cash-strapped Child and Family Agency, Tusla’. The warning came after it emerged that a review of child protection services (Feb. 2015) found 27,337 open cases, 5,000 of which had not yet been allocated a social worker. Furthermore, Jennifer Gargan (2015) of Empowering People in Care (EPIC) reported that:

Tusla has not been given the resources to enable it to do what it was set up to do; to protect our children. Nothing substantive has changed since the publication of the *Ryan Report* in 2009, and we have clearly not learnt the lessons from our history; children are still at risk. In a society such as Ireland, which claims to cherish all children equally, we must prioritise the safety and protection of all children. There is a legal duty and a moral imperative to do so. By not providing the necessary resources to Tusla, the Agency is not able to respond to children at risk appropriately. Not intervening in families at an early stage can cause greater damage and harm in the longer term, not to mention the need for more expensive, less effective treatment later on (ibid, 2015).

The Child Care Law Reporting Project (2015) which reports and publishes case reports involving children reported 37 new case reports on October 1st 2015, - detailing the neglect, physical and sexual abuse of children.

In response to this trend and to counteract the austere findings reported above, a welcome step was that extra resources for provision of services were announced in Budget 2016 (Finlay, 2015), even as the *Growing Up in Ireland* study published by the Economic and Social Research Institute (ESRI, 2015) revealed stark findings about the impact of the recession on young people, including long-term scars such as mental health issues. The Ombudsman (Muldoon, 2015) reported that children with mental health issues were being accommodated in adult psychiatric or general children's wards without mental health supports.

We have seen that resources were obviously not made available for vital services, so it remains to be seen if budget funding will be used for CPD or if stakeholders and employers will deliver on regular relevant CPD for their employees. Albeit there are scarce resources and high demands on Tusla, there is also a welcome emphasis on CPD; many occupations are engaging in it and it is being driven by forces such as accountability and transparency; State reports; professionalisation and globalisation.

Key drivers of CPD: Globalisation

A varied learning base will provide rich knowledge for professionals to update their skills and values. This is important as they work with different classes and cultures of people as a result of globalisation across the generations. The list of professions under the Act indicates a drive for CPD across a broad range of social professions and it could be argued that it is being targeted now on the global level: Halton et al (2014b pp. 1-17) explore the international context of CPD and the influences of globalisation, emigration, migration and multiculturalism.

A testament to the previous comment can be garnered from the following study by Gouda et al (2015). They show that 90% of Irish medical students are considering emigration after they qualify; a third of students said they had a poor understanding of how the Irish health system works. These results may have been the consequence of the economic recession in Ireland. At the same time Ireland recruits a very high number of medical personnel of all types from overseas – more evidence of a global medical labour market.

In addition, Halton et al (2014b, p. vii) suggest the slogan ‘think global, act local’ in relation to the contemporary context of CPD. Whether social care practitioners are working in populous English speaking countries across the continents such as USA, Canada, Australia and UK or in non-English speaking countries in Asia such as China or India or in Latin American countries, the social problems and issues with regard to children in care are the same and necessitates ongoing CPD. Instead of dividing, geographical borders are uniting practitioners in a shared agenda (Halton et al 2014, p.vii) with the need for up-to-date relevant CPD.

An instance of globalisation familiar to social care practitioners is mandatory TCI training, which is global. TCI was founded at Cornell University in New York and is still widely practised; currently practitioners use the level six edition of the manual. Other instances of globalisation familiar to practitioners include the work of authors notable in the field of residential child including Mark Smith (2009) and Smith, Fulcher and Doran (2013) from Scotland. Furthermore, globalisation has taken a new turn at present (2016) with the influx of refugees who are displaced and fleeing from the war in Syria and who are trying to claim asylum across the world including in Europe, UK, USA and in Ireland. These people will need support, care and attention regarding their varied needs, which will be a challenge for professionals because of, amongst others, the language barrier, their culture and resources available in the various countries. It is hoped that professionals will provide support with dignity and respect while adhering to accountability and transparency across all professions.

Key drivers of CPD: Accountability and Transparency

CORU is aware of the importance of accountability and transparency (CORU website, 2015). CORU (2013b, p. 9) states that one of the functions of a

Registration Board is to give guidance and support to registrants concerning CPD. The CORU Code of Professional Conduct and Ethics, adopted by each Registration Board, requires registrants to keep their professional knowledge and skills up to date, of a high quality and relevant to their practice. The Code requires that registrants take part in CPD on an ongoing basis, maintain records of the CPD activity, in a CPD portfolio and comply with registration boards requirements (CORU, 2013b, p. 12). CPD is an important component in the continued provision of safe and effective services for the benefit of service users. If a Board finds that a registrant is not compliant with its scheme it can make a complaint to the Council on the grounds of professional misconduct. Any person, including or members of the public, can also make a complaint to the Council in relation to the failure to comply with the CPD standard and requirements (ibid, 2013b, p. 9).

This is crucially important because as was discussed above, the *Ryan report* (2009) highlighted malpractices that had been ongoing for many years in State institutions. Therefore maintaining CPD is important as the public must have confidence that registrants who provide health and social care services are professionally competent by actively engaging in CPD throughout their careers so they have up to date knowledge to deliver a safe service. The registrants' practice must be guided by changes in working methods, in research, in role and in legislation. Evidence of CPD is important as it provides the mechanism for registrants to reassure the regulator, on behalf of the public, that they are maintaining their professional standard of performance (ibid, 2013b, p. 11).

This level of accountability is what is needed now and is an aspect that CORU is trying to encourage. This is being addressed in the following ways: first, the onus is on each professional, in keeping with their CPD framework, to review and reflect on their learning needs and assess if they require specific CPD to assist them in their work practice; this can be arranged by their organisation. CORU requires registrants to engage with a wide range of learning activities and although current CPD requirements for CORU can be met without referring to supervision, the IASW (CORU, 2015e) recommends that a minimum of 20 CPD credits in each two year audit cycle are for learning activities related to supervision.

Educational awards and certification to learners at all levels of the National Framework of Qualifications (NFQ) are given by Quality and Qualifications Ireland (QQI) (QQI, 2015). The Health Information and Quality Authority (HIQA) is enhancing accountability and transparency through ongoing inspections of all agencies/organisations, checking if they are adhering to national standards such as the protection and welfare of children (HIQA, 2012). There are inspections of foster care and high support units for children (HIQA, 2013a, 2013b) and for centres for children/young people with disabilities (HIQA, 2013c). There is a collective and collaborative ethos of work between the individual professional, their organisation and CORU/HIQA.

The key is that registrants must keep their portfolios up to date showing how they have advanced their skills and knowledge. With the advances made by CORU in guiding CPD and the uptake on same by some agencies, it can be said that there is evidence that resources and structures are being provided so that each professional, once registered, will know what is expected of them in their work practice and in their organisation.

For professionals, knowing what CPD to expect and getting what they require will be a significant improvement from the previous situation where they were often sent to training that was of no benefit to them. Likewise, professionals will not be able to blame the organisation for putting on irrelevant training as they previously may have done, as they will now have an input into sourcing the CPD training they require. Because there was little evidence of CPD or accountability in organisations in the past, it can be argued that its absence has been a driving force and has contributed to the establishment of structures now in place by CORU.

While there is a global drive for CPD for social workers and residential social care practitioners, it can be argued that a major driving force for CPD in recent years in Ireland has been the publication of numerous studies by academics and government reports, such as the *Ryan report* (2009) into child abuse in State run residential centres. Resulting from easy accessibility to global internet and social media, the public are more aware now about what is happening in society and whereas once the pillars of society: Church and State in Ireland (Inglis, 1998) were regarded in high esteem, now they are the subject of conjecture and concern. The public are debating and questioning them and every organisation with respect to accountability and transparency, with the added bonus of being able to access information/data via freedom of information. As outlined in chapter one, this is where CORU is of immense importance with their primary role, 'to protect the public' (CORU, 2015h). In turn, this accounts for better professionalisation.

Professionalisation

While social care professionals are already actively involved in CPD, once registered, this will be recognised and will enhance their professionalisation. To ensure compliance with the CPD standard a random selection of registrants will be required to submit their CPD portfolio for audit following each 24-month cycle. Once the regulation has been finalised CORU will publish annually the audit cycle for each profession. Portfolios will be assessed against the requirements and the assessors will make a recommendation to the Registration Board (CORU, 2013b, p. 12).

If a registrant is not compliant, they can be struck of the registrar. *Fitness to Practice* commenced on the 31 December 2014. This allows CORU to accept and deal with complaints from that date onwards (CORU, 2014a). When all twelve

professions are registered by CORU it will ensure that there is all-round professionalism in the caring sector.

Halton et al (2014b, p. 9) note that professionalisation and education are inextricably linked and cite Tovey (1994, p. 8) who states that 'education plays a key role in achieving and securing status and marking off lines of differentiation from non-professionals'. Halton et al also mention Madden and Mitchell (1993) who point to occupations that are in the process of professionalisation using CPD schemes as part of their strategy to improve credibility and status. Halton et al mention that Houle et al (1997) and Lester (1999) in the US, discuss the notion that CPD has been seen as a means of defining professional expertise in the face of criticism from the public, media and the State regarding various professional groups. Houle et al (1997, p. 90) suggests that 'education appeared to be one of the more 'enlightened' responses to the matter' (Halton, 2014b, p. 9).

Houle et al's comments were relevant in the light of various crises and scandals that have beset the social work profession in recent years and the policy response to them. For example, they cite that in the UK the deaths of several children, following months or years of abuse, led to widespread criticism, particularly from the media (Franklin and Parton, 1991; Fitzgerald, 2012). Halton et al (2014b, p. 10) point out that while a number of reforms to the child protection system were subsequently put in place, CPD was also posited as a way to better prepare social workers for their role in child protection. They quote the *Laming report* (Laming, 2009, p. 54) that highlighted the importance of continuing education in enabling social workers 'to carry out their roles effectively' and the Munro review of child protection in England (Munro, 2011, p 116) that 'places a premium on CPD'. In Ireland, the Roscommon Child Care Case Report made the case for more effective supervision (Gibbons, 2010).

While Halton et al (2014b, p. 10) mention that these reports boosted the case for CPD; they state that 'some commentators have questioned whether they take sufficient account of the political and social context within which child protection systems operate'. With regard to the Munro review, they cite Featherstone et al (2012, p. 14) who argue that 'without a clear understanding of the likely impact of the wider political context within which recommendations are located, its analysis and recommendations for practice may be undermined'. Halton et al suggest that 'it could be argued that the Roscommon Report, focuses entirely on the immediate circumstances of the child abuse case, and ignores wider constitutional and political issues' (Halton, et al 2014b, p. 10).

Professionalisation of social care practitioners is underway; in March 2015 the Minister for Health confirmed the establishment of and appointment of members to the Social Care Workers Registration Board, under the Health and Social Care Professionals Act 2005 (amended) to regulate the profession of Social Care Workers. The first meeting took place in May 2015. Registration of the profession

will include the approval of education courses and requirements for registration including the code of Professional Conduct and Ethics. The register for social care workers is to open in 2017 and CORU will consult with social care workers about how the profession is to be regulated (CORU, 2015g).

Where social workers are represented by the IASW, social care practitioners are represented by SCI and have a CPD officer who informs them through the website about upcoming CPD workshops around the country as well as conferences and other information on CPD including recording templates for CPD portfolio (SCI, 2015b). Like social workers, social care practitioners are continually engaging in CPD. It can be argued that CPD has different meaning for different professionals. For social workers it can emphasise their professional identity while for social care practitioners it can be about the needs of the clients. Social workers need to keep up to date with legislation and changes in the law whereas social care practitioners may be more interested in CPD that would assist them better in addressing specific work challenges, for example, how to manage challenging behaviour. Similarly, it can be argued that CPD has different meaning for stakeholders and employers, as suggested earlier. Current and future debates focus on the allocation of resources, including post-qualifying (PQ) education, which will be reflected in the provision of CPD to social care practitioners.

While there were no available studies specifically in relation to social care practitioners, Halton et al (2014b, p. 30-33) note that in the US, Carver (2000); in the UK Green (2006); in Australia, Roseman (2007); as well as Wilson et al (2005), Highman (2009), and Taylor (2010) in Northern Ireland discuss collaboration between universities and workplaces. Taylor et al (2010) suggest the key to success in PQ education is partnership: 'proactive and committed work between employers, candidates and educated bodies'. On the other hand, Halton et al (2014b, p. 32) cites Green (2006, p. 249) who argues that the involvement of various stakeholders in planning, evaluating and delivering social work education raises questions about the discipline's own intellectual status and independence, and may further contribute to the low academic status of social work. Halton et al (2014, p. 36) cite Parsloe (2001, p. 14) for whom such partnerships may reflect 'the creeping managerialism that is engulfing social work'.

Halton et al (2014b, p. 32) conclude that in Ireland there is no tradition of collaborative working between universities and employers to provide PQ education. However they note that employers do play an important role in the provision of certain types of CPD as found in the findings of the social workers survey: almost all respondents had undertaken in-service training over the previous two years. Halton et al suggest this was far higher than those undertaking academic or other external courses.

Halton et al (2014b, p. 32) also stress that employers have a key role in providing funding for courses and for the future employer policy will have an important –

albeit indirect – influence on the development of CPD, defining what is ‘relevant’ and appropriate for their workforce (ibid, 2014b, p. 32). Moreover, it could be that future employers may need to build in structures where they allocate time for employees to attend CPD. Currently, the need for CPD and our understanding of CPD is explained well by Ginny Hanrahan, CEO and Registrar of CORU who, speaking at the launch of *Fitness to Practice*, asserted that CORU (2015h) was established in response to the increasing complexity and increasing demands within our modern health and social care services.

While pointing out that CORU’s mission is to protect the public by promoting high standards of professional education, training and competence among registrants of the designated professions, Hanrahan emphasises:

As care continues to evolve and health regimes become even more complex, it was clear that a regulated, controlled and safe environment would help to ensure the safety of the public and would also protect professionals providing high quality services. Also CORU achieves this by ensuring that registered practitioners are qualified for their profession and that they continuously seek to enhance their knowledge through CPD and that they adhere to Codes of Professional Ethics (CORU 2015h).

In exploring if a typology of CPD existed or if CORU recommends their own typology of CPD models, the researcher contacted CORU (personal communication Kellegher, CORU 6 July, 2016). CORU responded that it:

Does not specifically prescribe a typology of CPD within a Registration Board's CPD standard and requirements. CORU run a self-reflective and self-allocation model of CPD whereby the registrant allocates CPD credits for each activity ... Our model is very broad, varied and flexible. As such a registrant could include all three typologies [of]: structured/active learning; reflective learning and self-directed learning. Any learning activity that supports the registrant’s professional role can be included. We do not stipulate what activities the registrant should undertake, this is determined by the registrant. At the end of the 24-month cycle, a percentage of the register will be asked to submit their portfolio as part of a random audit.

Following Dewey (1933); Freire (1970, 1977) Schon (1983) and Lyons (2010) among others, reflective learning is focused on the self, is active, the practitioner is attuned to their own self-awareness and is reflecting back on what they did and looking for better ways to improve it for the future. This process can be accompanied by a typology of learning such as *structured/active learning* which could involved going to a relevant training course; *reflective learning* can include sourcing and reading an article in a reputable peer-reviewed journal and

afterwards, reflecting on it and self-directed learning could involve the practitioner discussing at supervision with her supervisor about: ‘how am I developing my skills in dealing with children/young people’? At each supervision session the practitioner can ask about different relevant themes that will assist them in their work, such as discussing attachment theory; discussing dealing with aggressive young people and/or ‘how am I managing my workload’?

CPD: Summary

In summary, the central research question presupposes that CPD needs to be reconfigured. The above section has justified this presupposition; the key issue is *who decides about CPD*; it is a question of accountability between the stakeholders versus the organisation regarding what CPD will be done by whom, where and when. It can be argued that professionals like CPD from an individual point of view but does it have the impact for the profession? Moreover, it may be much harder to establish its benefit for the profession; it can be easier to ask the professionals than look at the systemic impacts - especially if you have not done baseline studies beforehand. How do researchers control for that? Furthermore, it can be argued that CPD can be seen as evidence on the individual professional and arguments on the profession. It can be viewed as enhancing professionalisation. Professionalisation of practitioners will move forward considerably when practitioners like social workers are registered by CORU and are assigned their own competency framework tailored with the knowledge, skills and values needed for their profession.

This will assist them in engaging in relevant CPD where they will reflect on their work and record issues that need further training/clarification. This is discussed later in relation to reflective practice; first, competencies are discussed. CPD links directly to competencies. For example, the CPD portfolio can be seen as part of the answer to the assertion below by O’Hagan who claims that some professionals are unable to recount details about their learning/knowledge/skills. CORU’s guidelines on keeping the portfolio up-to-date puts an onus on every professional to account for and record their learning/knowledge and skills.

2.3.3 Competencies

O’Hagan (1998, p. 20) states that ‘it is surprising how many professionals, who engage in so much sound practice, are unable, when asked, to recount the detail and the benefits of the practice’. He emphasises that ‘too much of what they do is taken for granted, goes unrecorded, and is quickly forgotten about’. To overcome this situation he recommends competency frameworks which, he claims, ‘will encourage students and professionals to think positively’. In addition, ‘competencies can facilitate their realisation and acknowledgement that even the smallest action or gesture (should it stem from or be compatible with the appropriate knowledge, values and skills) will probably constitute an evidence

indicator, another step towards fulfilling the practice requirement of a particular competence’ (ibid, 1998, p. 20). In acknowledging O’Hagan’s sentiments, it can be argued that competencies will collate and coordinate the ongoing learning and knowledge assimilated by practitioners. Given the importance of competencies for social care practice, this section will examine them in some detail.

In the early days of the development of the competency approach, McClelland (1973) argued that aptitude and intelligence tests were not entirely valid and tests should be designed to reflect changes in what people had learned. He claimed it was difficult, if not impossible, to find a characteristic that could not be modified by training and/or experience. He identified that most competencies should try to measure clusters of life outcomes that could include occupational, leadership, and interpersonal skills. In the UK, Tippelt et al (2003) suggest that ‘competency refers to the group of skills and knowledge which are applied in order to carry out a task or function, in accordance with the requirements imposed by the job’ (p. 9).

Competencies including ‘core skills’ such as communication, numeracy, information technology, interpersonal competence, and problem solving were incorporated into the *UK National Vocational Qualification* (NVQ) in 1986 (Holmes, 1992), replaced subsequently by Diplomas in Health and Social Care (Skills for Care, 2013). Similar changes were made to educational qualifications in Ireland. The current framework for qualifications developed in response to a need for a more flexible and integrated system of qualifications that could accommodate all needs in education and training. Three new organisations were developed in 2001 under the Qualifications (Education and Training) Act (1999):

- The National Qualifications Authority of Ireland (NQAI)
- The Further Education and Training Awards Council (FETAC)
- The Higher Education and Training Council (HETAC)

These have now being merged into a new body Quality and Qualifications Ireland (QQI, 2014).

In 2003, the NQAI developed the National Framework of Qualifications (NFQ), a ten level system that incorporates awards made for all stages of learning: gained in schools, the workplace and community, training centres, colleges or universities. It is an important development for those responsible for advising learners and others and is designed to meet the needs of learners, employers or recruiters, providers and advisors (NFQ, 2010). Figure 2.2 below, illustrates the national qualifications system in an integrated manner showing how the NFQ can be used as an advisory tool.

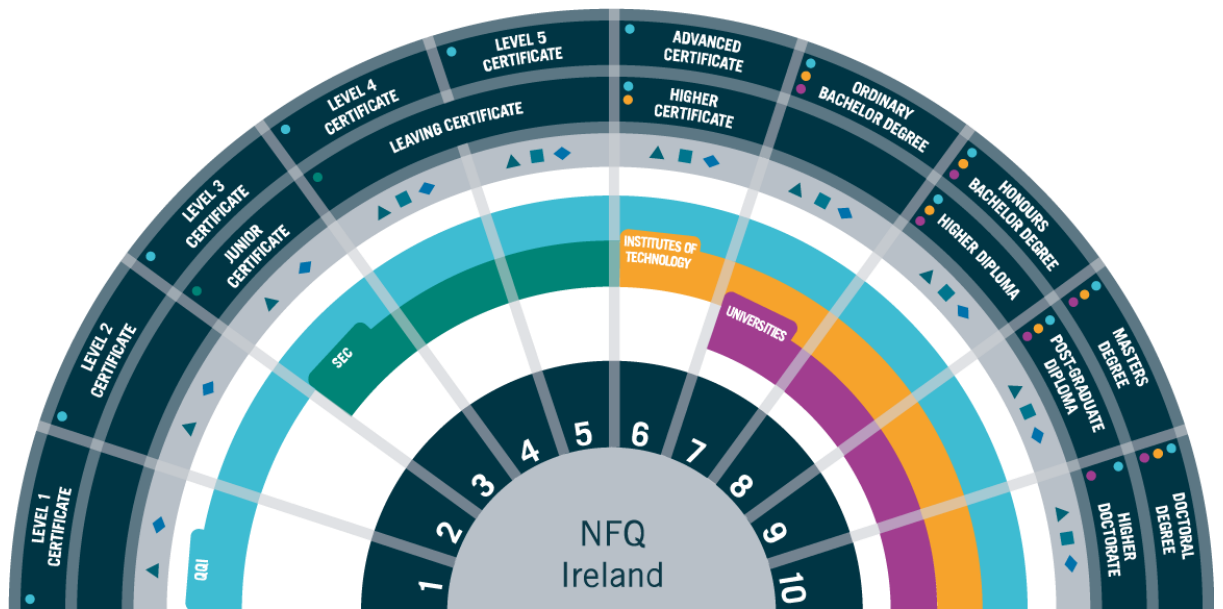


Figure 2.2: NFQ Ten Level Framework

In addition, the *Awards Standards* (2009) determine in broad terms the standards of knowledge, skill and competence that must be achieved before a major higher education and training award may be made in social care work¹³ at NFQ Levels 6 to 9. The standards are designed to be used by providers when designing new programmes and establishing minimum intended programme learning outcomes; and by awarding bodies when validating new programmes. At present, practitioners in the Republic of Ireland do not have a competency based training (CBT) framework.

In Northern Ireland social care practitioners utilise the *Code of Practice for Practitioners* by the Social Care Council (NISCC, 2002). Although not familiar to most Irish practitioners, competency based education and training (CBET) has been tried and tested in many countries.

2.3.3.1 Worldwide views

Competency-based education is perceived by some as *the* answer, and by others as the wrong answer to the improvement of education and training for the complex contemporary world (Harris et al 1995; Smith, E., 2010, pp. 54-64). Concurring with McClelland (1973); Melton (1994); Harris et al (1995) and O'Hagan (1998) explain that competency-based education and training was initiated in the US in the 1970s in the performance-based vocational teacher education movement. Competency approaches strengthened in the 1990s with the *National Vocational Qualifications* (NVQ) system in England and Wales (1991), and by similar frameworks in New Zealand, Australia and in the US. Competency

¹³ To view these standards see: http://www.hetac.ie/docs/B.2.95.5_Awards_Standards_Social_Care_Work_2010.pdf

standards were propelled by a strong political impetus as the way to prepare the workforce for the competitive global economy (Harris et al, 1995).

Proponents of CBET promote it as a way to improve the correspondence between education, training and workplace requirements (ibid, 1995). Competency frameworks outline what is to be achieved and the standards for measuring same. In theory, they overcome the divide between hands and mind, theory and practice, general and vocational education. This thesis understands competency as the effective and creative demonstration and deployment of knowledge and skill in human situations. Competence draws on attitudes, emotions, values and sense of self-efficacy, as well as on declarative and procedural knowledge (HETAC: *Assessment and Standards*, 2009, p. 46). Competency models go beyond describing the traits an employee must have to successfully perform work; they capture elements of how those traits should be used in the organisational context or work setting and can include elements of an organisation's expectations or culture (Dubois and Rothwell, 2004). In exploring competencies further, O'Hagan (1998) identifies three important attributes that link to professionalisation.

2.3.3.2 Attributes of Competencies

Knowledge, values and skills form the basis of professional competence for frontline professionals (O'Hagan, 1998, p. 5). While new practitioners can bring theoretical knowledge to the team, long serving experienced members can have amassed a wealth of learning. Halton (2014a) summarises that:

Certainties in practice do not exist and professionals need to be able to respond flexibly in situations of great complexity; moreover, professional practice cannot be reduced to the application of rules and procedures, it requires the application of professional knowledge, skills, and values in diverse situations of practice.

As we have seen, professional knowledge develops its own knowledge.

2.3.3.2.1 Knowledge for Competent Practice

The knowledge that underpins the work of practitioners is obtained from many diverse sources. These might include those mentioned above and from the study of organisational policies, procedures and guidelines, diverse schools of thought, and different evidence based work methods/disciplines, such as: advocacy, mediation, therapeutic intervention, reflective practice and team work. Cha et al (2006, p. 111), reporting on a survey conducted with social workers, noted that both the tasks of practice and the knowledge used to accomplish these tasks are defining characteristics of any profession. They are the basis by which professions differentiate themselves from one another and the means by which they legitimate their activities to the larger society and culture.

Theorists and researchers of knowledge utilisation have identified it as having both conceptual and instrumental aspects. In the above survey, social workers expressed appreciation for theoretical knowledge, but gave the highest utility ratings to knowledge that helped them solve problems they confronted every day in practice: information about a social problem or about the effectiveness of particular interventions/work practices (ibid, 2006, p. 121). Lester (1999, p. 5, cited in Halton et al, 2014b, p. 5) point out that: ‘the acquisition of formal knowledge does not equal enhanced practice; CPD must include opportunities of experiential learning, to assist the transfer of learning beyond the classroom into professional practice’. As this research shows, there is a strong desire for ‘useful knowledge’. The attainment of knowledge, coupled with the significance of the understanding of values in their work, is important for practitioners, but can also lead to neglect of a broader conceptual/critical understanding. As well as knowledge, it is crucial for practitioners to have an understanding of values.

2.3.3.2 Values for Competent Practice

‘Professional values’ refers to the core ethical principles underpinning the profession, often found in codes of ethics. This encompasses general principles such as ‘promote the individual autonomy of the patient/client/service user’; and respect the confidentiality of information gained from the service user’ (Banks, 2004, p. 138). ‘Values’ can be regarded as particular types of belief that people hold about what is regarded as worthy or valuable. In the context of professional practice, the use of the term ‘belief’ reflects the status that values are stronger than mere opinions or preferences (Banks, 2006, p. 6).

For Banks (2006, p. 7), there is increasing tendency to distinguish ‘values’ from ‘principles’ in statements of professional ethics, with ‘values’ denoting broad beliefs about the nature of the good society and the role of professions within this (belief in human dignity and worth; integrity in professional practice; promotion of welfare or well-being of service users and in society generally; and promotion of social justice, including working to remove inequalities and promoting fair distribution of goods and services among people and groups) ‘Principles’ are general statements about actions that promote these values (treating people with respect, placing service users’ needs first) (ibid, 2006, p. 7).

Professional values can be distinguished from personal values, in that individual personal values of practitioners may not be shared by all members of an occupational group. It does not follow that personal, professional and agency values should be treated as totally separate (Banks, 2006, p. 7). Indeed it is very likely that they are linked, in that people often work for organisations whose values they share (or at least are prepared to accept). As noted by Banks: ‘where they conflict, the professional as a person has moral responsibility to decide those that have primacy and to justify this decision’ (p. 136).

Ethics are crucial in care provision, and this is reflected in the fact that ‘values’ have been given the status of a separate unit of competence. Assessors of all care training programmes expect to see evidence that the maintenance of values (such as upholding individual rights, personal beliefs and identity, promotion of anti-discriminatory practice, etc) has been manifest throughout the demonstration of each unit of competence; nowhere is this more obvious than in the professional training of social workers (O’Hagan, 1998, p. 7) and social care practitioners. There are no more contentious issues for practitioners than values and it is of great importance that they are familiar with their codes of ethical conduct, stating clearly the values and principles to be adhered to in their profession.

Given the similarities between social workers and social care practitioners, and that the people they work with are much the same, practitioners’ work values would be similar to those listed in the social workers Code of Professional Conduct and Ethics:

- Respect for the inherent dignity and worth of persons:
 - Pursuit of social justice
 - Integrity of professional practice
 - Confidentiality in professional practice
 - Competence in professional practice
- (Social Worker’s bye-law 2011: Irish Statute Book, 2013).

2.3.3.2.3 Skills for competent practice

O’Hagan (1998, p. 12) affirms that the intellectual quality of skills can be described as the ability, coming from one’s knowledge, practice, aptitude, etc., to do something well. Arguably, the ability to utilise proper professional skills should be one of the foundational pillars of the work of practitioners who work with vulnerable children/young people in centres. Evidence-based practice shows that practitioners are continuously bringing the skills together, a skill in itself, and are committed to working to solve children’s/young people’s problems (Maynard, 2005, p. 98). Effective report writing, coupled with good communication skills are essential; as is being able to listen attentively, ask the right questions to find out more about the child’s needs, be observant, and be able to read situations and identify problems. Although practitioners should try to be non-judgmental and avoid imposing solutions, they must also be able to make difficult decisions, sometimes relatively quickly, while being firm and able to act calmly, such as when quelling aggressive situations between children/young people or possibly intervening in a dispute between a staff member and a child/young person (p. 98).

The preceding paragraphs illustrated that: ‘fundamentally competence is demonstrating knowledge and skills appropriate to a context that is underpinned by professional ethics and values’ (Northern Ireland Post-Qualifying Education and Training Partnership, 2008, p. 34). Competencies can assist practitioners who

are protecting and assisting vulnerable children by employing a child/person centred care approach while at the same time working as a team and upholding public trust and confidence in the service they represent. Practitioners can enhance their competencies by engaging in lifelong learning.

2.3.4 Lifelong Learning

Lifelong learning, with a particular focus on adult learning, encompassing education and training in the workplace, is an important part of CPD. Firstly, a field note from this study gives an example as to why lifelong learning is a necessity for practitioners in residential child care centres:

It was a very busy afternoon; two female staff had come on duty: a young woman named Mary* and an older woman named Ann. There were three children in care at the centre, two boys and one girl. Mary was doing a life story session with Flan, the girl in care. Norma, the Social Care Manager came rushing into the activity room, saying: 'I'm so busy; I'm up to my eyes, would one of you be able to send an email with the respite referral form to Tom Black, the social worker for the Shaw children who are to be placed here for respite in the coming weeks?' Ann, the older woman immediately said to Mary: 'would you do that Mary as I don't know how to work the computer, never mind send an email or attach a letter?'

(Field notes: conversation at the centre) *Pseudonyms used to protect anonymity.

Being present during this discussion raised the question: why had Ann not been trained or why was she not competent enough to send the email/attachment? It also highlighted that information technology skills is a key skill to be availed of through lifelong learning.

There are EU policies, including the following, that are in favour of lifelong learning which has developed intensively over the last several years; (European Council, 2000; PPMI, 2010, p. 24; Council of the European Union and the European Commission 2008 and *Access to success: lifelong guidance for better learning and working in Europe*, 2010, p.7; and *Learning while working: Success stories on workplace learning in Europe*, 2011, p. 1). Ireland should implement similar policies, where these are lacking.

Since 2009-10, Member States have been working on the theme of career management skills (CMS) through the European lifelong guidance policy network. CMS can be regarded as a competence that helps individuals to identify existing skills and necessary learning goals, to improve employability and social inclusion. Regardless of the knowledge and skills acquired by professionals, they will need to be upgraded/'re-learned' throughout life. Specific attention should be paid to key competences, which lay the foundations for further learning. Continuing learning can be enhanced by a clear theoretical orientation in training.

2.3.4.1 Theoretical Orientation in Training

Berridge and Brodie (1998) suggest ‘a strong association between the quality of care and the ability of professionals to articulate and stick to a clear theoretical orientation’ (Smith, 2009, p. 84). Therefore, it can be argued that a strong theoretical, knowledge-based training is required by practitioners, in order to address the myriad social problems and work-based challenges they may have to deal with in their every-day work. Practitioners need to be trained to respond to vulnerable people in a positive way by understanding the person and knowing how to help them. This can be enhanced and complemented by relevant theories.

It can be argued that most of the CPD training provided to professionals in Ireland, especially to practitioners, should be based on the use of theory and research, for example, practitioners regularly refer to the theoretical principles of Therapeutic Crisis Intervention (TCI). When working with vulnerable children/young people, practitioners need to have acquired knowledge about theories that they can rely on to back up their experiences in their work practice, rather than solely basing assumptions/judgements on their own ideas or on that of colleagues. Reflective researchers will find that theory underpins the dynamic and responsive nature of care work and together with research it directly informs and supports practice (Sharpe, 2009). ‘Theory’ links into evidence-based practice and is seen as a way of ‘making sense’ that helps to structure thoughts and influence behaviour (Oko, 2008, p. 6). According to O’Hagan (1998, p. 10) ‘the two most important functions of theory should be enhancing understanding and enabling one to predict process and/or outcome’.

A theory is an explanation for events; it is not ‘truth’ (Clough, 2000, p. 84). Smith (2009, p. 84) acknowledges that ‘there is no one theory that provides any sort of silver bullet in professional work, no one theory directly associated with better outcomes for service users’. Nevertheless, Visser (2002) with Clough et al (2006) highlight how professional staff groups that work to a particular theoretical model are likely to be more focused and effective in their work. For instance, practitioners who have studied, among others; theories of Child Development (Bowlby, 2000) at college would be able to link this to symptoms of poor attachment or abandonment displayed by a child when placed in care; all practitioners trained in this way would be able to somewhat understand the symptoms and feelings displayed by the child, thus as a team it makes it easier to work with and address the behavioural issues of these children; practitioners experience a shared body of knowledge, this underpins a community of practice.

O’Hagan (1998, p. 11) notes that ‘theory also enables its advocates to formulate strategies of intervention and articulate goals’. Theory is not (as some practitioners may believe) divorced from reality; rather, it consists of concepts and propositions about reality. Theory is not rigid or inhibiting, but demands vision and imagination. If practitioners were to approach their work within theoretical

frameworks, it could enable them to add a dimension to their work which observation, rules and guidelines, policies and procedures cannot themselves provide. Learned theory can often lead to greater insights for practitioners in their daily work, especially when linked to reflection. It is an instrument by which practitioners can construct more comprehensive and effective intervention strategies, and predict outcomes with more confidence (ibid, 1998, p. 11).

It can be argued that having a theoretical knowledge can empower professionals to improve their work practice. ‘Doing the job’ is no longer the sole prerequisite for qualification; how one thinks about the job, prepares for it, applies and integrates the knowledge, values and skills normally required for it, demonstrates it, accumulates and displays the evidence for it – these are the essential tasks that students and professionals are now expected to carry out (Central Council for the Education and Training of social workers (CCETSW), 1995).

The following paragraphs outline the formal training available for practitioners.

2.3.4.2 Social Care Practitioner Formal Training

As already mentioned, practitioners will not have a CBT framework or code of professional conduct and ethics until standardisation and registration takes place. Figure 2.1 above, shows the Irish social workers’ code of professional conduct and ethics; this is the closest one we have at the moment and as it is a similar area, values may be similar to practitioners.

Initial formal training for a practitioner is a combination of college work (Ordinary degree: three years; honours degree, four years) with two work placements including, but not necessarily, a 12-week residential child care placement in year three. Garda vetting takes place prior to students taking up placement. During placement students compile a reflective journal/training portfolio; in order to progress, they must pass the placement module.

Once employment has commenced, in both TUSLA/HSE and private residential centres, practitioners must attend regular CPD training (when and if available). TCI training (Holden et al, 2009a) is the primary theory-based training given to all residential child care practitioners. It involves an initial five days training course, followed by two refresher training days, one every six months, both consisting of role plays and theory; an examination of theory and techniques takes place on one of the two refresher days. Together with other theories, namely attachment, psychoanalysis, behavioural, cognitive and humanistic theories, TCI theory gives recognition to the role of the practitioner as described by Ginnott (1972, p. 47):

I have come to a frightening conclusion; I am the decisive element in the juvenile (treatment) centres. It is my personal approach that creates the climate. It is my daily mood that makes the weather. As a teacher (counsellor), I possess tremendous power to make youth’s life miserable

or joyous. I can humiliate or humour or heal. In all situations it is my response that decides whether a crisis will be escalated or de-escalated, and the youth humanised or de-humanised.

Working on a 25 hour shift with up to four young people who can be vulnerable and may be volatile at times is very stressful for staff; most work two shifts per week. It is imperative that they can apply emotional first aid (Holden, 2009b) to children/young people; TCI incorporates the following strategies for this:

1. Let the child/young person drain off emotions.
2. Clarify events with them i.e. what exactly happened/is happening.
3. Maintain the relationship and lines of communication; when they are talking, they are not acting out.
4. Remind the child/young person of expectations (for example, pre-planned visit to the cinema) and mediate the situation if necessary.

In ending emotional first aid, it is important that the child/young person should understand that the worker believes they have the ability to successfully re-enter the activity and will have time later again to talk, if needed (ibid, 2009, p. 102).

Practitioner-based evidence indicates that if social care practitioners/managers want to further their education or attend CPD training beneficial to their work practice, the onus will be on individual practitioners as post qualifying education is not provided by the HSE; in many cases practitioners do it in their own time and at their own expense. On the other hand, Halton et al, (2014b p. 71) cite Higham, (2009) who informs us that a major component of CPD in the UK in relation to social work has been the post-qualifying (PQ) awards. However, Halton et al, (2014b p. 89) also quote Leinster (2009) who says that in Ireland, there are relatively few postgraduate higher education courses relevant to social workers, and fewer still that are specifically designed for them. Halton et al (p. 89) suggest that this situation is unlikely to change significantly unless practitioners are supported and encouraged to undertake PQ education. The same can be said for residential child care practitioners in Ireland. Based on the researcher's experience, and during the empirical research stage, CPD training offered to HSE practitioners taking part in this study was limited to: TCI, fire safety and Children First training (when available).

2.3.5 Reflective Practice

The concept of reflection is that people come to a situation as active learners and they build on that (Halton, 2014a). People need to reflect; reflection relates to changing/complex dynamic situations, resilience, theory, competence and professionalisation. Multiple definitions of reflective inquiry have evolved over time; three major approaches have been identified: Dewey's (1933) reflective

inquiry as a kind of thinking of how we think; Schön's (1983) reflective practice as a kind of knowing through and in the actions of our actual professional practices and Freire's (1970, 1977) reflective inquiry as critical interrogation of the social and political contexts of learning for the promotion of critical reflective consciousness. Practitioners could benefit from having knowledge and experience in how to apply all three approaches in their work. Lyons (2010b, p. 20) claims that 'especially at present, in time of social and economical upheaval in Ireland, there is a critical need for reflective inquiry as the foundation for professionalism amongst professionals'. Halton et al, (2014b, p. 152) state that:

We have seen an incremental loss of trust by the public in institutions of the state. We believe that this loss of trust will continue and will be exacerbated if those institutions and public servants cease to be critically reflective, and continue to defend themselves. The challenge now posed for organisations of the state is to seriously engage in what Freire (1996 [1972]) refers to as a praxis that is performed in public and that has transformation at its heart.

Practitioners would thus need to employ Dewey's function of reflective thought (1933, p. 100 cited in Lyons 2010b, p. 12) where they could transform a situation 'in which there is experienced obscurity, doubt, conflict, disturbance of some sort, into one that is clear, coherent, settled, harmonious'. This could be accomplished by their engaging in awareness and conscious thinking about any misconduct in their workplace and reporting it to the relevant manager/professional. It is also about knowing you are making informed decisions in the face of complex challenges and not feeling you are making a mess of things.

Schön (1983) was concerned about understanding how professionals know through practice and he also explored a retrospective knowing in action, where practitioners question themselves and their actions and try to make sense of it by reflecting on the understandings which have been implicit in their [prior] understandings (Schön, 1983, pp. 49-52). It can be argued that Schön puts the practitioner at the centre of learning, open to recognising new information on a daily basis. This type of thinking is currently needed by frontline practitioners because in their practice they encounter many conundrums associated with Schön's 'swampy lowlands' (where situations are confusing 'messes' incapable of technical solution), (Schön 1987, p. 3 cited by Halton et al, 2014b, p. 138).

In citing Schön (1987), Halton (2014a) discuss balances and tensions in professional practice while referring to *Art* as practice wisdom and *Science* as knowledge and technical proficiency. They claim that in these situations reflection acts as a bridge that helps professionals to manage the divide between the art and the science of professional practice. This could be accomplished by practitioners being aware of their knowledge, values and skills, and linking their practice knowledge to the theory.

Freire's (1970; 1977) reflective inquiry can also be incorporated by practitioners to link practice knowledge with theory by being scaffolds to children (Vygotsky, 1978) while teaching them to look critically and acknowledge the social situations in which they find themselves. Freire identified this process as critical reflection, or critical consciousness, by which he believed learners achieve a deepening awareness of both the socio-cultural reality which shapes their lives and the capacity to transform that reality through action upon it. Practitioners can help to empower marginalised children in care, from low socio-economic backgrounds by helping them to understand issues related to power and oppression (Heron, 2005), why they did not have a secure base (Bowlby, 1988) and can assist them to get a good education by encouraging them to attend school/college.

It can be argued that by adopting aspects of reflective frameworks, practitioners can 'learn how to learn' from practice and integrate this learning in a cyclical fashion, for example through Kolb's 'cycle of learning' (1984). Learning from experience and reflecting on how to do better next time can empower practitioners, especially given the intensive nature of work with vulnerable children/young people. Halton (2014a) suggests that reflective learning is an approach that assumes that all learning is constructed on the basis of the individual's previous experience, knowledge, beliefs and views of the world. It makes active use of this prior knowledge in new situations and requires the learner to actively integrate new knowledge with their values and world view.

Engaging in a reflective process can boost the education and practice of professionals, meeting the need both to tell and retell stories in order to increase understanding of ourselves and our practice (Brown and Rutter, 2008). It can be understood as the process of learning through and from experience towards gaining new insights of self and/or practice (Mezirow, 1981; Jarvis, 1992 and Boud et al 1996). Ward and McMahan (1998, p. 34) state that 'reflective practice is essential for helping practitioners to become aware of their own feelings (Lyons, 2009, pp. 122-137) in and about their work'.

A reflective practitioner is aware of professional accountability and quality assurance which, together with upholding human rights and human dignity, are central to the integrity of a profession (Share, 2009). This can involve examining assumptions of everyday practice which can include the individual practitioner being self-aware by critically evaluating their own responses to practice situations. The point is to recapture practice experiences and mull them over critically so as to gain new understandings and improve future practice, which can be understood as part of the process of lifelong learning (Finlay, 2008, p. 1).

Self-reflection by practitioners is crucial in examining these dynamics; it integrates the identity/sense of self of the professional into her/his work practice (Moffatt 1996; Fook 1999; cited in Heron, 2005, p. 342). Reflexivity has been described by Parton and O'Byrne (2000) as responding to the uniqueness of each

individual. These practices can empower practitioners/managers and can allow them to reflect on their own knowledge, ideas, experiences and values that impact on their action. It gives them and their colleague's time to take a moment to stand back and think about the meaning given to a situation (involving a child/colleague) or a set of circumstances in a particular time and place; in relation to self, others and the wider context (Payne 2005, p. 35).

Reflective practice sessions like those cited above, including at handovers and team meetings/supervision can generate a wealth of experience and ideas from the tool kits of all practitioners present. Reflection can help to transform and solve problems from different angles because the team also brings their life experiences to the reflective space. It can be argued that if such a forum for reflection was open to and practiced by practitioners together with their trans-disciplinary teams, it could greatly enhance their work practice and give them the impetus to continue by being competent professionals working in communities where their voice could be heard and where they could make a difference to the lives of vulnerable children/young people. Engeström's (2001) Change Laboratories (CLs) (explained in the next chapter and discussed in chapters six and seven) provide a forum where reflection can take place.

Rodgers and Raider-Roth (2006, cited in Lyons, 2010a, p. 49) suggest that professional training including reflective practice needs to be an ongoing process for professionals and more especially now in times of economic harshness where there are cut-backs in staffing and resources. Reflection involves being 'wide awake', and conscious: being able to pose questions to the world and being able to reflect on what is presented in experience (Greene, 1997, cited in Lyons, 2010a, p.vi). Reflective practice can be copper-fastened by presence theory i.e. the practitioner being aware/alert/present in the moment with the child/young person (Baart, 2002; 2003; Rodgers, cited in Lyons, 2010a, p. 55).

The *Youngballymun* report (2010) suggested that 'radically reflective' processes, training and supports are needed for professionals working in care and justice settings (cited in McEvaney et al. p. 2013, p. 148). Practitioners could benefit from structured reflective practice, given their close contact and engagement in one-to-one work with vulnerable children/young people. Reflective practice can only work well if proper time is allocated to it in practitioners' busy work schedules, while increased self-awareness could encourage them to be aware of their negative characteristics and biases (Wosket 1999; Byrne, 2000; and Taylor 2002), thus enabling them to do their best in full confidence of their emerging self. Structured supervision, may give practitioners an opportunity to reflect on their experiences, critique and update their learning knowledge:

2.3.5.1 Supervision

Supervision is a crucial part of reflective practice and an integral part of professional work (Fook, 1996). It can build on competencies and enhance

professionalisation in that knowledge, values and skills can be systematically reflected upon with the view to implementing new learning for the future. In centres, supervision is provided by a senior member of a profession, for example, the team leader or centre manager; the relationship built in supervision can extend over time (Reed, 2014). Personal and professional development can be strengthened through the skilful manner in which a properly trained supervisor provides invaluable opportunities for reflection and learning during supervision (Bromberg, 1982, cited in Inskipp and Proctor, 1995; Munson, 2002). Harris (2002) claims that professional supervision is the changing and contingent context of professional and expert action and can be seen as a way of orientation, and gaining deeper understanding of our agency. Morrison (1993, p. 11) states that supervision is:

A process in which one worker is given responsibility by the organisation to work with another worker in order to meet certain organisational, professional and personal objectives.

The three main functions/roles of supervision are *managerial, educative, and supportive* (Kadushin, 1992; Morrison, 2003). Shulman (1999) argues that practitioners are at their best in their work when they integrate their personal self into their professional role. This reflective process provides an opportunity to evaluate their performance: on learning, thinking, feeling and response in practice.

O'Neill (2009) discusses informal supervision, which can be conducted at handovers or at weekly team meetings as well as through on-going conversations with colleagues, while formal supervision sessions should be conducted every six weeks between practitioners and their supervisor/manager. During supervision, practitioners should be able to discuss and clarify all issues of concern and supervision should encapsulate time for reflective practice and for feedback on work practice which can prove invaluable in the process of practitioners moving forward and developing their professional work ethos. Feedback should be given in an open and transparent way (Mezirow, 1981; Gould and Baldwin, 2004). Professional supervision can also be a platform for learning and discussing research related to practitioners work. Yip (2006) suggests that 'supportive colleagues and supervisors nurture a warm, empathic rapport that is crucial for constructive self-reflection in reflective practice/supervision' (p. 781). Lyons (2010c, p. 35) states that in the supervision forum: 'professionals need to give their views on inquiry through research and reflection - in this way they gain an understanding of knowing which can help them to take an inquiry stance and to create a culture of reflective inquiry in their places of work'.

Supervision facilitates the link between practice and theoretical knowledge; team supervision is closely aligned to professional supervision and can involve an independent person (from outside the agency, but experienced) offering professional supervision to a team (Payne and Scott, 1982). Regular professional

supervision enlightens the professional to changes that have occurred and can open up the debate for more questions in relation to all aspects of their work and training, with the focus at all times on the betterment of the child. This confidence building approach helps to bridge gaps in information and can highlight ineffective practice in teams; such an approach could improve work practice if it were applied across all agencies that work at the frontline with vulnerable people.

A summary of research on supervision by Munro et al (1989, p. 147); Loughry and O'Donovan (2000); and Hawkins and Shohet, (2007, p. 59) provides an argument that in supervision, the beneficial focus is on the supervisee as supervision is ideally an intensive learning experience provided in an atmosphere of support and encouragement. Supervision is a prerequisite for practitioners because their work is complex and is constantly changing (Murphy et al, cited in Lyons, 2010a, p. 173). Changes have to be competently addressed, albeit within tight budget restraints by practitioner management who are aware that professional activity is being challenged and monitored (p. 173).

This may lead to tension between professionalism and bureaucratisation in agencies and can give a new impetus for reflective engagement in professional education (Murphy, et al, cited in Lyons, 2010a, p. 187). At handovers and in team meetings supervision can be aided by a portfolio/learning journal (Lyons, 2010c, p. 34) that can be used in conjunction with competencies and built up over time; also practical reasoning can be used; it is a concept linked to the development of virtues and involves the collective activity of reasoning together with others (MacIntyre, 1999, p. 107).

In summary, the above research shows that supervision is a necessary requirement for practitioners advancing their professionalisation. While practitioners do not have a competency framework as yet, they are aware of the necessary qualifications required to enter this profession and are attuned to reflective practice and supervision, albeit in these economically depressed times, where they have little time/resources to allocate to either at present. The research emphasised that practitioners who reflect on their work experiences, have an increased awareness of their personal value base and how it impacts on their professional development. In their duty of care to vulnerable children/young people and their colleagues, practitioners are required to always be present and wide awake to ask and answer relevant questions that will improve the quality of their care provision and practice. The on-going process of personal development is essential and the reflective engagement with this process is not simply an option, but is a necessity for each and every ethical professional practitioner; this is necessary for engaging in and being aware of the discourses of and culture of accountability/risk.

2.4 ACCOUNTABILITY/RISK CULTURE

Accountability is an aspect of modern society; it is in the whole professional area as well as in social care. Accountability is a broad issue that relates to the

activities of the public and private sector at ever-increasing levels, in terms of new types of regulation (e.g. consumerism), the influence of market mechanisms (e.g. league tables in education) and surveillance of all types. Now, consumers demand more accountability, for example, in politics, health, the banking sector and the Church. In the 1960s and 70s in Ireland people thought everything was working well but then they saw failures and the issue of trust came to the fore. Now, people want evidence, there is increased risk assessment; people want to be able to see transparency. People can now access freedom of information (FOI), this brings its own challenges in that with increased information they become more concerned which informs them but causes them to look for further information. Also, there were State and Church child abuse scandals over the past few years. For these reasons accountability is discussed here.

In recent years in Ireland and especially among the social care/residential child care profession, there is much discourse and awareness of accountability/risk culture. This is due in part to the changing nature of the profession, clients becoming more challenging and the move to full professionalisation in the future. The last ten years have seen a bigger emphasis on accountability/risk culture/discourse; local issues include reports, scandals and exposures, and there is an international trend also, in the UK/USA. Halton et al, (2014b, p. 97) state that ‘as recent public inquiry reports demonstrate (Laming, 2009; Gibbons, 2010; Munro, 2011), social workers along with other professionals have become the subject of extraordinary public commentary and critique’.

As seen in chapter one, and in line with being more accountable, a broad range of reports, including among others, the *Ryan report* (2009) and the Roscommon abuse case (2010) into child abuse, have been published and debated. These reports, portraying system failures, can pose challenges for practitioners in terms of accountability

O’Regan (2013) quotes Taoiseach Enda Kenny, who opened the 13th European Regional International Society for the Prevention of Child Abuse and Neglect conference in Dublin (September 15th 2013); by saying:

Child abuse had not gone away because in 2012 referrals to child protection service was up by a quarter; the increased awareness generated by Children First guidelines had resulted in the increase; it had put a huge strain on services already under pressure and Minister for Children Frances Fitzgerald was working hard to address the issue. Right now, as Irish professionals will know, work is under way to finalise the Children First Bill; As set out in the guidelines, this will both demand and guarantee best practice of every professional involved in child protection; the pilot of the national audit of neglect cases, published in June, showed there was a great reporting of child neglect (O’Regan, 2013).

O'Brien (2013) cites 29 inquiries into State's handling of child abuse over the past two decades. He elaborates on his report by stating that Gordon Jeyes, (HSE's head of child and family services) when commenting on the 29 inquiries states that: 'despite the volume of proposals, each report or inquiry has produced a 'limited response' from authorities'. In line with these facts, it is again worth noting Keehan's (2014) figure of 21,040 child welfare and protection reports received by social workers, in 2011. It is as a result of improved practice that practitioners are becoming more aware of this reported abuse; however, there is a funding shortfall when dealing with children and families:

While there have been increases of more than 20 per cent in the child population and in referrals to social work services in recent years, there has not been a corresponding increase in funding; this risk to the establishment of effective services for children and families [has] been at times overwhelming (Jeyes cited in O'Brien, 2013).

In response to these reports, O'Gorman (2011), Executive Director of Amnesty International Ireland, said: 'The abuse of tens of thousands of Irish children is perhaps the greatest human rights failure in the history of the State'. Howard (2010, p. 12) said: 'Church and state, the two unquestioned pillars of Irish society, criminally neglected the poorest and most vulnerable children and failed in their duty of care'. Through education, competencies, professionalisation and reflection of their practice, in conjunction with regular CPD training sessions that practitioners will learn to be better equipped to address these complex issues for the future, including the problem of young people going to prison.

In 2011, in Ireland, the daily average number of children aged 16-19 in custody was 204 (IPS, *Annual report*, 2011, p. 45). In the UK, a report by Stockwood's (2010) found that 23 per cent of prisoners were children at one time in care. The cost of this to the State was £871,785,000, per year. Amongst other findings, the report found that adopting a strategic and creative approach to care and special education – through early and appropriately intensive interventions – can create millions of pounds of savings for local and national government (ibid, 2010, p. 8). On the benefits of early childhood interventions, see Murphy (2010), Heckman (2004), Heckman and Masterov, (2004), Heckman and Cunha, (2005), Gershoff (2003) and Early Childhood Ireland (2013).

Trauma and abuse poses many problems for vulnerable children in care but also for practitioners (Ward and McMahon, 1998; Tomlinson, 2004). A report by Logan (2014) the Ombudsman for children, cites repeated failures to protect children in care who are at risk of sexual exploitation. Key areas in need of attention include, amongst others: shortcomings in the assessment of children needs and in care-planning; poor record-keeping about individual children; provision of residential care – many children experience multiple placements; child protection while in care; lack of supervision of junior social workers;

inadequate co-operation between agencies and unclear governance arrangements in child and family services. Some children placed in care now can be quite traumatised from sexual abuse as well as physical and emotional abuse (ibid, 2014). In addressing these issues, consciousness of risk and accountability is now at the forefront of practitioners work.

On the one hand due to enhanced education and training, though some would say due to increased practice and procedures/bureaucratisation, practitioners are now learning how to address these issues better. For example, when a child/young person is placed in care, each child has their own individual care plan. It is not a generic plan to treat all children/young people the same. Now, care plans address individual needs of children/young people. From their care plan it could be decided that a child needs a psychology assessment. The results of this could mean that the child be referred for therapy to a relevant specialist. Care plans are regularly reviewed and updated and could point to another service being required for a child to address a different need. This will be measured and the issue attended to.

Where the researcher works, where possible, they try to employ therapeutic interventions in their work practice (Garfat, 2003). It requires staff to be empathetic and conscious of the child's feelings and involves working one-to-one with each individual child. While staff are conscious of self-care (McHugh and Meenan, 2009, p. 302) they are also aware that these children can get very confused and agitated and when this happens, it is the professionals that are on duty who witness the backlash from these situations, when children act out (ibid, 2009, p. 303). Increased accountability requires practitioners to be more aware in adhering to their ethical principles.

2.4.1 Ethics at Work

Banks (2004, p. 25) states that ethical problems are inherent in the practice of social work and in other social professions. A care worker is a public service professional dealing with vulnerable residents who need to be protected from exploitation; but also part of State welfare provision based on contradictory aims and values (care and control; capital accumulation and legitimation; protection of individuals rights and promotion of public welfare) that cause tensions and dilemmas for professionals, who very often find themselves the victims of media scrutiny and moral panics (Banks, 2004, p. 25).

Professional values and ethics are used worldwide and are a set of moral principles and standards of conduct, supporting the moral prestige of professional groups in society. The tasks of professional ethics is to identify norms, moral standards and assessments, judgments and concepts, typical to certain activities and characterising people as representatives of a particular profession. Ethics is designed to educate people, to help them to behave properly with others, and above all how to communicate in the workplace; ethical requirements include,

respect, honesty, integrity and humanity, attributes that are crucially important and applicable to the profession of practitioners (Newman, 2009).

Practitioners carry additional moral responsibilities to those held by the population in general and in society, as they are capable of making and acting on informed decisions in situations that the general public cannot, because they have not received the relevant training or do not have the relevant knowledge about rules and values used in a professional setting. An ethical code for their work greatly enhances and improves practitioners' practice on many levels. At present, based on traditional ethics, for a professional to work effectively within a multi-disciplinary setting, an understanding of the dynamics between team members and an appreciation of different professional cultures and practices is required.

Equally, the values that underpin and are integral to each set of core competencies may not be fully understood or shared by colleagues from other disciplines and tensions may arise which may impact upon the effectiveness and cohesion of the team. It may be incumbent for example, for practitioners to disseminate and promote such values within their multi-disciplinary team (Working in a multi-disciplinary setting in Northern Ireland, 2000, p. 45). According to Joseph (2000), in their workplaces, senior management, including all those who work at the frontline, should set ethical standards by showing respect, being honest, and promoting trust. Joseph (2000) claims that if the management team uses unethical forms of communication, the team can fail.

Promoting ethics gives employees a sense of worth and trust that can help them in every way to succeed (Joseph, 2000). This additional knowledge comes with authority and power. The client places trust in the professional on the basis that the service provided will be of benefit. In their work with vulnerable children, it is of immense importance that practitioners adhere to professional ethical standards. It can be argued that within residential care work there needs to be both a top-down and bottom-up emphasis on ethics in training, thus ensuring a completely ethically based organisation. Ethics underpins professional practice which aids accountability. It is important that a practitioner's work meets a specific standard; it should be planned, monitored and reviewed on a regular basis and such working underpins their role and function in residential child care. Professional bodies such as the IASW have their own ethical statements (Quinn, 2011; Irish Statute Book, 2013). While ethics and values are important, as yet social care practitioners or the Irish Association of Social Care Educators (IASCE) do not have a code of ethics but it is expected that this will form part of upcoming registration. The IASCE statement of principles is included in the practice placement manual (IASCE, 2009) issued to students commencing practice placement. Charleton (2014) in a widely used text discusses ethics for the social care profession in Ireland. We have specific bodies to support ethical practice and that helps to create a structure of professional accountability: CORU and HIQA.

2.4.2 CORU

CORU, as discussed above in section 2.3.2, is in the process of promoting change in work practice for Irish professionals and is Ireland's first multi-profession health regulator (CORU, website 2014a). CORU will work alongside the newly established Child and Family Agency (Tusla). After all 12 professions are registered; CORU will conduct regular audits of professionals' CPD portfolios from each profession. This is in line with being accountable to the public and providing a better professional service for everyone.

2.4.3 HIQA

HIQA, an independent authority, was established in May 2007 to drive continuous improvement in Ireland's health and social care services. HIQA derives its mandate from, and undertakes its functions pursuant to, the Health Act 2007 and other relevant legislation (the Child Care Act, 1991, Children Act, 2001). Reporting directly to the Minister for Health, its role is to promote quality and safety in the provision of health and personal social services for the benefit of the health and welfare of the public. Workforce standards are covered under theme six, (HIQA: National Standards for Safer, Better Healthcare, 2012, p. 111). Being independent, the authority is committed to an open and transparent relationship with its stakeholders. Their independence within the health system is key and central to them being successful in undertaking their functions. Their mandate extends across the quality and safety of the public, private (within their social care function) and voluntary sectors (HIQA website 2013).

HIQA has statutory responsibility for setting standards for health and social services; monitoring healthcare quality; health technology assessment/information and for the social services inspectorate that includes registration and inspection of centres' and standards for children's services (ibid, 2013). HIQA, through its reports, are showing some improvements in professionalisation of services, for example, interagency work is improving. Standard 2.9 refers to how well agencies work together. During 2013, HIQA published inspection reports on Child Protection and Welfare Services in six Local Health Areas (LHAs). Of these, three LHAs met standard 2.9. Prior to de-institutionalism there was little emphasis regarding accountability/risk in centres; now practitioners are vigilant and are preparing for HIQA inspections. Evidence of this links back to many of the issues discussed earlier. For example, from their education, competencies, theory, including reflection and practice, practitioners have learned and are conscious of adhering to their professional standards and benchmarks:

2.4.4 Professional Benchmarks

Centres have mission statements or standards where they state what they do and how it is achieved: equality is maintained through standards; of importance for

residential child care is the *standard* and *function* statement outlining the purpose and practice of their work:

2.4.4.1 Standard in Residential Child Care Centres

The *National Standards for Children's Residential Centres*, (Department of Health and Children (2001) state that:

The Centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

The statement of purpose and function needs to be reviewed regularly and may need to be updated for example if younger children i.e. under 12 are placed in a centre whose statement is designed for children aged 12-18. HIQA (2013a, p. 19) has stated that 'the quality of children's residential services is almost entirely dependent on the commitment and quality of the staff team and its leadership'. Quality and accountability of care in residential child-care centres is checked regularly both with announced and un-announced inspections. Accountability can contribute to the paper trail that encompasses the web of bureaucracy:

2.4.5 Bureaucracy

Weber (1946) claimed that bureaucracy led to an increasing 'disenchantment with the world'; he considered this organisational form to be the clearest expression of a rational world-view because its chief elements of offices, duties and policies were intended to achieve specific goals as efficiently as possible. Weber claimed bureaucracy treated people as a series of cases rather than as unique individuals. In addition, working for large organisations demands highly specialised and often-tedious routines. In the end, Weber envisaged modern society as a vast and growing system of rules seeking to regulate everything and threatening to crush the human spirit (Macionis and Plummer, 2008, p. 109).

As well as having limited staff numbers and resources, it can be argued that bureaucracy can over-rule practitioners' work causing them to be overwhelmed by the timeframes involved in the business process where they are expected to adhere to what Howard (2012, p. 45) calls 'the demands made by *Ryan* (2009) and other reports' which is reflected in practitioners needing to spend much time attending to paper work on their shifts. Paper work can be time consuming and can take away from the real work of therapeutically interacting and rehabilitating children/young people. From the researcher's experience, practitioners regularly discuss how now most of their time is taken up with administrative duties, with little time to focus on the important part of their work which should be building relationships with children and dealing with whatever issues occur for them: listening to the voice of the child.

On a daily basis practitioners are very mindful of completing all tasks assigned to them from the handover meeting. This means having everything up to date and followed through along the paper chain. Apart from this, documentation/records may be required later by other professionals and/or by judges in courts. Based on a heightened awareness of accountability and risk, staff are aware of litigation and the need to have everything correct and in order from their perspective.

Bauman (1994), when speaking about business and bureaucracy said: 'Bureaucracy strangles or criminalises moral impulses, while business merely pushes them aside' (p. 13). Based on the researcher's experience, practitioners spend time both on the computer and writing manually in order to comply with daily record keeping. At the same time they are aware that when working with vulnerable children who are traumatised from abuse, time is crucial for them so that opportunities are not missed.

For example, a child intending to tell a practitioner about being sexually abused may not do so if on each occasion they summon up courage to do it, the practitioner is in the office doing paperwork. It could be argued that some practitioners may not be attuned to cues when children are about to disclose or are not given any relevant training in how to deal with same. Relevant CPD training would help to address the process of de-humanising while at the same time helping practitioners to cope and to be competent when working with vulnerable children as opposed to spending time in the office at administration work.

On the other hand practitioners need to be protected. CPD needs to say this is how it is and when practitioners become familiar with it, it will progress their professionalisation by empowering and enhancing them, and may free them, somewhat, from the 'iron cage' (Weber, 1979) of bureaucracy. Included in their many challenges, practitioners also have to contend with the public's attitude to children/young people placed in care.

2.4.6 Public Attitudes/Children in Care

Public attitudes are an important part of the accountability equation, especially with the wide use of social media. McEvaney et al (2013, p. 80) cite an Amnesty International Ireland poll, undertaken in 2011 which showed that:

A total of 50 per cent agreed that 'wider society is prejudiced against children in the care of the State today'; children who commit crime, Traveller children and children seeking asylum in Ireland were considered low priorities for government attention. The potential for social exclusion and poorer outcomes increases when the experience of a mental health problem is added to the mix.

Professionals consulted during the above report described a 'traumatised and traumatising system' (ibid, 2013, p. 80). McElwee (1998) observed that the public

spotlight only seems to fall on residential care work in times of crisis and scandal, thus blurring the image and value of the work. The media regularly reports on cases of neglect of children in care, for example, amongst others: Phelan (2009), Children's Rights Alliance (2009); Shatter (2010); and O'Brien (2010) reported and discussed the inadequacies of the HSE. Furthermore, discussions in the media, resulting from reports: *Fifth Rapporteur Report on Child Protection* (Shannon, 2011) and *Report of the Independent Child Death Review Group* (Shannon and Gibbons, 2012), highlighted neglect and deaths of children in care, and while these reports are welcome, sometimes they can denigrate good work done in centres. Happer and Philo (2013, p. 333), talk about the representation in the media of public opinion/belief and how it can impact on professionals in their work:

the information that people are given in media accounts can both legitimise the actions of the powerful, and facilitate change at the collective level, but can also limit and shape the behaviours of individuals which are central to wider social change. There is a need to examine the relationship between beliefs about the world and the political conclusions drawn by the public, the relationship between political conclusions and taking political action, and between those conclusions and individual and collective commitments to behavioural change. Findings across these areas show the way in which the media shape public debate in terms of setting agendas and focusing public interest on particular subjects. For example, in our work on disability we showed the relationship between negative media coverage of people on disability benefit and a hardening of attitudes towards them.

Practitioners are awakened to the need for transparency and accountability both in their work and of themselves yet their input comprises only one small part of a larger team; there is a need for interagency/inter-professional/collaborative working:

2.5 INTERAGENCY/INTER-PROFESSIONAL/COLLABORATIVE WORKING

Originally, when children were placed in care, practitioners worked with them in institutions (Artane, Dublin; St. Joseph's industrial school, Letterfrack, Galway) where everything was provided in the one building and where practitioners had access to various professionals that they required (see the Commission to Inquire into Child Abuse: *Investigation Committee Report Vol. I* (2009, p. 239). Then de-institutionalisation took place and split the organisation into lots of smaller organisations with children being moved to small units/bungalows in communities and cared for by practitioners and their manager but with very little extra supports.

Many such units are dotted around Ireland and if practitioners require the services of any other professionals they must contact and arrange to meet them; sometimes

there can be long waiting lists, for example for a child psychology appointment or specific therapeutic services for a particular child in care. For reasons such as this it is vitally important that interagency/inter-professional/collaborative work takes place between staff in centres and all trans-disciplinary teams associated with them who have input into the care of children/young people. In order for interagency work to be effective, good communication is required.

2.5.1 Communication

The sharing of information between individual professional staff was quite good but paradoxically the quality of communication between them left a lot to be desired ... Effective communication is more than just the sharing of information and is influenced to a significant extent by the relationship between professionals and between agencies (Government of Ireland, 1996).

This section explores if interagency/inter-professional/collaborative work is taking place in centres. Cedefop (2010, p. 75) states that to improve client interaction, practitioners need good communication skills. Engeström (1987) posits that communication and development should be viewed as collective transformation; instead of just vertical movement across levels it should be viewed as horizontal movement across borders. Communication is a key competency referred to by the European Commission (2006, 2010). It is a competency used in a person/child-centred approach by practitioners, who can be 'facilitators of individuals' personhood' (Cedefop, 2010, paper 7, p. 58).

A Canadian study by Suter (2009) on inter-professional education and collaborative practice focused on core competences for collaborative practice of professionals at the frontline. Based on interviews with 60 professionals, it identified two core competencies: professional role understanding/appreciation and effective communication. Frontline workers can be crucial in prevention, offering stepped care support, easing relations, supporting and making adequate referrals; this only works if their role is clearly perceived as valuable and if they feel appreciated (Cedefop, 2010, paper 7, p. 64). At work, professionals, through their communication, have a duty of care to protect and help children/young people at the centre; clear lines of communication detailing every aspect of their care should be laid out and discussed with all professionals concerned from when they are first admitted into care.

At organisational level, communication could be improved thorough innovative team models such as trans-disciplinary teams (Cedefop, 2010, p. 62) involving:

- Members such as (social workers, youth workers, gardaí, probation officers, GPs, psychiatrists, judges, solicitors, psychologists), sharing roles systematically across discipline boundaries; the primary purpose is to pool and

integrate the expertise of team members to provide more efficient and comprehensive assessment and intervention services.

- Communication style in this type of team involves continuous give-and-take between all members on a regular, planned basis.
- Professionals from different disciplines teaching, learning, sharing and working together to accomplish a common set of intervention goals. The role differentiation between disciplines is defined by the needs of the situation rather than by discipline specific characteristics.
- Assessment, intervention, and evaluation are carried out jointly by members of the team (Cedefop, 2010, paper 7).

Trans-disciplinary team meetings are a good way to ensure that as opposed to single-loop learning, professionals are also engaging in double-loop learning (Argyris and Schon 1974; 1978). Single-loop learning emphasises the detection and correction of errors within a given set of governing variables and is linked to incremental change in organisations. Single-loop learning seems to be present when goals, values, frameworks and, to a significant extent, strategies are taken for granted. The emphasis is on techniques, making them more efficient. Any reflection is directed toward making the strategy more effective.

Double-loop learning, in contrast, involves questioning the role of the framing and learning systems which underlie actual goals and strategies; double-loop learning involves interrogating the governing variables themselves and often involves radical changes such as the wholesale revision of systems, alterations in strategy and so on (ibid, 1974; 1978). Through effective communication, managers will be able to employ competencies to enable them to centralise by mission and decentralise by operations; create an organisational culture that identifies and tries to live by key values; create an organisational structure and culture that empowers their employees and themselves and ensure that staff are trained in human technology (Cedefop, 2010, p. 2). Positive relationships and ease of communication should be developed between all stakeholders of knowledge management (ibid, 2010, p. 81).

Communication and organisational behaviour play a major role in the work of practitioners who sometimes are the only voice of children/young people, some vulnerable who are in need of protection, care, understanding and help. Practitioners can advocate on their behalf if they are in trouble at school or in the community and may be referred to gardaí/probation. Practitioners cannot solve problems on their own, there needs to be collective, direct, effective and efficient, continuous communication and organisation by all professionals, both individually and in teams, in all types of frontline work because they may be caring for children who may be at risk. It is incumbent on practitioners to incorporate effective communication into their organisational behaviour.

Singularly (as key workers) or collectively, practitioners can be involved in actions to achieve a common purpose, although as the evidence above suggests: better outcomes can be achieved when professionals are functioning as a responsive team, where everyone's relational agency is recognised:

2.5.2 Relational Agency

Relational agency is evident in the ability to work with others to expand the 'object of activity' or task, that one is working on by recognising and working with the resources that others bring to bear as they also interpret it (Leadbetter, 2006). It also involves aligning one's own responses to that enhanced interpretation with the responses being made by other professionals. It includes a capacity to recognise that another person may be a resource and that work needs to be done to elicit, recognise and negotiate the use of that resource in order to align oneself in joint action on, for example, a child's developmental trajectory. It offers an enhanced version of personal agency and as a capacity it can be learnt.

Edwards et al (2009, p. 40) recognise that to work flexibly and responsively with expertise distributed across a system, in order to improve the life chances of children, requires a high degree of professional responsibility. They highlight from their experiences of professions (the same may be said of social care practitioners) that they are often characterised by strong external accountability with little room for manoeuvre in professional decision making. As a result of this finding, Edwards et al (2009) developed the idea of 'relational agency' to capture the agentic aspects (that people are producers as well as products of social systems) of interpretation and response in collaboration with other professionals that is demanded by inter-professional work (Edwards, 2005; Edwards and Mackenzie 2005). At the same time relational agency can only arise in organisations that permit such expansive forms of practice; some teams may not meet often enough to experience relational agency, instead of face-to-face meetings, they may capitalise on technology by utilising email or social media.

2.5.3 Technology Culture

In today's age of technology, teamwork in organisations has changed due to social networks and the rise of the network society based on automation. Driedonks et al (2010, p. 114) suggest that management executives, which can include those in charge of practitioners, should shift their focus towards employee involvement and team processes, to enable teams to actually meet and even surpass the expectations placed on them. Personal intervention, involving face-to-face communication with all members of an organisation, affected by an idea or change can be better than emailing each other and can have lasting effects. Team-members who have been trained in team working skills are significantly better able to work together effectively as a team, and cooperate more effectively with

others outside the team in order to achieve both general overall team effectiveness and external cooperation effectiveness (ibid, 2010, p. 114).

Practitioners are required to fill forms and write many reports, copies of which are always sent to other professionals, via email: computers/printers. Recording, duplicating and filing of documents is essential. Emails can be of immense use to busy practitioners, although some older and longer serving practitioners may not be fully trained to use this medium. Mobile phones are useful when checking in with children absent from the centre; there are advantages/disadvantages for children/young people/practitioners in using social media sites. Practitioners have access to RAISE (internal computer system/HSE) where social workers are supposed to input/check data about children. In providing more transparency to the public, reports on child protection proceedings were made public through the setting up of the Child Care Law Reporting Project; reports can be accessed on the project's dedicated website (Coulter, 2013).

The literature above signifies that while technological advances have assisted the work of practitioners/managers it can also be argued that bureaucracy together with a host of 'technologies of care' (Webb, 2006) and ideas of 'evidence-based practice' or 'best practice' may have reduced the relational and holistic nature of care to a series of administrative tasks (Smith 2009; Howard, 2012). Moss and Petrie, (2002, p. 84) claim that this brave new world was said to represent progress, modernisation, professionalism and a host of other 'hurrah'; yet, they argue: 'residential child care is fundamentally, irredeemably, a moral endeavour, yet it has, over time been reframed as a technical-rational one'. Smith, M. (2010, p. 2) suggests: 'We should put aside the conceit and the false certainty promised, by such technical-rational fixes' (ibid, 2010).

Based on the preceding comments, it can be argued that, the work of practitioners in centres with very vulnerable and often traumatised children/young people is very complex and for these reasons, it is imperative that they engage in interagency work and receive relevant and ongoing CPD training to address the varied and challenging issues that they can face on a daily basis. Some of the challenges reflect the changing field of social care practice, changes in the nature of the client group, the move towards professionalisation of the workforce, increased accountability and transparency, all pointing to the necessity now to establish and maintain an interagency/collaborative working ethos for the future.

Despite the arguments and the need for interagency, inter-professional and collaborative work, little evidence is available of it actually happening. Over the past 20 years every report into child abuse (including *National Review Panel Annual Report* ([2012] 2013), and deaths of children in care or known to the HSE, has highlighted the complete absence of interagency collaboration (Jones, 2014a). There is an overarching need for change, including the development of trust within the residential child care and associated professions providing care in order

for interagency/inter-professional work to be done properly. Children are falling between services; there is little evidence of face-to-face contact between social workers and other professionals (Jones, 2014a). While de-institutionalism led to smaller centres, children/young people have more complex problems; practitioners do not have the support they had in the bigger agencies. Interagency work is needed and the voices of practitioners who do the hands on work need to be listened to if necessary changes in organisational behaviour, including collaborative working, are to be made, albeit in times of limited resources.

2.6 CONCLUSION

This review began by exploring topics under the first theme: the changing field of social care practice, the snapshot of numbers in residential/social care gave an overview of changing numbers in the sector. Next, we saw that changes occurring in the organisation have contributed to its present position today. Thereafter, what do social care practitioners do and room for improvement were discussed before moving on to explore resilience in social care practice. This theme relayed that many significant changes have occurred in the practice, including over the past decade and, despite ideal definitions given for social care practice, practitioners are still experiencing tensions on the ground. The second theme explored why residential care work can be challenging before looking at personal/academic qualities required to be a social care practitioner. It demonstrated that children/young people coming into care now are more challenging, requiring practitioners to have certain new skills to enable them to understand and work around the complex issues that these children/young people are presenting with.

The third theme, professionalisation of the workforce, explored competencies, and reflective practice in some detail, concluding that professionalisation is being established. Theme four: accountability/risk culture debated if there was too much accountability by outlining research pertaining to ethics in work, CORU, HIQA and professional benchmarks in centres. A culture of risk and accountability is evident; practitioners are more alert now and are aware of transparency. The final theme: interagency/inter-professional/collaborative work explored communication including organisational behaviour and relational agency. It established that interagency work is only in its infancy; more work on collaboration is needed and stressed the contradicting role of modern communications/technology.

In summary, what is evident is a picture of a sector that has evolved and developed significantly. It has matured, and has become more professional and more organised in how it deals with issues. While the sector is becoming more regulated, yet, all five themes pointed to gaps that need to be addressed. While in itself it will not address all these issues, an important part of any response will be the development of relevant CPD training for practitioners/managers, engaging in this complex challenging work, where they are contending with many changes occurring in their profession. It is imperative that a cohesive and coordinated

approach involving thinking and strategy is taken towards CPD training of practitioners, involving both staff at the top as well as those at the bottom, including practitioners.

Evidence from experienced practitioners, in this study, some with 18 years experience, suggest that caring for children in centres has become much more difficult in recent years. This is not helped by fewer staff, less resources, and more time required for administration and bureaucracy, in line with accountability. While better CPD training is required, it also needs to incorporate other staff working in communities, such as gardaí, probation officers, youth workers, teachers, social workers, solicitors, judges and practitioners, in order to equip and empower them to address and cope with the escalating, aforementioned social problems and to support interagency work.

It is clear from the above research that practitioners' work is challenging and demanding, where in many cases their life may be at risk and where their conduct and work practice should always be of the highest quality and performance. In order for them to be competent in engaging in interagency work, it is important that they are fully trained which will enable them to protect themselves, their colleagues and the children/young people they are caring for. Ongoing CPD training and lifelong learning is part of this process. In proposing a way that CPD training could be effectively delivered, the next chapter outlines Cultural Historical Activity Theory (CHAT) (shortened to AT); the framework proposed to theorise this study.

CHAPTER THREE - THEORETICAL FRAMEWORK

3.0 INTRODUCTION

Chapter one introduced the five themes of the study: the changing field of social care practice; changes in the nature of the client group; professionalisation of the workforce; accountability/risk-culture/discourse; and greater focus on interagency work. Chapter two delved more into the literature revealing that as the residential child care sector is changing, it is becoming more dynamic, accountable and professional; staff are better educated. The literature shows an increase in child protection and child welfare referrals, and that children/young people's needs are more complex and more challenging. With this sector there are new demands, weaknesses and structures, but at the same time inadequate resources. It can be argued that there is a problem: a key theme emerging from the literature is the need to support staff with relevant CPD training. Over the years, problems and challenges were addressed by various forms of training. Some worked and some did not; this has been recognised and is being addressed now by CORU.

Social care practice is a complex area and the development of CPD is a complex issue. As a practitioner, the researcher can re-locate herself in a field that is wishing to bring about change. She is drawn to a research approach that involves action in relation to the issues and, in this chapter, will show that she is going to draw on an existing theoretical framework – Cultural Historical Activity Theory (CHAT), normally shortened to Activity Theory (AT) – in order to address the CPD issue. The researcher recognises the complexity of the situation and wants to bring about change in the reconfiguration of CPD for practitioners for the future, this justifies why AT is relevant. The aim of the thesis is to address the issues highlighted by practitioners as well as addressing the research questions.

3.1 OVERVIEW OF CHAPTER

Because of the complexity of the issues faced by current practitioners working with vulnerable children, and in order to keep up to date with the changes in social care field, it was recognised that a more expansive, holistic research approach is required to enhance the professional CPD training of practitioners/managers. The chapter argues that AT can meet this need; AT is described and a rationale for its use is given; its history is explored and references are made to the Helsinki health case study by Engeström (1999a, 2000a, 2000b, 2001, 2006, 2007a, 2007b). In this study, Engeström describes work re-design/re-organisation by incorporating his methodology, Developmental Work Research (DWR) which includes Change Laboratories (CLs). Four questions and five principles are utilised in the CLs to address 'contradictions/disturbances in activity systems' and to explain and describe 'knotworking' and 'co-configuration'. This action leads to expansive learning shown in Engeström's cycle of learning. The chapter concludes with a

synopsis of Engeström's Helsinki study case and a discussion of how AT might be applied to the social care CPD case.

To recap for the reader, the central question and research questions are listed next:

Central Question

How should the CPD training that social care practitioners receive, be reconfigured?

Five associated questions

1. How is the work in the social care sector in Ireland changing?
2. What type of CPD training is delivered to social care practitioners in Ireland?
3. What aspects of CPD training are the most useful to meet the needs of social care practitioners?
4. How can CPD training be reconfigured to respond appropriately to changing contexts and cultures of professional practice?
5. What has been the impact of relevant developments in CPD?

3.2 COMMONLY USED APPROACHES TO TRAINING

There are established ways to assess and examine the training needs of organisations. I am going to outline some of these and show why they may be lacking in terms of addressing the CPD question in an active, bottom-up way that I would like to see as a means for reconfiguring CPD for practitioners. Problems and issues that lead to a requirement for training could be accessed by having a training needs analysis (TNA). This is a systematic investigation of training needs within an organisation that could be done through using a questionnaire (Skillnets, 2013). The advantages of a TNA is that many people can be surveyed at the same time, it is inexpensive and it does not require a lot of time; the disadvantage is that it may be difficult to design questionnaires to allow for follow-up or more elaborate responses and they might not identify the specific causes behind employee actions/behaviours (Training Needs Assessment Survey, 2014).

Performance Management (PM) may also be used; it is a process that brings together many people management practices including learning and development, also it aims to contribute to the effective management of individuals and **teams** in order to achieve improved levels of individual and organisational performance and development (HSE, 2013c). A major advantage of a PM system is it allows managers to evaluate and compare employees in ways that are relevant to the overall organisation's goals (Mack, 2014). For Freifeld (2012) the disadvantage of PM is that there is no solid evidence that the process motivates people.

It frequently is noted that conventional designs are based on theories of motivation that have been largely disproved over the last 20 years, with the more productive employees playing a dramatically greater role in driving their own management and direction. Employees perceive PM systems to be more punitive than productive. Considering the significant investment of time, capital, and energy (it is widely used in the Irish public service as Performance Management System's (PMS), and is a predominant approach in the HSE) dedicated to PM, it is disappointing to discover how negatively it is perceived (ibid, 2012).

These training approaches have merit; they can get quick answers but they may not work. This has implications for CPD; I will be contrasting them with an alternative approach: AT, and showing how it is better if practitioners contribute to a multi-voiced collaboration, involving their management, about specific training that is beneficial to their particular needs at a certain time in their work practice. Beforehand, it is useful to review a small number of influential but more conventional approaches to the conceptualisation of training and development needs, including Maslow's Hierarchy of Needs theory, which has formed the basis of many training approaches (Jerome, 2013).

3.2.1 Maslow's (1970) *Hierarchy of Needs*

For McLeod (2014) the most significant limitation of Maslow's theory concerns his methodology. He explains that Maslow formulated the characteristics of self-actualised individuals from undertaking a qualitative method called biographical analysis, on a sample of self-actualised individuals, mostly males, looking at the biographies and writings of 18 people he identified as being self-actualised. From these sources he developed a list of qualities that seemed characteristic of this specific group of people, as opposed to humanity in general (ibid, 2014).

Another criticism concerns Maslow's assumption that the lower needs must be satisfied before a person can achieve their potential and self-actualise. This is not always the case, and so Maslow's hierarchy of needs in some aspects has been seriously challenged. Through examining cultures in which large numbers of people live in poverty (such as India) it is clear that people are still capable of higher order needs such as love and belongingness. This should not occur, according to Maslow, as people who have difficulty achieving very basic physiological needs (such as food, shelter etc.) are incapable of meeting higher growth needs. Also, many creative people, such as authors and artists (e.g. Rembrandt and Van Gogh) lived in poverty throughout their lifetime, yet it could be argued that they achieved self-actualisation (ibid, 2014).

Critiques listed by Akrani (2010) argue that Maslow's theory is over-simplified as there is a lack of direct cause and effect relationship between need and behaviour. Akrani also claims that the theory has to refer to other motivating factors like expectations, experience and perception and to recognise that the needs of all employees are not uniform. Many are satisfied only with physiological needs and

security of employment and the pattern of hierarchy of needs as suggested by Maslow may not be applicable uniformly to all categories of employees. In addition, Arkani posits that Maslow's assumption of 'need hierarchy' does not hold good in the present age as each person has plenty of needs to be satisfied, which may not necessarily follow Maslow's need hierarchy. While Maslow's theory is widely accepted there is little empirical evidence to support it; it is largely tentative and untested while his writings are more philosophical than scientific (ibid, 2010). It can be argued that Maslow's theory does not fully address efficacy or participation needs of employees.

It can be argued that these conventional theories do not fully address the current and possible future CPD needs of practitioners. This led to the search for another more suitable holistic theory as opposed to an individualised theory. Rather than individuals assessing and addressing their own needs, I wanted to find a theory that could simultaneously address the collective needs of many practitioners. While searching the Internet I found AT and was intrigued to learn that this theory had been modified, adapted, tried, tested and used by Engeström and his research teams when reconfiguring a work situation, also with practitioners experiencing similar issues, in the caring field in Helsinki. Hence, AT, with particular reference to Engeström's concrete example from his Helsinki study (described at the end of this chapter) was deemed the appropriate theory. It serves an analysis of data generated; addresses all of the research questions and has a guided structure that uses appropriate tools to develop relevant CPD for practitioners. Thus, there is a clear connection between AT and the research focus of this thesis.

3.3 OVERVIEW OF AT

The term AT refers to the theory and a process that comes out of the theory and feeds back into the process. While it is a theory, also it is more than a theory; it provides a structure within which to do the intervention in practice. It is a process that simultaneously diagnoses the problem and acts on it, incorporating the practice into the theory. Unlike traditional theories, with AT you cannot think out the theory and do it yourself – you have to have the collaboration of the others in the activity system. For example, Maslow's is a theory that other people have applied; it is a universal theory of peoples' needs, whereas AT uses theory to change peoples' behaviour; theory and application are intertwined in AT. AT can point out the issues but it cannot do it, it is a theory that emerges from the practice. AT is unusual; it is a theory of action, a combination of action and theory. While AT is a theory of action, it differs from action research in some aspects, such as data gathering. Relevant data is gathered initially by the researchers/facilitators (it can be gathered later by training participants) and not by participants themselves. As discussed by Virkkunen (2014) 'what separates action CL methodology from action research is the use of the historical analysis in the process as well as the use of the AT concept and models'. Additionally, the CL methodology focuses on the entire activity system more than on the individual

actions of participants, in contrary to action research, which tends to focus on the individuals actions.

As I go along I am going to illustrate with examples from residential child care, for example using practitioners as ‘subjects’ and CPD as ‘object’. I am not analysing AT at this stage, just giving examples to the reader.

The basic aim of AT is to understand individuals and the social entities they compose in their natural everyday lives. AT uses five principles and four questions. The subject (practitioners) acts on an object (CPD training) using mediational tools (CPD models) given to them by researchers to transform the object, using actions, goals, motives and conditions to get an outcome. The community in AT comprises the whole community involved in this work of transforming the object, such as psychologist/addiction counsellors who interact and work with the subjects. In AT terms the division of labour is described as both vertical and horizontal. With reference to this thesis, vertical comprises workers in the centre, such as practitioners, team leaders and social care managers. Horizontal can comprise other workers, in the area, across the spectrum of caring for children, such as social workers, principal social workers or foster care leaders. The rules can be ethics, time, policies and procedures that need to be adhered to. All these comprise the activity system (see figure 3.3, p. 103).

In comparison to previously discussed training approaches, the AT process is initially aided by independent trained professional researchers/interventionists, who collect data, using video and interviews, from participants and who discusses this data by giving participants tools/models to transform their activity systems (Engeström et al, 1996, p. 8). AT looks at the team and the whole organisation; it is an holistic theory but also a process that takes each persons’ agency and experience into account. In this way it addresses some of the shortcomings mentioned above, with regard to training needs analysis and performance management. Principles of AT include: everyone focusing on the object orientated, and multi-voiced participation from all participants, they take a complete history of the organisation/problem, exploring its past, present and future. Disturbances and contradictions in the activity system are explored and examined and transformations sought and implemented; in AT this means everyone’s learning is expanded and a new object is formed, this addresses the lack in Maslow’s theory by including the full range of employees needs.

As mentioned above, the AT processes comprises *subjects*¹⁴ /practitioners engaging in *developmental work research* (DWR) interventions, where they *knotwork*, which involves discussing their issues in structured forums called *Change Laboratories* until they reach *co-configuration*. Collective dialogue takes place by asking seven questions that form the cycle of expansive learning. Table 3.1 outlines key theorists involved in the creation and continuation of AT.

¹⁴ terms specific to AT that will be explained later

	1 st Generation AT	2 nd Generation AT	3 rd Generation AT
<i>Key People</i>	Kant, Hegel, Fichte, Vygotsky 1920s/1930s	Leont'ev 1978/1981 Luria, Ilyenkov, Davydov Bateson, Bakhtin, Engestrom, Cole	At present: Engeström, Cole, Edwards, Daniels, Sannio, + many more researchers.
<i>Key Ideas</i>	Individual - Culture	Collective activity, meditational means, division of labour as basic historical process	Dialogue; multiple perspectives; cultural diversity. Activity systems analysis in DWR where investigator takes a participatory and interventionist role in participants' activity to help them experience change

Table 3.1: Key people/ideas in three generations of AT

3.4 ACTIVITY THEORY EXPLAINED

Vygotsky and Cole (1978); Wertsch (1991); Cole (1996) and Daniels (2001) note that AT has links to socio-cultural theories of learning. As mentioned above in 3.2, AT refers to a theory and a process utilised by Professor Yrjo Engeström¹⁵ and fellow researchers at the Centre for Research on Activity Development and Learning (CRADLE)¹⁶ Helsinki, Finland. Roth and Lee (2007, p. 186) describe AT, as a theory that inherits the constructivist work of Lev Vygotsky, (first launched in the Soviet Union in the 1920s & 30s) and a whole tradition of scholars that developed what is now known as the second and third generation of the CHAT (Engeström, 2001) as 'one of the best kept secrets of the academia'. The remainder of this chapter will explain AT in detail. Figure 3.1 shows the advantages and disadvantages of AT:

¹⁵ <http://www.helsinki.fi/universtiy/index.htm>

¹⁶ <http://www.edu.helsinki.fi/activity/people/engestro/>

Advantages of AT

1. It emphasises motivation and rationale for an individual or group.
2. The multi-voiceness of the team is useful in identifying the outcome or goal of an activity; everyone's voice is heard.
3. Through the sharing of historical conventions the members of the community are exposed to new tools and resources.
4. There is an opportunity to learn from others within the community.
5. AT has structure (models) that can help a group to achieve their goals.
6. AT provides a space for collective discussion and reflection.

Disadvantages of AT

1. The system cannot anticipate specific contradictions that will likely make the activity evolve in a direction that makes one adapt.
2. The theory itself is relatively new and therefore has some abstract ideologies that may be difficult to comprehend and apply completely.
3. Rigid structure in carrying out an activity can discourage creativity.
4. The methodology: Developmental Work Research (DWR) can be time consuming.
5. It can be expensive: getting researchers to come to talk to practitioners and managers.
6. It can take time to achieve results; it is a longitudinal process of chains and transformations, in development and learning in collective activity systems.

Figure 3.1 Advantages and disadvantages of AT (adapted from Forrest, 2011)

In bringing AT to the West, Engeström critiqued the Russian studies of AT and in his dissertation on 'expansive learning' in 1987, combined this approach with the system theoretical work of Bateson (1972) on double-bind situations and learning levels, thereby introducing the notion of conflicts that were absent in Vygotsky's framework. AT is deployed by researchers who seek to analyse the development of consciousness within practical social activity settings. Their emphasis is on the psychological impacts of organised activity and the social conditions and systems that are produced in and through such activity (Daniels et al, 2007, p. 522). In a social care context this refers to the work of practitioners and how it impacts on them, for example, the stress for them of engaging in irrelevant CPD training.

The overarching position of this theory is that ‘the human mind emerges, exists, and can only be understood within the context of human interaction with the world’ (Kaptelinina et al, 1999, p. 28). Engeström (2000a), in his paper: *Activity theory as a framework for analyzing and redesigning work*, addresses issues close to this thesis. He explains that AT is a research framework that aims to move beyond the micro-macro, mental-material, observation-intervention binaries that typically frame workplace analysis. Activity theory attempts to distinguish between ‘short-lived goal-directed actions and durable, conscious object-oriented activity systems’ (Kaptelinin, 1996; Engeström, 2000a, p. 960).

The origins of AT can be traced to the classical German philosophy of Kant, Hegel and Fichte, involving active, developmental and constructive roles of human actions (Klaus and Buhr, 1987, pp. 1203-1207). Rubinstein (1957) first formulated the notion of human action as a unit of psychological analysis, and Leont’ev (1978, 1981), a student of Vygotsky, building on Rubinstein, developed the conceptual framework which became known as AT (Kuutti, 1996). Today AT is mostly associated with Vygotsky and the cultural-historical school of Russian psychologists, who explored objective, ecological, and socio-cultural perspectives of activity-based philosophy of Marx and Engels (Kuutti, 1996, Lewis, 1997). While continuously critiquing AT, Engeström drew on Ilyenkov (1977, p. 82) (another Soviet philosopher) to emphasise the importance of contradictions within activity systems as the driving force of change and thus development.

Whilst conflicts may not be fully overcome or resolved, they are accommodated and may indeed encourage creative and innovative solutions leading to the transformation of practice. AT’s interest in the localised and particular practices of an activity system is founded on a specific form of Marxism (Edwards, 2011). Such a stance easily aligns with Marxist understandings of social practice.

It is through such practice that social relations as well as activity systems are reproduced and transformed. Interventions into practice rest with the Marxist adage: ‘The philosophers have only *interpreted* the world, in various ways; the point however is to *change* it’ (Marx, 1972, p. 285). This represents a well established position that ties activity to the on-going transformation of social relations and practices. New practices are developed as the old are superseded.

AT has relevance for studying practitioners as it is a philosophical and cross-disciplinary theoretical framework for studying how humans purposefully transform natural and social reality, including themselves, as an ongoing developmental process (Davydov, 1999; Engeström, 1993; Kuutti, 1996). They make these transformations when they collectively engage with others in the CLs and an example of how this was conducted in this study is outlined in chapter six. Central to AT is the view that ‘contexts are neither containers nor situationally created experiential spaces, contexts *are* activity systems. An activity system integrates the subject, the object, and the instruments (material tools as well as

signs/symbols) into a unified whole' (Engeström, 1993, p. 67). AT provides a conceptual framework from which we can understand the inter-relationship between activities, actions, operations and artefacts, subjects' motives and goals, and aspects of the social, organisational and societal contexts within which these activities are framed (Engeström, 1993, p. 67).

Throughout his research programmes, Engeström uses creative combinations of, and variations on, these research strategies tailored to the contours and subtleties of specific research projects on adult learning in various disciplines. Much of his research was conducted in ways that help to identify and resolve local problems and contradictions; this distinguishes it from much theoretical work. Engeström's work provides transferable accounts and facilitates 'naturalistic generalisation'; common statistical methods are not particularly useful for Engeström's research purposes (Engeström et al, 1984). Engeström (1987) sought to accommodate explicitly the fact that practical activity is typically carried out by groups constituted in institutions such as doctors' offices, schools, and - potentially - child care centres (Witte and Haas, 2005, p.137). Activities take shape through a series of socio-material mediations depicted originally by Engeström (1987) as relations between nodes in a multilevel triangle. As a theory of change and learning in concrete, local, socially situated practices, AT can be applied critically for summative purposes but better lends itself to developmental or illuminative requirements in situations where people are learning to do things that have not been done before (Lave, 1996, Avis, 2007, Andrews and Du Toit, 2010, p. 2).

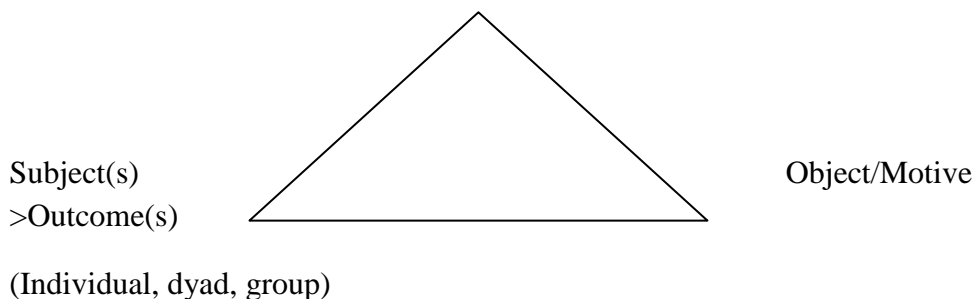
3.5 THREE GENERATIONS OF AT

The three diagrams presented here (Figs. 3.2, 3.3) illustrate changes from Vygotsky's insights, through Leont'ev's articulation of the fundamental structure of activity, to a still-emerging third generation of AT incorporating difference, discourse and dialogue into the framework (Bakhurst, 2009, p. 199).

3.5.1 First Generation AT

Meditational Means (Tools)

(Machines, writing, speaking, gesture, architecture, music, etc)



(Individual, dyad, group)

Figure 3.2: First generation AT model basic mediated action triangle (adapted from Cole and Engeström (1993) Vygotsky (1978, p. 40).

This first approach drew heavily from Vygotsky's concept of mediation in which the stimulus and response formulation (common to behaviourism) is transcended by a complex mediated act. This became formalised in the triangular model of the instrumental act. The triangle represents how Vygotsky brought together cultural artefacts with human actions in order to dispense with individual/social dualism. A critique of first generation AT during this period (Russia 1920s/30s) showed that the unit of analysis remained individually focused. Studies were largely limited to play and learning among children, and contradictions, referred to in conjunction with Ilyenkov above (p.101), remained an extremely touchy issue due to the potential to focus on individuals as the cause of problems.

This was overcome by the second generation, which centred around Leont'ev (Leont'ev, 1981, pp. 210–213), a student of Vygotsky who focused on the relationship of mediation with other components of the activity system. The activity concept enabled an enormous advance for the paradigm, in that it changed the focus to the complex interrelationships between individuals and their community. In his famous example of 'primeval collective hunt' he explicated the crucial difference between an individual action and a collective activity. A criticism of Leont'ev was that he never graphically expanded Vygotsky's original model into a model of a collective activity system. Engeström did this; it is depicted in figure 3.3 (Engeström 2001, p. 134).

3.5.2 Second Generation AT

Here, in figure 3.3, Engeström advocates the study of artefacts 'as integral and inseparable components of human functioning' and he argues that the focus of the study of mediation should be on its relationship with the other components of an activity system (Engeström 1999b, p. 29).

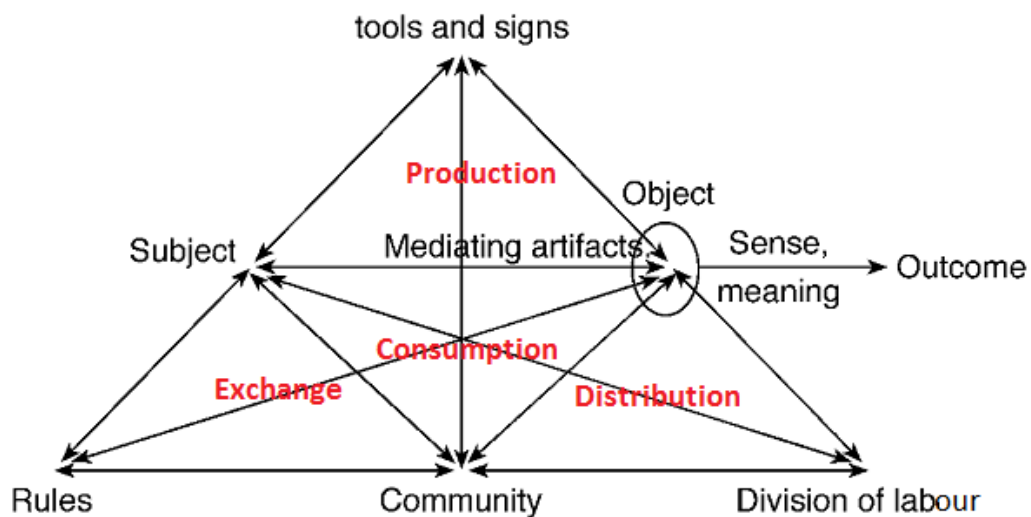


Figure 3.3: Second generation AT model: the structure of a human activity system (Engeström, 1987, p. 78).

Activity theory places the focus on doing. Edwards (2011), states that the idea of ‘object motive’ is at the core of Engeström’s work in AT; his biggest contribution is the idea of the *activity system*, (figure 3.3) which can be a work team which provides a framework for interrogating the relationship between individuals and groups and their interactions with objects and the tools which are designed to assist in producing intended outcomes (Issroff and Scanlon, 2002). Further to this AT views subjects (e.g. practitioners/managers) as being situated within a social context that influences the way in which different individuals and groups participate in activities (ibid, 2002). A key idea is that of internal contradictions, (within an activity system), driving change and development.

In figure 3.3, the top triangle is identical to Vygotsky’s basic structure of mediated action. The activity system consists of four sub-activities: production, consumption, exchange, and distribution. The activity system enables the analysis of these multiple relations but it is essential to ‘grasp the systemic whole’ in the analysis (Kerosuo et al, 2010, p. 115). Production is the consumption of the individual’s abilities and of the means of production. Correspondingly, consumption is also production of human beings themselves. Distribution seems to be not just a consequence of production but also its immanent prerequisite in the form of distribution of instruments of production and distribution of members of the society among the different kinds of production. Finally, exchange, too, is found inside production, in the form of communication, interaction and exchange of unfinished products between producers (Engeström, 1987, p. 79).

The rules, community, and division of labour, in the bottom portion of the triangle model, add the socio-historical collective nature of mediation that was not addressed by Vygotsky (Engeström, 1999a). The subject refers to the individual or subgroup whose position and point of view are chosen as the perspective of the analysis; subjects are motivated toward a purpose or attainment of the object. The object refers to the ‘raw material’ or ‘problem space’ at which the activity is directed (for example, attaining relevant CPD training) also it can be the goal of an activity, the subject’s motives for participating in an activity, and the material products that subjects gain through an activity. The object is turned into outcomes with the help of instruments, that is, tools and signs. Community comprises the individuals/subgroups who share the object.

Rules are any formal or informal constructs that constrain or allow activities to occur; rules refer to the explicit and implicit regulations, norms, conventions and standards that constrain actions within the activity system (Engeström, and Sannino, 2010, p. 6). Additionally, rules are the procedures and acceptable interactions to engage in with other community members (Engeström, 1993). Division of labour refers to horizontal division of tasks and vertical division of power and status. The outcome is the results or consequences that the subject finds once the activity is completed (Engeström, 1993). Additionally, the outcome is the consequences that the subject faces because of his/her actions driven by the

object. These outcomes can encourage or hinder the subject's participation in future activities (Yamagata-Lynch and Haudenschild, 2009 p. 508).

The circle around the object in figure 3.3 indicates, at the same time, the focal role and inherent ambiguity of the object of activity. The object is an invitation to interpretation, personal sense making and societal transformation. One needs to distinguish between the generalised object of the historically evolving activity system and the specific object as it appears to a particular subject, at a given moment, in a given action. The generalised object is connected to societal meaning; the specific object is connected to personal sense (Engeström, p. 78). For example, in residential care work, the generalised object may be children placed in centres because of societal challenges (neglected or abandoned by parents), whereas the specific object may be a particular child/young person who is either self-harming or abusing alcohol/drugs, thus requiring staff to have specialised CPD training to address such issues.

Engeström's activity system (figure 3.3), is dynamic and open to change through working on the *contradictions* (discussed below) that arise when, for example, new tools are introduced and old rules inhibit their use. Engeström's analyses of activity systems centre on systemic learning, that is, on how work systems change as a result of working on and transforming the object of activity (Engeström 1999a, 1999b). The concept of activity took a huge step forward in that it turned the focus on complex interrelations between the individual subject and his/her community. A tremendous diversity of applications of AT began to emerge as in: (Chaiklin et al, 1999; Engelsted et al 1993; Engeström et al 1999; Nardi, 1996; Kuutti 1996; Yamagata-Lynch, 2007). With Vygotsky's foundational work, the cultural-historical approach was very much a discourse of vertical development toward 'higher psychological functions'.

As AT changed and developed, critiques (Engeström et al 1995, cited in Owen, 2008, p. 52) suggested that as activity systems are increasingly interconnected and interdependent, many studies of expansive learning take as their unit of analysis a constellation of two or more activity systems that have a partially shared object. Such interconnected activity systems may form a producer-client relationship, a partnership, a network, or some other pattern of multi-activity collaboration (Engeström, and Sannino, 2010, p. 6). A critique of second generation AT was that Luria's (1976) cross-cultural research remained an isolated attempt with Cole (1988; see also Griffin and Cole, 1984) being one of the first to clearly point out the deep-seated insensitivity of the second generation AT toward cultural diversity. When AT went international, questions of diversity and dialogue between different traditions or perspectives became increasingly serious challenges, which third generation AT (Engeström, 2001) aimed to address.

3.5.3 Third Generation AT

Engeström (1999a) sees joint activity or practice between two or more activity systems (figure 3.4) as the unit of analysis for AT. He is interested in the process of social transformation and includes the structure of the social world (though how to define this is obviously a challenge) in analysis, taking into account the conflictual nature of social practice. He sees instability, internal tensions and contradiction as the 'motive force of change and development' (Engeström 1999a p. 9) and the transitions and reorganisations within and between activity systems as part of evolution; it is not only the subject, but the environment, that is modified through mediated activity. He views the 'reflective appropriation of advanced models and tools' as 'ways out of internal contradictions' that result in new activity systems (Cole and Engeström 1993, p. 40).

In Engeström's (2001) expanded model, which visualises multiple interacting activity systems, the concept of boundary crossing has been elaborated, wherein the object of one activity system moves into the sphere of another, potentially generating between-system contradiction. AT is a meta-theory focusing on whole systems, rather than individual users (Learning Theories Knowledge Base, 2010). Yankar (2011, p. 186) states that AT can be used to study learning phenomena within the complicated, ill-structured and contradiction-laden world of adult professional life.

As a conceptual framework AT has been used to inform organisational change interventions in work, health, education, information, technology/computers/the media and in informing exploratory research such as, among others by the following: (Engeström, 1999a; 1999b). In work by: Engeström (1993); Engeström et al. (1996); Engeström (2000a); Engeström (2000c); Engeström (2002); Engeström (2001); Engeström et al (2003b) Engeström and Kerosuo, (2007); Daniels et al (2007) and by Warmington (2011), in education by Engeström (1996c); Edwards (2004); Edwards and Mackenzie, (2005); Leadbetter et al (2007); Daniels et al, (2009); Edwards et al (2009) and by Engeström and Sannino (2010), in health by Engeström, (1993); Engeström (2000b) and by Engeström, Engeström, and Kerosuo, (2003a) in Information technology/computers by Engeström, (1995); Engeström, (1999e); Virkkunen and Ahonen, 2004; Engeström et al, 2002); Engeström and Ahonen, (2001) and by Westberry (2009) and in the media by Helle, et al (2009a, 2009b). Figure 3.4 illustrates joint activity or practice between two or more activity systems.

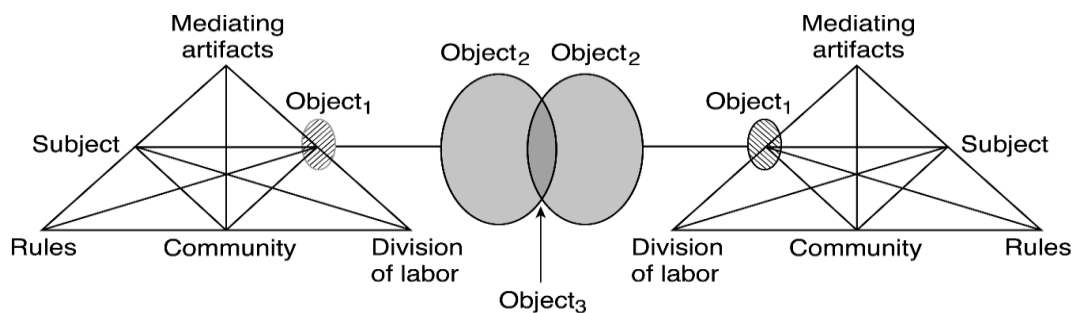


Figure 3.4: Two interacting activity systems as minimal model for third generation AT.

The minimal representation that figure 3.4 provides, shows two of what may be a myriad of systems that exhibit patterns of contradiction and tension (Engeström 1999a, p. 3). It shows how the object moves from the initial state of un-reflected, situationally given ‘raw material’ (object 1; eg practitioners/manager highlight concerns about CPD training) to having a collectively meaningful discussion with management/trainers about a particular CPD issue of concern (object 2; eg a child self-harming who constitutes risk and concern for practitioners/managers at the centre), to a potentially shared or jointly constructed object (object 3; eg a collaboratively constructed understanding of the child’s life situation discussed by practitioners/manager, social workers, social care team and trainers and where self-harm risks and precautions are emphasised and training put in place: such as Applied Suicide Intervention Skills Training (ASIST) and changes are made to the child’s/young person’s Individual Crisis Management Plan (ICMP).

Another interpretation of third generation AT is illustrated in Figure 3.5. It presents the practitioners’ and the child’s life activity systems. The practitioners’ activity system is currently oriented at completing a list of separate routine tasks, in accordance with the child’s care plan, when a child is placed in care. In contrast, the child’s life activity is oriented at maintaining a meaningful and safe life in the centre while struggling with threats such as co-operating with their care plan, meeting many new staff, negotiating their needs and their rights, attachment issues - loss of family, friends and their home environment and in some cases of older children the ability to act independently, and many other issues, maybe around alcohol/drugs and self-harm among others.

The two activity systems are intertwined in that they must act together to produce a collaborative outcome and a new shared object, yet their objects are different and there can be increasing tension between them. The outcome is achieved by them working through their issues where compromises and conclusions are reached between the child/young person and the staff at the centre (figure 3.5, shared object box). Any deteriorating states of affairs can be changed by means of an expansive learning process in which the two parties generate a new shared object and concept for their shared activity. This kind of extension of the unit of

analysis makes it more demanding to identify and give voice to the actual flesh-and-blood human subjects who have their own emotions, moral concerns, wills and agendas. As stated by Engeström and Kerosuo, (2007, p. 340) ‘organisation must necessarily be translated back into a workplace, inhabited by human beings’.

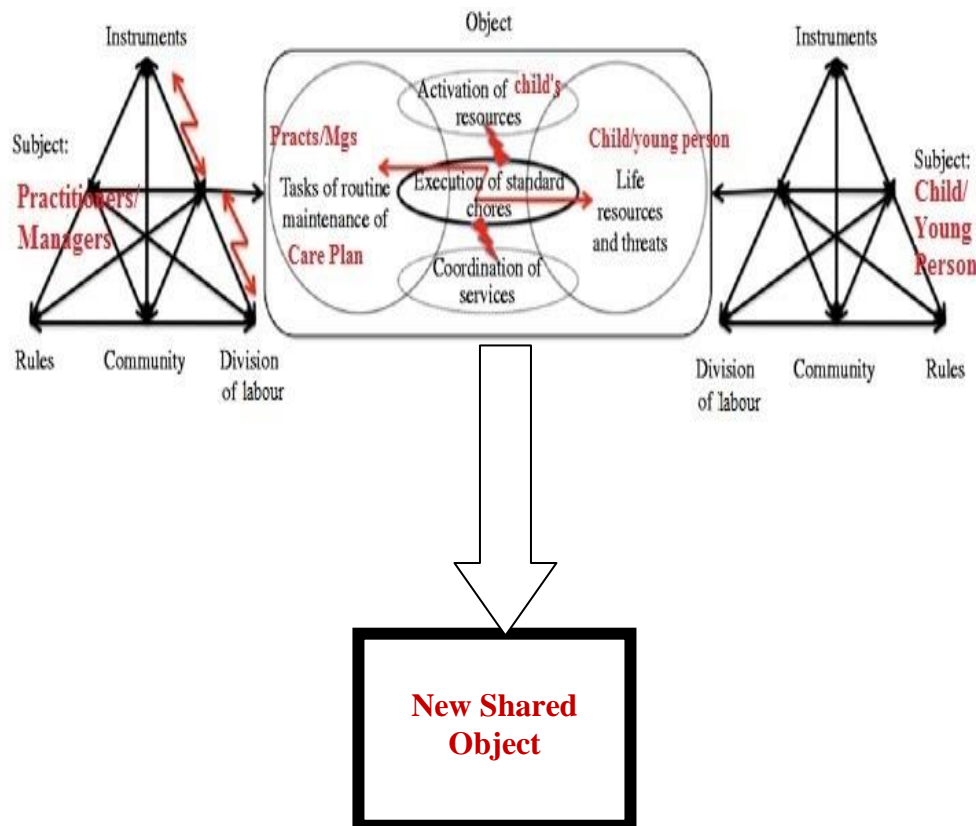


Figure 3.5: Activity systems of practitioners and the child adapted from Engeström and Kerosuo, (2007, p. 340).

Because the object of activity is a moving target, (various types of CPD training issues can be discussed at different times, such as self-harming now and at another time, key working), it is not reducible to conscious short-term goals (Engeström, 1999a, p. 3). Third generation AT expands the analysis both up and down, outward and inward. Moving up and outward, it tackles multiple interconnected activity systems with their partially shared and often fragmented objects. Moving down and inward, it tackles issues of subjectivity, experiencing, personal sense, emotion, embodiment, identity, and moral commitment (Engeström, 2010a, p. 8).

Third generation AT, emergent since 1999, aims to develop conceptual tools to understand dialogues, multiple perspectives and networks of multiple interacting activity systems adopting joint activity or practice as the unit of analysis, focused on partially shared objects (Engeström, 2010a, p. 6). After critiquing the Vygotskian framework, Wertsch (1991) introduced Bakhtin's (1981) ideas on dialogicality (the formation of ideas in dialogue) as a way to expand it. Riva Engeström (1995) went a step further by pulling together Bakhtin's ideas and Leont'ev's concept of activity and elaborated the concept of boundary crossing.

Engeström (2010, p. 323) explains that ‘boundary crossing occurs because human beings are involved in multiple activities and have to move between them’.

Engeström and Sannino (2010, p. 12) note that processes of innovation and learning are increasingly taking place in collaborative constellations and networks of multiple activity systems. In studies of expansive learning, this was first taken up in a paper that put forward boundary crossing as a serious theoretical concept (Engeström, 1995). Boundary crossing was characterised as ‘horizontal expertise where practitioners must move across boundaries to seek and give help, to find information and tools wherever they happen to be available’ (Engeström, et al, 1995 p. 332). Engeström et al., (1995, p. 333) state that:

Boundary crossing entails stepping into unfamiliar domains. It is essentially a creative endeavour which requires new conceptual resources. In this sense, boundary crossing involves collective concept formation

This development opened the door for the formulation of third generation AT.

Bakhurst, (2009, p. 197) criticises third generation AT by suggesting that:

Although many suggest that AT represents the most important legacy of Soviet philosophy and psychology, Engeström’s third-generation development of AT is troubled because it is at tension with the concerns of AT’s Russian founders. In particular the Soviet tradition of AT ‘saw the concept of activity as a fundamental category to address profound philosophical questions about the possibility of mind,’ but ‘activity theory in the West has principally become an empirical method for modelling activity systems’ (ibid, 2009 p. 197).

The argument here is: how do you bring in human actors into AT? Engeström’s third generation AT considers agency (*situated activity* and *self*): ‘Interventions in human beings’ activities are met with actors with identities and agency, not with anonymous mechanical responses’ (Engeström, 2010a, p. 20). Roth et al (2008, cited in Engeström, 2010a, p. 7) call for the inclusion of sensuous aspects of work into the unit of analysis. They name emotions, identity, and ethico-moral dimensions of action as salient sensuous aspects. Roth (2008) suggests that sensuous aspects may be approached by focusing on actions and their effects.

While Engeström (2010a, p. 7) agrees that analysing actions together with their social and material consequences is indeed a promising way to approach emotions and other sensuous aspects of activity empirically, he thinks it is important to ask: Why emotions? What is their role in activity? In referring to children in residential child care, emotions and relationships play a big part. Moreover, it can be argued, as suggested by Stecley (2012), that staff experience anxieties related to touching young people, that some young people use physical restraint to meet needs for touch, that touch is used to contain distress and avoid restraint, and that

touch-related fears may be limiting its ameliorating use, thus potentially increasing the use of physical restraint. Piper (2010, p. 12), argues that the damaging effect of no-touch practices, alienates adults and children and says what is needed is a different kind of professionalism, including a return to notions of professional trust and agency, and a reassertion of individual responsibility and integrity. This means a more ethical practice: that encourages professionals to not slavishly follow no-touch guidelines, but to put touch back into its proper context (relationships), and take account of trust and friendships (ibid, 2010) .

For Leont'ev (1978), emotions were, above all, signals of the subjective construction of object-related motives that are difficult to access and explicate consciously. To gain access to motives one must proceed along a 'round-about way' by tracing emotionally marked experiences (Leont'ev, 1978, p. 125). In other words, the study of action-level emotional experiences is an avenue to an understanding of activity-level motives which keep, as mentioned above, activity systems (figure 3.3) in motion through constantly working through *contradictions*.

Incorporating the three generations of AT, it can be posited that AT is well positioned to address the challenges posed for professional practitioners related to the progression and advancement of more techno - rational models of practice and the bureaucratisation of practice. As described in section 3.7.1 below, practitioners, in utilising the change laboratory (CL), will get a chance to come together to discuss such models and the impacts - good/or not - before implementing them. In my view AT gives people the opportunity to challenge issues; while they may not always get a successful outcome, it can help people to confront top-down technological transformation by giving them a space to challenge the 'inevitability' of such change. In addition AT requires participants to generate viable alternative courses of action: thus they do not merely 'reject' techno-rational change, but address it in a more proactive way. This means that they are more likely to be seen by management and themselves as active participants in, rather than 'victims' of change. Kerosuo (2006); and Engeström and Sannino (2010, p. 18) conducted on co-configuration work in the care of patients with multiple chronic illnesses. They showed that digitisation had no effect but argued that a need for co-configuration and knotworking in this domain arises because of the severely negative human and economic consequences of excessive fragmentation of care.

Ripamonti and Galupo (2016, pp. 206-223) analyse the process of expansive learning and development following the introduction of enterprise resource planning (ERP) systems in the human resources department of a multinational pharmaceutical company. In this case, people undergo a top-down technological transformation, with strong implications on daily workplace experience. The paper shows how the process of expansive learning can meet turbulence and obstacles, even the closure of a CL intervention process.

In explaining the differences between the three generations of development of AT it can be seen that AT moved from the first generation, which focused mainly on the individual, to the second generation which included the collective. The third generation emphasised two or more activity systems working together while focusing on the object with the aim of finding an outcome to the problem. It can be seen that each additional 'generation' of AT has broadened the range of factors that are taken into consideration: it has moved from the psychological towards the sociological.

This study makes a contribution to the debate between the different emphases between all three because, as outlined in the TCI intervention in chapter six, firstly individual practitioners began questioning themselves about the concept of doing TCI restraint; in the CLs they discussed it collectively with their colleagues. The main contribution to the debate from this study is located in third generation AT. For example, during the boundary crossing CLs (when management/other professionals were invited to the CLs, which encompassed collective psychological thought processes in a sociological context) they were successful after not working and debating the issues in which they transformed their problem into a rewarding outcome in that they had part of their behaviour management policy amended which permitted them to discontinue employing TCI restraint.

In the interest of reconfiguring CPD for practitioners and with reference to figure 3.3 above, the next section interprets the various AT terms and explains how they correspond to terms/concepts in this study.

3.5.4 Applying Engeström's Activity Theory (AT) to this study

Subjects Practitioners/managers and can also be the HSE organisation; (goal-directed actions; beliefs; ideas; mental models).

Objects CPD training (patterns of behaviour; relations with children/fellow professionals) or can be children/young people, being cared for in centres.

Mediation Socio-cultural ideas about CPD training (tools; theories; approaches; historical traces and cultural meanings associated with professions, and identities).

Instruments/Tools Anything used in the transformation process: relationships with children/young people, colleagues, interagency staff and management; asking questions, sign systems, instruments, procedures, policies, methods, laws and processes; care plans, court orders, children's logs, records, training manuals, presentations and files. Computers/Internet/E-mail and telephones are tools used to act upon the object: CPD training to achieve outcomes (arrange meetings; filling in significant event reports (SERs); accessing centre policies, reports or templates; sending/receiving emails and accessing RAISE.

Outcomes including intended and unintended Practitioners/managers receiving relevant CPD training (effectively informing, assessing, advising, enabling, advocating, feeding back, networking, managing and innovating); also can include among others, child protection, welfare and security, a better understanding of life in general and better outcomes for service users.

Intended outcomes could include improvements in overall situation; better relationships with others; de-escalation of aggressive behaviour.

Unintended outcomes these can be hard to predict as they may happen as a result of other things happening but may include: reduced stress and/or staff moving on as they become better trained.

Community extent to which value systems are shared (ideas about 'good practice', meeting targets, nature of professionalism); encompassing trans-disciplinary teams, with a common motivation of understanding the situation - to provide effective quality child care to the children/young people at the centre. Teams can include: social workers, gardaí, juvenile liaison officers (JLOs), GPs, addiction counsellors, psychologists, teachers, psychiatrists etc

Division of labour, both vertical and horizontal concerning contradictions of power, roles and status (staffing, training, resources).

Vertical Interactions between managers and team leaders (TLs); between practitioners and TLs; between managers and practitioners; between practitioners and their colleagues at the centre, between centre staff and service users.

Horizontal between the members of the community (roles and relationships), for example with the social work manager (SWM)/area manager in HSE/Psychiatrist /Psychologist; and with all trainers in the HSE.

Rules: Practitioners/managers (subjects) are governed by rules and social norms to perform his/her work (Engeström 1993). Rules also concerns time, measurement of outcomes and criteria for rewards, also staff work-contracts, cultural norms, organisational practices, plans, policies and changing frameworks for regulation of practice (focus of CPD practice; statutory entitlements; service targets); also among others: Children First Guidelines (2011, Department of Children and Youth Affairs); The Child Care (Placement of Children in Residential Care) Regulations 1995, (Irish Statute Book, 1995). As alluded to above, contradictions, discussed next, keep the activity system in motion.

3.6 CONTRADICTIONS

Contradiction is a term used by activity theorists in reference to ruptures, breakdowns and clashes within an activity system (Kuutti, 1996). In Engeström's AT framework, changes in systems occur as a result of participants recognising and working with the contradictions (Figure 3.6) in them. In explaining

contradictions Leont'ev (1981), along with giving the 'primal hunt' example, also talked of contradictions in terms of a doctor in provincial Russia who set up a practice to reduce sickness, but, if his work was to be sustained he needed the number of sick patients to increase (Edwards, et al 2009, p. 104). Contradictions are to be found everywhere as few systems are so completely bounded that new ideas, resources or expectation are prevented from entering. When people first meet a contradiction – such as a new expectation that they will collaborate in parallel with other professionals to support a particular child, but at the same time are bound by rules in their workplace that are based on onward referral without continuous collaboration – they will feel frustrated with either the expectation or the rules. If they are convinced, because of professional values, that parallel inter-professional collaboration is best for the child, they are likely to work around the rules in order to change them (ibid, 2009, p. 104). Figure 3.6 indicates areas of contradiction:

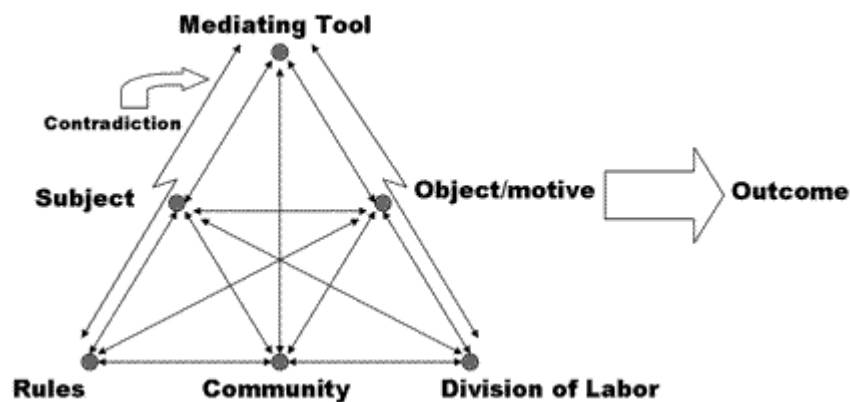


Figure: 3.6 Activity System Model indicating area of contradiction (Engeström, 1987).

Figure 3.7 gives a brief description of the four contradictions.

Contradictions arising in this study that reflect and impinge on CPD for practitioners are outlined and discussed in chapter seven. In identifying, debating, discussing and sometimes transforming contradictions, Engeström (2007a) utilises a methodology process called Developmental Work Research (DWR), explained in section 3.7 below:

- *Primary contradiction*: This occurs within each node of the activity system; it relays the fundamental tensions in general society and is the result of a double bind e.g. the opposition between the exchange value and use value in capitalist political economies; it is manifest in tensions that arise from the dual construction of everything and everybody as both having inherent worth and being a commodity with market based socio-economic relations, the idea of care and control, for example, doctors in the US both fostering health and increasing revenue to improve their practice (Engeström, 1996a, pp. 72–73). Even if attempts to resolve the other levels of contradictions are temporarily successful, the primary contradiction remains and is not only continually present; it is also foundational to the other levels of contradiction. This fundamental tension keeps the activity system in constant tension, surfacing in everyday contexts in various forms and in the other levels of contradiction (ibid, 1996a, pp. 72).
- *Secondary contradictions*: Occurs when two nodes of the activity conflict with one another; it is manifest if a new element (object) enters a system, leading to contradictions between elements that pre-dated it. For example, if a student on placement shows existing staff new techniques or tells them new ways to do things, this may cause friction within the team. Another example is that if a child who had been sexually abused is placed at the centre and if this is the first time staff has cared for a child with such symptoms, there will be conflicting views from staff members on how best to care for this child. In Engeström’s health study case, the new objects were children with chronic illnesses or it can be the rule used by doctors in the US who limit their time per patient to increase their revenue while preventing illness.
- *Tertiary contradictions*: Arise when the object of a more ‘culturally advanced’ activity (Engeström, 1987) is introduced into that system (Engeström, 1999b, p. 34-35). The motive for introducing a new object to an activity system is typically to find relief from one or more secondary contradictions and the tensions stemming from them. For example, when/if practitioners use information relayed to them by an expert in a special unit, dealing with sexual abuse matters, to assist them to cope with a child who is acting out in a sexually explicit way, this will have an impact; it could possibly trigger the developmental phase through which the activity system will be redefined and reconfigured from then on, resulting in changes for staff in how to work with children/young people.
- *Quaternary contradictions*: Are triggered by a ripple effect from efforts to remediate a tertiary contradiction; they arise between the central activity (residential child centre) and its neighbouring activity systems when a new form of practice is employed based on a reformed and/or expanded object. For example, if practitioners after utilising information obtained (Tertiary contradiction example) are then required to re-locate a child to a unit/foster family who has not had the benefit of this professional advice/information, this can cause a disturbance between practitioners and the neighbouring service/unit, for example, among others, disturbances with the child’s school or with the home youth liaison service that the child attends. In other words, transformation of the central activity system’s object catalyses disturbances in that system’s relations with the other activity systems with which it interfaces (Kuutti, 1996, p. 34).

Figure 3.7: Contradictions explained

3.7 DEVELOPMENT WORK RESEARCH (DWR)

DWR is intended to elicit different professionals' understandings of their work and to reveal how practitioners from different backgrounds develop and use concepts to engage with newly emerging practices. Somewhat similar to DWR is action research, a systematic approach to investigation that enables people to find effective solutions to problems they encounter in their everyday lives. Like DWR, unlike traditional experimental/scientific research that looks for generalisable explanations that might be applied to all contexts, action research focuses on specific situations and localised solutions (Stringer, 2007, p.1). Eden and Huxham (1996, p. 526) suggest that a reason to conduct action research is 'to see if there is intent by the organisation members to take action based on the intervention'. Action research seeks to formulate ways of living and working together that will enhance the life experiences of the participants (ibid, 2007, p. 213).

Jones and Gelling (2013, p. 6) explain that 'action research has become increasingly popular with researchers and practitioners in health and social care because of the focus on changing practice and on engaging practitioners and stakeholders in the change process'. As with DWR, action research can involve the participants supplying their own data and contributing to the planning and conducting of the research; this gives them considerable ownership of the project (ibid, 2013, p. 6). In action research, the role of the researcher is not that of an expert who does research, but that of a resource person. He/she becomes a facilitator or consultant who acts as a catalyst to assist stakeholders in defining their problems clearly and to support them as they work towards effective solutions to the issues that concern them (Stringer, 2007, p. 24).

In utilising DWR, Engeström (2007a) employs Vygotsky's concept of dual stimulation in which he aims to help practitioners reveal understandings that are embedded in their accounts of their practices and the systemic tensions and contradictions they encounter when developing new ways of working (Leadbetter, 2006). Vygotsky (1997, p. 212), in describing dual stimulation points out that while utilising his interventionist methodology of double stimulation, instead of merely giving the subject a task to solve, he gave the subject both a demanding task (first stimulus) and a 'neutral' or ambiguous external artefact (second stimulus) which the subject could fill with meaning and turn into a new mediating sign that would enhance his/her actions and potentially lead to reframing of the task (ibid, 1997, p. 212). Next, the process of DWR interventions are explained in which practitioners utilise Change Laboratory's (CLs)¹⁷.

A CL is a physical space allocated for promoting innovation and learning within organisations. According to Miettinen (2006), the techno-economic change in society requires the adoption of context-specific forms of learning and

¹⁷ Change Laboratory(s) will be abridged to CLs throughout the thesis

development such as the knowledge acquired in CLs. The aim of the CL (discussed next) is to support participants to redesign their work and organisation by embedding new conceptual tools for expanding practitioners' thinking and practice by confronting 'everyday' understandings of their work practices with AT derived analyses of practice (Engeström 1987, 1996c, 2007a). Engaging in the CLs gives a true representation of how AT can be described as a contextual, dialogical and developmental theory because as described, with reference to this study in the TCI intervention in chapter six, all of these elements of AT are reflected in the way that the object is dialogically and collectively discussed by practitioners in their own context i.e. a structured space. From the discussions transformations (as was experienced in the TCI intervention) in the form of learning and development can be made.

3.7.1 Methodology: DWR Interventions using Change Laboratories (CLs)

Warmington (2011, p. 147) indicates that CLs can be intervention sites that utilise a series of DWR type research workshops, proposed as structured, formal boundary zones, 'free from prearranged routines and patterns, in which negotiation of new professional practices can emerge' (Tuomi-Gröhn et al 2003, p. 5, cited in Warmington, 2011, p. 148). While CLs are utilised by the practitioners within the activity: residential child care centre, if practitioners from another activity join in, this is called a 'boundary-crossing change laboratory'.

In the workshops, AT is used both by researchers and participating practitioners as an analytical framework to understand current work practices and propose new ways of working. The workshop series is preceded by quasi-ethnographic research, where practitioners are observed and interviewed in their organisational settings. These interviews and observations also continue between workshops.

'Mirror data' derived from the quasi-ethnographic stage are presented to the participants and jointly analysed by the research team and participating practitioners (In this study mirror data comprised practitioner interview findings about TCI restraint presented by practitioners during the TCI intervention). Workshops can comprise between two or more and up to 12 practitioners from the organisation in which the intervention is carried out. Teams (Figure 3.8) comprise: a session leader who presents mirror data for discussion, a second researcher who summarises and presents the discussion data on flipcharts (modelled on Engeström's triangle of mediations) and a third researcher who constructs a research note on outcomes of session. Sessions can be audio and/or video recorded, with audio-video data being used alongside other mirror data for analysis in subsequent workshops. In the workshops, quotes are coded to indicate where they fell in the workshop series; so, for instance a quote derived from the second workshop in a series is coded ('DWR2').

The CL brings work redesign closer to the daily work practice while still keeping it analytical. In this study this was done by practitioners in their own context bringing in and collectively discussing the every day concerns about TCI restraint and working out the contradictions associated with it through the AT framework in the CL while incorporating Engeström's analytical framework of the cycle of learning to make transformations to this contradiction. Also, CLs take place in the participants' own workspace, with their colleagues (thus close to daily practice) but, through its structured process of critique of practice, moves people to a new level of analysis. The discussion is rooted in people's own work experience; it is not theoretical or detached (in the way that evidence-based practice can be, for example). This brings forth a new dialectic of close embeddedness in and reflective distance from work, while bringing together practice-driven redesign processes and idea-driven construction of visions for the future, which means a new dialectic of specified improvements and comprehensive visions. Also it combines multiple parallel rhythms of development in work – a new dialectic of long, medium and short cycles of innovation and change. Lastly, it brings together the tools of daily work and the tools of analysis and design – a new dialectic of instrumentalities. The central tool is the 3x3 set of surfaces for representing the work activity as shown in figure 3.8:

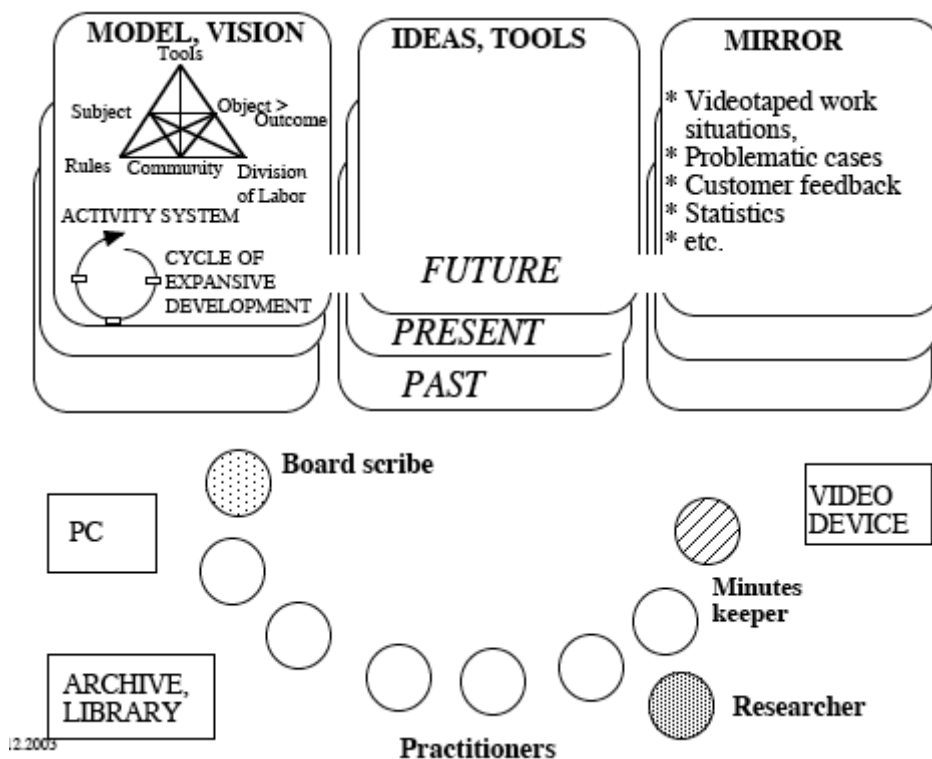


Figure 3.8: Prototypical layout of the CL (Engeström et al, 1996, p. 11).

In the time dimension of the past, present and future, it encompasses:

Professionals face the surfaces aided by a scribe appointed from among them; they can use video equipment and additional tools such as databases and a reference library. All three sets of surfaces are used as a ‘time travel’ device to trace the historical routes of the activity and to identify the source of its contradictions. Sessions move from the current problem in the activity to problems experienced in the past. They model their activity as it used to be in the past and then move on to more elaborate models of the current activity and its contradictions. The next step is about designing a future model for their activity and a number of concrete partial solutions connected to that vision, to be implemented in practice. In CLs, the focus for practitioners in this thesis will be the procurement of consistent, relevant CPD training, a necessary requirement for services to be coordinated and progressed successfully.

As suggested by Halton (2014a) this will involve a process where learning outcomes are influenced by: professional and organisational contexts; individual learning needs and objectives; learning styles and preferences and programme content and style of delivery. In CLs, when planning and discussing CPD all these elements can be involved and, by virtue of practitioners’ presence in the process, it is hoped this will help to allay barriers to CPD. The alternative is that of it possibly becoming a ‘tick-box’ exercise, when/if practitioners do not feel involved in the process (Halton et al, 2014b, p. 15).

Not exactly like CLs but somewhat similar, journal clubs (Crausaz, 2014) are in existence for over 20 years and can be defined as a group of professionals who meet regularly to critically discuss the applicability of current research findings to their place of practice. Such clubs may be a way of initiating debate around the effectiveness of customary practice and may serve to address the question of what is meant by ‘best practice’ and ‘best evidence’. They can be a uni- or multi-disciplinary forum to debate and explore research in order to demonstrate that customary practice is evidence-based. Crausaz (2014) reports that services who took the time to engage in journal clubs, found them rewarding, saying they solidified their team; the team felt more confident with themselves and defended why they worked they way they did. In CLs emphasis is on new practices that could be considered in ‘knotworking’ sessions (discussed next) (Engeström, 2001, p. 147, Engeström, 2005b and Leadbetter, et al 2007, p. 92).

3.8 ‘KNOTWORKING’

From the Helsinki study Engeström (2001), explains that *knotworking* means the movement of tying, untying and retying together seemingly separate threads of activity. This captures the idea of the new pattern of activity needed to achieve collaborative care of children with multiple illnesses across institutional boundaries; an emerging type of work organisation. For Engeström (2001), practitioners should be able to connect and coordinate with one another and with

the parents quickly ‘on the spot’ when needed, but also on the basis of a shared and mutually monitored long-term plan. The notion of knotworking serves as one link in an emerging configuration of concepts that defines the expanded pattern of activity (ibid, 2001, p. 147).

Knotworking can be described as going beyond conventional teamwork or networking and is ‘a rapidly changing, distributed and partially improvised orchestration of collaborative performance which takes place between otherwise loosely connected actors and their work systems to support clients’ (Engeström et al, 1999, p. 346). As opposed to sequential forms of collaboration, where a child is moved from one expert to another, with knotworking there are parallel collaborations amongst professionals whereby support is wrapped around a child or family with professionals timing their own interventions in relation to the needs of the child and the work of other professionals. In knotworking the tying and dissolution of a knot of collaborative work is not reducible to any specific individual or fixed organisational entity as the centre of control; the centre does not hold. The locus of initiative changes from moment to moment within a knotworking sequence. Subsequently, CPD training for practitioners should be available and wrapped around issues that arise in relation to children/young people and when specialised support and training is required, it should be provided (ibid, 1999, p. 346).

Knotworking cannot be adequately analysed from the point of view of an assumed centre of coordination and control, or as an additive sum of the separate perspectives of individuals or institutions contributing to it. The unstable knot itself needs to be made the focus of analysis. The rise and proliferation of knotworking is associated with ongoing historical changes in work and organisations. Victor and Boynton’s (1998) concept of *Co-configuration* is particularly interesting from the point of view of knotworking (Engeström, 2000a, p. 972). Key workers may help to promote this timely and responsive work (Edwards, et al 2009, p. 32). Co-configuration, discussed next, is a way of thinking about how practitioners work with each other and with clients to co-configure children's trajectories, for example, in accordance with their care plan in the centre (Leadbetter, 2006).

3.9 CO-CONFIGURATION

Co-configuration in responsive and collaborating services requires flexible knotworking in which no single actor has the sole, fixed responsibility and control (Leadbetter et al, 2007, p. 93). The origins of co-configuration lie in Victor and Boynton’s (1998) analysis of how work practices change and how they provide a useful historical framework for such a reintegration of organisation, work, and learning (Leadbetter, 2006). Victor and Boynton (1998) identified five types of

work (Figure 3.9 below) in the history of industrial production: craft, mass production, process enhancement, mass customisation and co-configuration.

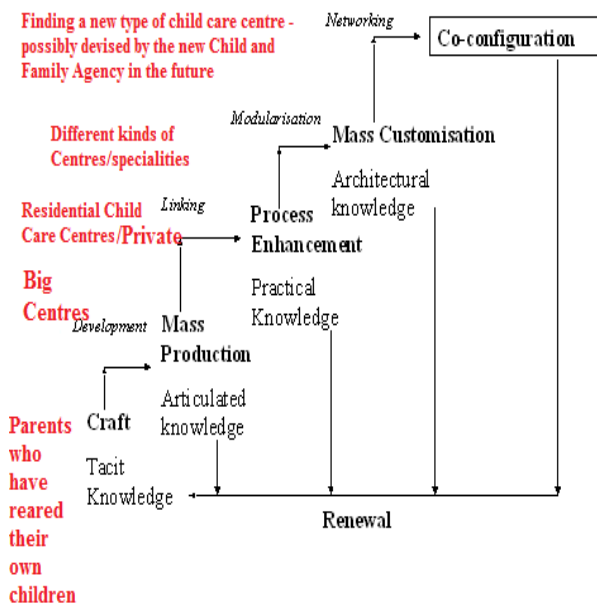


Figure: 3.9 Historical forms of work: co-configuration (adapted from Victor and Boynton, 1998, p. 6; p. 233).

In this thesis, the centres taking part in the study are moving from mass customisation (careful targeting of specialist provision, for example, centre’s required to provide short term placements only) to co-configuration (a way of labelling responsive interactions in inter-professional work by providing respite and outreach care in the community and also giving more of a ‘voice’ to the child) (Edwards et al 2009, p. 13). According to Victor and Boynton (1998), each type of work generates and requires a certain type of knowledge that is produced in different kinds of relationships. They suggest that change occurs through learning and the leveraging of the knowledge produced into new and, arguably, more effective types of work (Edwards et al 2009, p. 13). Co-configuration requires participants to be able to recognise and engage relationally with the expertise distributed across rapidly changing work places (Edwards 2005) and to work in new ways with those who hitherto had been seen mainly as clients. It has the potential to involve children/families in repositioning themselves in and thereby reshaping the social conditions of their development as they work on them and change them (Edwards and Apostolov 2007, cited in Edwards et al 2009, p. 16).

While Edwards et al (2009) were studying social inclusion of children in their research sites, for practitioners it may be asking for relevant CPD training to address occurring issues which would contribute to the provision of quality child

care in their centre (ibid, 2009, p. 16). Engeström (2002, p. 2) suggests that a viable theory of work-related learning needs to be founded on an analysis of the historical development of work. A new landscape of learning emerges as work is transformed from mass production and mass customisation toward co-configuration of customer-intelligent products and services with long life cycles.

This could be reflected in how de-institutionalisation has led towards more personalised, client-focused, forms of care. For example, in the larger institutions mentioned in chapter two mass production and customisation prevailed; now, since de-institutionalisation, children/young people have their own social worker and individual care plan. In consolidating these de-institutional changes, Engeström (2002, p. 2) claims that without a substantive understanding of the historically changing character of the work done in a given organisation, theories of organisational learning are likely to remain too general and abstract to capture the emerging possibilities and new forms of learning.

The move to mass customisation brings greater precision; in the centre in the context of de-institutionalisation this could involve the careful shaping of a specific service, through creating modules or tailored forms of provision that can be specifically targeted at particular groups (for example, using therapeutic one to one interventions to address children presenting with aggressive behaviour) or it can involve creating different types of centres/specialities and/or a new type of centre devised for the future by Tusla. One difference between this work and what happens in work labelled co-configuration is that with mass customisation there is little opportunity for ongoing reshaping of services; whereas the emphasis of co-configuration work is on the continual development of the services with others. Another difference is that the networks of co-configuration involve the users of the service alongside practitioners in the development work and everyone is involved in learning (ibid, et al 2009, p. 15). Victor and Boynton cited in Engeström, (2002, p. 2) explain co-configuration as follows:

The work of co-configuration involves building and sustaining a fully integrated system that can sense, respond, and adapt to the individual experience of the customer... Unlike previous work, co-configuration work never results in a 'finished' product; instead, a living, growing network develops between customer, product, and company (Victor and Boynton, 1998, p. 195).

Although this model of changing practices originated in the Harvard Business School and does not discuss the provision of welfare services, it resonates strongly with senior staff responsible for reconfiguring centres for children (Edwards et al, 2009, p. 15). Co-configuration is a way of labelling practices that are currently emerging in inter-professional work where practitioners work together to help shape a child's trajectory. It also recognises the point made by Furlong and Cartmel (1997) that young people currently find themselves

negotiating risks that were largely unknown to their parents (experimenting with drugs/alcohol/self-harm and sexual behaviours) and that those negotiations take place at an individual level even though they are shaped by wider structural changes. For CHAT researchers, an added attraction of the Victor and Boynton model is its focus on how changes in conceptual tools, that is the knowledge in use, are intertwined with changes in individual practices and in the services and systems in which they are produced (Edwards et al 2009, p. 16).

The implications of co-configuration work for practice in children's centres are considerable. In the context of professional collaboration for professional learning in organisations, co-configuration involves on-going partnerships between professionals to support young people's pathways when they are in the centre. It involves discursive construction of tasks, solutions, visions, breakdowns and innovations (Engeström and Middleton 1996). This work demands a capacity to recognise and access expertise distributed across local systems and to negotiate the boundaries of responsible professional action with other professionals and with children/young people (Daniels et al, 2007, p. 1).

From a human services point of view, it is welcome that children/young people are included; Edwards et al, (2009 p. 14) state that co-configuration is a very demanding mode of work and production and in professional organisations (such as Tusla) it can lead to the new types of knowledge (Victor and Boynton, 1998). It offers radical strategic advantages when the objects of work demand it. A precondition of successful co-configuration work is dialogue where parties rely on real-time feedback information on their activity. The interpretation, negotiation and synthesising of such information between the parties requires new, dialogical and reflective knowledge tools as well as new, collaboratively constructed functional rules and infrastructures (Engeström and Ahonen, 2001). The central features of co-configuration work are listed and described as follows (figure 3.10).

1. It is *transformative* learning that radically broadens the shared objects of work by means of explicitly objectified and articulated novel tools, models, and concepts that tend to form integrated multilevel instrumentalities or constellations.
2. It is learning by *experiencing* that puts the participants into imagined, simulated, and real situations that require personal engagement in actions with material objects and artefacts (including other human beings) that follow the logic of an anticipated or designed future model of the activity.
3. It is *horizontal* and dialogical learning that creates knowledge and transforms the activity, by crossing boundaries and tying knots between activity systems.
4. It is *subterranean* learning that blazes cognitive trails that are embodied and lived but unnoticeable. These trails serve as anchors and stabilising networks that secure the viability and sustainability of the new concepts, models, and tools, thus making the multi-activity terrains knowable and liveable (Engeström, 2007a, p. 38).

Figure 3.10 Central features of co-configuration work

In conjunction with exploring contradictions through DWR interventions Engeström, in the Helsinki health study, drew on four questions (discussed in Engeström's Helsinki case study at end of this chapter) and five principles to transform work re-design in the multi-organisational field of the healthcare.

3.10 FOUR QUESTIONS

1. Who are the subjects of learning
2. Why do they learn?
3. What do they learn?
4. How do they learn?

3.11 FIVE PRINCIPLES

1. Two or more activity systems are collectively taken as the prime unit of analysis
2. Activity systems emphasise the multiple voices of participants to accommodate different views, traditions and interests
3. Historicity is utilised to reflect the evolution over lengthy periods of time
4. The central role of contradictions used as sources of change and development
5. The possibility of expansive transformations in activity systems.

Principle One: a collective, artefact-mediated and object-oriented activity system, such as a (residential care centre), seen in its network relations to other activity systems, such as (social workers; Child and Adolescent Mental Health (CAMH) professionals; psychology, gardaí, teachers etc), which can be taken as the prime unit of analysis. Goal-directed individual and group actions, as well as automatic

operations, are relatively independent but subordinate units of analysis, eventually understandable only when interpreted against the background of entire activity systems. Activity systems realise and reproduce themselves by generating actions and operations. The collective (staff and management are involved), artefact-mediated system is oriented towards an 'object' (professional CPD training) and mediated (e.g. by tools/rules/cultural norms). While collectively involved and focused on obtaining ongoing, relevant CPD training the activity system also takes account of new laws, policies and procedures including cost-effectiveness which will ultimately benefit the children in care as well as the service.

Principle Two: an activity system is always multi-voiced: a community of multiple points of view, traditions and interests (trans-disciplinary teams working in tandem, including practitioners/managers; team leaders, SWM and social workers and all the above) as opposed to a single individual/organisation, giving direction from head office (either via email or to the centre manager). The division of labour in an activity system creates different positions for the participants; the participants carry their own diverse histories and the activity system itself carries multiple layers and strands of history engraved in its artefacts, rules and conventions. The multi-voicedness is multiplied in networks of interacting activity systems (for example, involving the above named professionals, to name a few). It is a source of trouble and a source of innovation, demanding actions of translation and negotiation.

Principle Three: historicity describes activity systems taking shape and getting transformed over lengthy periods of time. Their problems and potentials can only be understood against their own history (for instance, among others, practitioners learning from accounts of past child abuse case and how they were assessed). History itself needs to be studied as local history of the activity and its objects, and as history of the theoretical ideas (ethics, human rights, and standards affecting practitioners work) and tools that have shaped the activity (Child Care Act 1991; different kinds of CPD training). What happens can only be fully understood against its own history. Thus, CPD training needs within residential child care work needs to be analysed against the history of its local organisation and against the more global history of changes in how training is constructed and developed, together with concepts, procedures, and tools employed and accumulated in the local activity.

Principle four: the central role of contradictions as sources of change and development. Contradictions are not the same as problems or conflicts; they are historically accumulating structural tensions within and between activity systems. The primary contradiction pervades all elements of our activity systems. Activities are open systems. When an activity system adopts a new element from the outside (for example, a new technology or a new object, for example a new method of working with families or a new decision that practitioners now need to

send a fax to gardaí when a child is missing from the centre), it often leads to an aggravated secondary contradiction where some old element (for example, the rules or the division of labour: who will do this job now) collides with the new one. Such contradictions generate conflicts, dilemmas, disturbances and local innovations but also local innovative attempts to change the activity.

Principle five: extols the possibility of expansive transformations/cycles in activity systems. Activity systems move through relatively long cycles of qualitative transformations. As the contradictions of an activity system are aggravated, some individual participants begin to question and deviate from its established norms. For example, some practitioners may not want to change from doing things the old way that they were used to. In some cases, this escalates into collaborative envisioning and a deliberate collective change effort (recently qualified staff, with new shared ideas can initiate the driving change). Expansive transformations, in systems (centres) can be accomplished through involvement and implementation of Engeström's cycle of expansive learning which can include, for example, staff engaging in lifelong learning with a view to enhancing their development and practice. A full cycle of expansive transformation may be understood as a collective journey through the zone of proximal development (ZPD) of the activity:

It is the distance between the present everyday actions of the individuals and the historically new form of the societal activity that can be collectively generated as a solution to the double bind potentially embedded in the everyday actions (Vygotsky, 1978, p. 86, cited in Engeström 1987, p. 174)

When the five principles are cross-tabulated with the four questions above, they are presented with answers by Engeström in the matrix (Figure 3.13, p.141, below). The matrix serves as a framework for summarising the answers offered by the theory of expansive learning (Engeström, 2001, p. 138).

3.12 LEARNING BY EXPANDING/EXPANSIVE LEARNING

The history and theoretical roots of the concept of expansive learning are explained below, starting at 3.12.1. Engeström (1987, 1999d) claims that expansion of the basic model can be achieved by 'learning by expanding', defined as a 'thoughtfully mastered learning activity' that can be seen in terms of expanding involvement in a system of genres (Engeström, 1987, p. 210). Engeström's learning by expanding was built on the thesis of collective creative activity where he believed that human beings had to become able to transform their institutions and practices in a way that mobilises the intellects and energies of all participants from the ground up. Creativity is understood as involvement in such collective transformation of practices. Engeström's (1999f, p. i) critique of

theories of learning established that ‘although theories of learning have tried to explain enduring changes in human behaviour and cognition, they did not address the issue of how people can change themselves as they change their circumstances; that was why a new theory of expansive learning was needed’.

Expansive learning refers to processes in which an activity system, for example a work organisation, i.e. HSE resolves its pressing internal contradictions (the problems for practitioners when not receiving relevant CPD training because the structures are not there to provide the training) by interpreting and expanding the definition of their object of activity and responding in increasingly enriched ways by constructing and implementing a qualitatively new way of functioning for itself (Engeström, 1987, 2001; Warmington et al, 2004). For practitioners such learning is evidenced in enhanced analyses of CPD training and or care trajectories of children/young people, and of their own capacities for professional action. It is also evidenced in their dispositions to recognise and engage with distributed expertise in complex work places. For children it can be seen in the development of their interpretations of and actions in their worlds as they work within care trajectories (Yamazumi et al, 2005; Sannino et al, 2009).

The theory of expansive learning puts the primacy on communities as learners, on transformation and creation of culture, on horizontal movement and hybridisation, and on the formation of theoretical concepts and it relies on its own metaphor: expansion. Expansive learning captures the dynamics that arise when people who are engaged in an activity begin to recognise new complexities in the tasks they are working on, that is, they expand the object of their activity (Edwards et al 2009, p. 104). The core idea is qualitatively different from both acquisition and participation. In expansive learning, learners learn something that is not yet there. In other words, the learners construct a new object and concept for their collective activity, which they implement in practice. A question that can be posed is: can individual transformation occur in the absence of responsivity from the organisation? The answer to this question may be that yes it can occur in the short-term but it may not be possible in the long-term unless the organisation wants to do it. If this does not occur it could pose difficulties for a period of time if the organisation does not meet the practitioner half-way.

These dynamics may be seen in how they begin to use familiar resources in fresh ways, develop new ideas as they use those resources, question the practices that get in the way of their work and begin to work with different people or the same people in new ways. Changes in relationships between resources, ideas, rules and how the work is shared out are signs of expansive learning at the level of the activity system. Though these kinds of changes commonly occur in organisations, some are better than others at accommodating the shifts: by encouraging an expansion of the object of activity and by responding to the outcome of that expansion (management may begin to listen to practitioners’ concerns).

While critiquing AT's transformations/expansive learning, Steinnes (2004, p. 270) comments that in Engeström's terms, transformation is inevitably tied to an ethic of improvement but from another perspective Steinnes implies that transformation is not an unambiguous value by arguing that while there may be a global educational enterprise to make transformation synonymous with predictable, linear developmental growth, transformation also may be used to describe a change of form that is not predictable or linear. She describes this as an abyss between an 'ethic of improvement' around learning and the controlled and declared means and ends of transformation.

3.12.1 Theoretical roots of the concept of expansive learning

As alluded to above, the theory of expansive learning was built on foundational ideas put forward by key figures in the Russian cultural–historical school: Vygotsky (1978, 1997), Leont'ev (1981), and Il'enkov (1977, 1982). Another Russian, Davydov (1988, 1990), also played a major part. Six ideas developed by these scholars form the conceptual basis of the theory of expansive learning. Two additional roots come from the work of Bateson (1972) and Bakhtin (1981) cited in (Engeström and Sannino 2010, p. 4).

3.12.2 Differences with standard theories of learning and expansive learning

Engeström (1987) explains that standard theories of learning are focused on processes where a subject (traditionally an individual, more recently possibly also an organisation, such as the (HSE/Tusla) acquires some identifiable knowledge or skills in such a way that a corresponding, relatively lasting change in the behaviour of the subject may be observed. It is a presupposition that the knowledge or skill to be acquired is itself stable and reasonably well defined. There is a competent 'teacher' who knows what is to be learned.

Engeström claims that the problem is that much of the most intriguing kinds of learning in work organisations violate this presupposition. People and organisations are all the time learning something that is not stable, not even defined or understood ahead of time. In important transformations of our personal lives and organisational practices, we must learn new forms of activity which are not yet there. They are literally learned as they are being created. There is no competent teacher. Standard learning theories have little to offer if one wants to understand these processes (Engeström, 1987).

In this study the practitioners/managers (subjects) are learning and experiencing something new through their work that they are not familiar with (for example, how to care for children who are self-harming/have been sexually abused by a parent). The knowledge needed to learn is learned as it is being developed. Therefore there is no-one in the role of teacher (Yamazumi et al, 2005), though there are potential sources of knowledge: websites, magazines and articles etc.

Bateson's (1972) theory of learning is helpful for tackling this challenge. Engeström notes that Bateson (1972) distinguishes between three levels of learning. Learning 1: a simple reproduction and optimisation of existing practice, it refers to conditioning, and acquisition of the responses deemed correct in the given context – for instance, the learning of correct answers in a classroom. Ad-hoc and reflected problem solving in work processes can be related to such learning levels. Bateson (1972) points out that Learning II includes the methodological aspect 'learning how to learn'. Wherever we observe Learning I, Learning II is also going on: people acquire the deep-seated rules and patterns of behaviour characteristic to the context itself (Engeström, 1987).

Thus, in classrooms, students learn the 'hidden curriculum' of what it means to be a student: how to please the teachers, how to pass exams, how to belong to groups, etc. Sometimes the context bombards participants with contradictory demands. Bateson defines this situation as 'double-bind' (1972). Learning II creates a double bind. For example, a pupil may have little interest in a subject such as (psychology) but may like the teacher and therefore study for the subject and do well in the examinations. Although level two includes a complex examination of the situation and the adoption of experiences from other contexts, general assumptions and understandings are not questioned. Such pressures can lead to Learning III, where a person or a group begins to radically question the sense and meaning of the context and to construct a wider alternative context. Learning III is essentially a collective endeavour. Bateson points out that processes of Learning III are rare and dangerous (Bateson, 1972, pp's 305-306) for example, the student revolution in Paris, France 1968 see (Duhan, 2013).

In Learning III - learning level problems cannot be solved on the basis of the existing background of an individual or community. Contradictions between experiences, values, understandings, and possible problem solving occur. While Bateson above is giving examples regarding pupils learning in school, also a double bind situation can occur in a change laboratory in a centre. For instance, a practitioner may question a previously discussed procedure regarding how information was to be shared by social workers to the team in the centre. A double bind can be created if the social worker is present when the practitioner openly questions and discusses this procedure and comments that it has not been adhered to and as a result of same the practitioners have had to deal with challenging behaviour from a young person affiliated with the information who thinks that the practitioners know the information but will not tell them.

Engeström (1987, 2001) explains that triggers for such double bind can be unexpected problems that occur in work processes, new framework conditions or newcomers that join an existing community of practice. These causes are characterised through the confrontation of an existing community with facts that challenge its valid understandings and convictions. In this study the concept of

double bind was discussed in the TCI intervention in relation to management/trainers hearing the discussions and explanations from practitioners, based on their experience about why they did not want to continue employing TCI restraint yet TCI was the policy of choice used by HSE. Engeström claims that individuals or communities can only overcome this double-bind situation through questioning the background assumptions and redefining their understanding of work through expansive learning (in what he terms a change laboratory).

The theory of expansive learning develops Bateson's idea into a systematic framework. Learning III is seen as learning activity with its own typical actions and tools. The object of expansive learning activity is the entire activity system in which the learners are engaged. Expansive learning activity produces culturally new patterns of activity and is understood as the capacity of participants in an activity to interpret and expand the definition of the object of activity and respond to it in increasingly enriched ways. For practitioners/managers such learning is evidenced in enhanced analyses of the potential of the education and training of staff, and of their own capacities for professional action (Engeström, 1987). It is also evidenced in their dispositions to recognise and engage with distributed expertise in complex work places/activity systems (trans-disciplinary teams).

Systems do not simply evolve: changes are stimulated by imbalances in the system and these lead to dynamic shifts in the practice; sometimes barely discernable, as they arise from small tensions that occur. For example, a lack of clarity over whether a team leader should make contact with a child's parent may indicate a tension that may be resolved by a brief conversation, or it may be the first sign of a contradiction in a system where a new emphasis on attainment, which is the responsibility of team leaders, is beginning to override the centre's historically established emphasis on informal relations with the children families through team leaders (Edwards, et al 2009, p. 104). Contradictions, principles, and questions are transformed, through utilising the cycle of expansive learning.

3.12.3 Cycle of Expansive Learning

Engeström (2004a, p. 4) cited in Warmington (2011, p. 147) stresses that expansive learning is 'intertwined with *horizontal or sideways* movement across competing or complementary domains and activity systems'. Building upon principles of collective transformation, DWR promotes the questioning of contradictions in existing practice that is, contradictions (as above) between the different elements of activity, such as 'tools,' 'rules' and divisions of labour.

Warmington (2008, p. 4), critiquing Engeström's analytical understanding of contradictions in relation to activity and what he terms 'expansive learning', suggests that the definition of contradictions that underpins Engeström's notions of 'expansive' learning and his 'DWR' methodology is restrictive. He claims it is

restrictive as it underplays the wider social contradictions and antagonisms inherent in the *commodification of labour-power*. Peim (2009), Daniels (2004), Avis (2007), Hartley (2009), Martin and Peim (2009), Blackler (2009); and Kontinen (2004, 2013) claim that Engeström does not address issues of power politics and managerialism in the workplace, or the wider social antagonisms in which work is embedded (social class, neo-liberalism). They claim that DWR can become a managerialist tool that has a rhetoric about ‘radical exploration’ of work but which, in fact, really serves to make the worker more manageable and more efficient within narrowly defined, conservative notions of professionalism.

Engeström (2000a, p. 964) had said in anticipation of this criticism that activity systems are driven by communal motives that are often difficult to identify and articulate by individuals but are directed at particular objects embedded in the activity. The object and motive give actions their ultimate continuity, coherence and meaning, even if individual actions that make up that system does not coincide with the object of the overall activity (ibid, 2000a, p. 964).

For Engeström, AT is much more radical than ordinary management tools. He recognises that activity systems are in constant movement and internally contradictory, but says that by concentrating on and working around the everyday systemic contradictions, manifested in disturbances and mundane innovations, that can occur in the activity system, work can be redeveloped in expansive and transformative ways by utilising *expansive learning*. In order to perform the task of redesigning work, Engeström (2000a, p. 960; Engeström, 1999c, pp. 383-384; cf. Engeström, 1987, pp. 188-191, 321-336) suggests that practitioners should work through the learning cycle in seven stages, culminating in figure 3.11.

Engeström, (1987, p. 214) claims that knowledge creation often requires sustained periods of time and is not correctly described by traditional narratives of heroic individuals making ingenious discoveries through sudden moments of insight; knowledge creation is not linear. Engeström emphasises the element of thirdness (i.e., mediation) in expansive learning (Engeström 1987, pp. 221-222; 302-304). The concepts of activity and dialectics operate as mediating factors, bringing dynamics to the model (pp. 140; 310). Equally, Fullan’s (2001) work on leadership from an organisational development viewpoint (cited in Edwards et al, 2009, p. 105) has some echoes of Engeström’s analyses. Fullan also recognises the dangers of constant equilibrium in organisational systems, the importance of ‘disturbances’ for their development and the centrality of moral purpose to organisational change. For example, an organisation has to keep reflecting and questioning itself about what it is doing and why it is doing it and how can it improve and change so that the quality of care to the children/young people is constantly improving in line with societal changes.

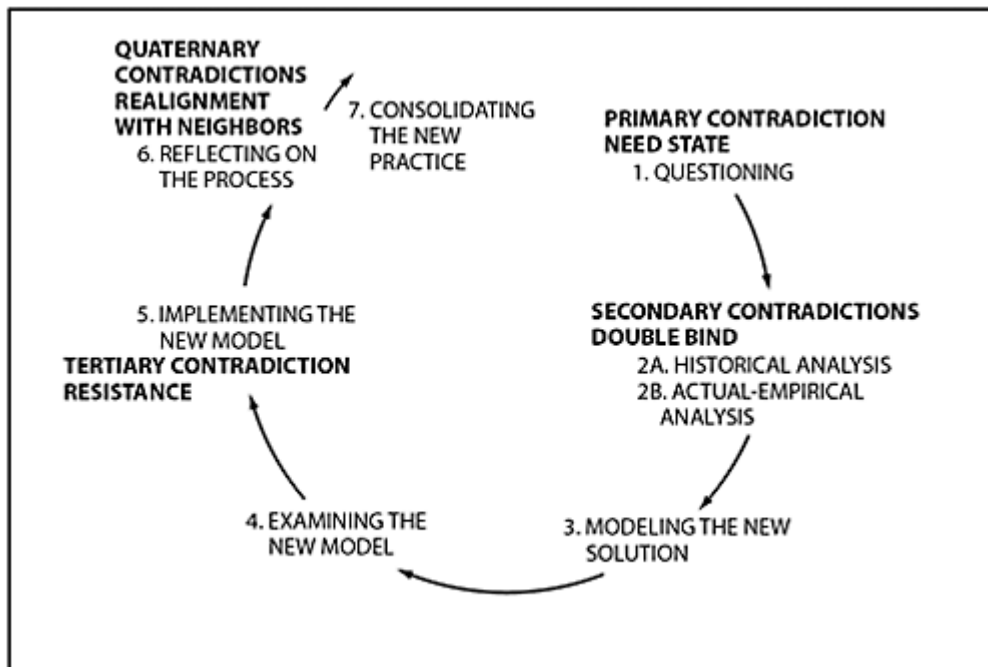


Figure 3.11: The model of expansive learning actions (adopted from Engeström and Sannino 2010, p. 8).

In Engeström’s model and in the cultural-historical approach, knowledge is always embedded in practices, in contrast to the mentalistic tradition of ‘knowledge in the head’ (Engeström 1999c, p. 397). According to Engeström, ‘learning and expansion are becoming integrated, forming a historically new type of activity’ (Engeström 1987, p. 27 cited in Paavola et al, 2004, p. 571). Mediation is the mechanism through which external socio-cultural activities are transformed into internal mental functioning when working through contradictions (Basharina 2007, p. 85).

In critiquing the concept of contradiction in Engeström’s work, Langemeyer (2006, p. 3) compares and contrasts Engeström’s theory of expansive learning with the learning theory of the critical psychologist Holzkamp (1993), arguing that the latter’s theory is limited by its exclusive emphasis of the subjective and individual aspects of learning, while Engeström’s problem is the opposite, namely ‘a certain neglect of the subjective problematic’. In other words, the theory of expansive learning ‘conceptualises the emergence of an alternative practice, or any solution to contradictions, on a collective, but not really on a subjective, plane.’ For Langemeyer (2006) this means that the theory underestimates the probability that when practitioners face systemic contradictions, they only accommodate themselves to them in order to avoid any conflict. Contrary to Langemeyer’s criticism, this study elaborated on this issue of power, with evidence of same noted in the TCI intervention (chapter six): practitioners stated that for years they had contacted management with the view to desisting from using TCI restraint on young people in their centre. Immediately, when practitioners met management face-to-face for the first time in the CL they

collectively seized power and conveyed to management/trainer about the pressing contradiction of using TCI restraint citing their arguments for wanting to desist from using it. When management heard the arguments they set about trying to change the policy on this contradiction (TCI restraint).

In personal communication (2 July, 2016) the researcher asked Anu Kajamaa, who specialises in CL intervention, about her views of Langemeyer's critique: 'that when practitioners face systemic contradictions, they only accommodate themselves to them in order to avoid any conflict'. Her reply is as follows:

I am a Change Laboratory facilitator trained by Yrjö Engeström and Jaakko Virkkunen (main inventors of the method) and certified by University of Helsinki. I also train researchers and practitioners to use this formative intervention method. I would answer to Langemeyer's criticism that if a researcher is skilled in collecting ethnographic data from the activity (which is step number one in our interventions), she or he gets powerful "mirror data" from the manifestations of contradictions at the work site. This mirror material is then shown in the Change Laboratory session(s). Once the participants/practitioners see this data depicting e.g. disturbances in their own work activity they cannot really "accommodate themselves to them in order to avoid conflict". The data is thoroughly discussed and analysed with the researcher(s) and solutions to overcome the problems are discovered collectively. Of course, this is a very complex process, it takes time and usually involves change resistance but in many cases very successful results are gained.

Lompscher, (2004, p. 388) and Rückriem (2009) critique Engeström et al's concept of expansive learning, saying it neglects the radical transformative impact of computers, digitisation and the Internet. They argue that activity theory, as it presently exists, is a captive of the historically passing medium of print and writing. They argue that computerisation will bring about a revolutionary change in culture as contrasted with the dominant culture of books and print. For Rückriem, the whole idea of mediation of specific activities by specific tools and signs misses the point of the ongoing societal and cultural transformation engendered by digital media, especially by Web 2.0.

Engeström and Sannino (2010, p. 18) disagree; citing that studies conducted on co-configuration work in the care of patients with multiple chronic illnesses (e.g., Kerosuo, 2006) show that digitisation has no effect. They argue that the need for co-configuration and knotworking in this domain arises because of the dire human and economic consequences of excessive fragmentation of care. Engeström and Sannino (2010, p. 18) claim that computerisation of medical records may offer new possibilities for implementing co-configuration – but digitisation can also be used as an excuse to avoid or postpone such deep changes in collaboration and

division of labour, for example staff could use the excuse that because their systems are now computerised they no longer need to engage in CLs.

Within an activity system, all elements constantly interact with one another and are virtually always in the process of working through changes. For example, changes in the design of a tool may influence a subject's orientation toward an object, which, in turn, may influence the cultural practices of the community. In addition, it is possible that the object, (even the notion of CPD) can change, and motive themselves will undergo changes during the process of activity (Kuutti, 1996). It is not surprising that Engeström (1987) called an activity system 'a virtual disturbance and-innovation-producing machine' (p. 11) and emphasised the importance of *contradictions*, driving these changes (Basharina 2007, p. 85). This is very similar to construction of new knowledge in a community of learners as a result of negotiation of different, and often times, opposite meanings (Wenger, 1998, cited in Basharina 2007, p. 85).

As noted by Engeström and Miettinen, (1999), there is a key interest in making interventions that result in the transformation of activity systems. This is especially apparent in Engeström's work in the Helsinki health case, chosen and adapted for this study, in which he addresses the work of general practitioners. Through CL and DWR, the research process *itself* enables the transformation of these systems. Transformation can lead to expanded learning of the practical work activity. This position adopts a theory of social practice in which participants through their collective activity transform the object of their labour and develop new mediating tools (ibid, 1999). In this study the process of transformation took place after management/trainers had attended the CLs and listened to practitioners' concerns about using TCI restraint: this led to them agreeing that practitioners could desist from using this specific technique (discussed in chapter six).

As outlined earlier, Engeström (2000a, p. 966) posits that it is through the resolution of these contradictions that the activity system is transformed, learning arises and the system moves beyond its previous form to become something new. Such transformations, tied to localised contexts, may bear only slight relation to wider structural relations and indeed may support these (it may look like a CL, a fake scaled down CL co-opted for other purposes thereby becoming conservative practice), as suggested in Warmington's (2008) critique above. As Engeström (2000a, p. 966) writes, this is the place in which expansive learning occurs:

The identification of contradictions in an activity system helps practitioners and administrators to focus their efforts on the root causes of problems. Such collaborative analysis and modelling is a crucial precondition for the creation of a shared vision for the expansive solution of the contradictions.

Engeström emphasises that as well as the fundamental societal relations and contradictions being found in localised practice, so too is the possibility of qualitative change (Engeström, 1999b, p. 36). DWR and the use of CLs are mechanisms that draw upon the knowledge and skills of participants and seek to rearticulate these in ways that can improve performance as displayed in figure 3.11. Dialogue transforms the system as well its object. There is a dialogic process through which the object (CPD professional training) of the activity system is continuously constituted.

In discussing how contradictions make changes in organisation, Edwards et al (2009, p. 121) note that the emotional or affective aspects of changing organisations and practices should not be down played, by explaining that Vygotsky was quite clear that emotion cannot be filtered out of analyses of how we act in the world. For example, he argued that if emotion were ignored:

Thought must be viewed ... as a meaningless epiphenomenon incapable of changing anything in the life or conduct of a person (Vygotsky 1986, p. 10).

Vygotsky's thinking on the importance of emotion was developed by Vasilyuk (1991) when he introduced the notion of 'experiencing', which involves living through personal crises in creative ways in order to restore meaning to life. Vasilyuk has helped us to see that coping with change is not simply a behavioural response, but also involves a relatively slow process of working through contradiction or 'crises' and gaining new forms of mental equilibrium that enable functioning (Edwards, et al 2009, p. 122).

Engeström's work on AT has been accomplished over a number of years. Meyers (2007) emphasises that cultural historical activity theory (CHAT) addresses human activities as they relate to artefacts, shared practices and institutions, thus it goes beyond individual knowledge and decision making to take a developmental view of minds in context. As people work, play, think and solve problems together they demonstrate an accumulated set of habits and values. Learning is not an isolated act; rather it is situated in time and space and influenced by the surrounding actors, resources and behavioural constraints. One should also recognise that agents in the learning process, through their activities, influence the contexts in which such learning takes place (ibid, 2007).

CHAT, then, as a dynamic model, is particularly appropriate for the study of professional learning that can occur in consistent CPD training and can be applied to the work of practitioners/managers with the view to transforming their activity systems. Engeström's continuous scholarship has contributed to deeper understandings of work activity in the many diverse, complex fields referred to above, involving the world of adult professional life, including the study of expert work and learning in complex work settings such as healthcare, often looking at

emergent forms of work organisation, including among others Engeström et al, (1999) work that ‘crosses boundaries’ of activity systems with different objects and cultures, such as workers and patients (Engeström, 2001); and work that involves the design of innovative and complex industrial products (Miettinen and Hasu, 2002). Contemporary developments in AT in Europe (particularly the Nordic countries and the UK) have been strongly influenced by the Helsinki Centre’s focus on work-related research and the DWR model that focuses on supporting professionals’ ‘learning in practice.’ The following are some current examples (Figure 3.12) of recently published work from the CRADLE, Helsinki. In the first reference, an interview in 2013 with Engeström, he discusses where AT is now and where it is going, the future state of the art of AT.

Lemos M., Pereira-Querol M., Almeida I. (2013) *The Historical-Cultural Activity Theory and its contributions to Education, Health and Communication*: interview with Yrjö Engeström. Available online @ http://www.scielo.br/scielo.php?pid=S141432832013000300018&script=sci_arttext&tlng=en

Impedovo, M.; Ritella, G.; Ligorio, M. B. (2013) ‘Developing Codebooks as a New Tool To Analyse Students’ ePortfolios’, in *International Journal of ePortfolio*, 2013, Volume 3, Number 2, 161-176

Virkkunen, J. and Newnham, D. (2013) *The Change Laboratory. A Tool for Collaborative Development of Work and Education.*, Netherlands: Sense Publishers

Toiviainen H., Kerosuo H. (2013) ‘Development Curriculum for Knowledge-Based Organisations: Lessons from a Learning Network’, in *International Journal of Knowledge-Based Organisations*.

Pereira-Querol M., Seppänen L., Virkkunen J. (2013) ‘Exploring the developmental possibilities of environmental activities: On-farm biogas production’, in *Environmental Science and Policy*.

Glăveanu, V. (2012) Interview on Third Generation Activity Theory: Interview with Yrjö Engeström, in *Europe's Journal of Psychology* 2012, Vol. 8(4), 515–518, available online @ <http://ejop.psychopen.eu/article/viewFile/555/388> [Accessed, 12th December 2013]

Kajamaa, A. and Hilli, A. (2013) ‘Clients’ Initiatives and Caregivers’ Responses in the Organisational Dynamics of Care Delivery’, in *Qualitative Health Research*, pp 1-33.

Figure 3.12: Current examples of recently published work by Engeström and the cradle centre

In collaboration with the critiques of various aspects of Engeström's AT by contemporary writers mentioned above: Langemeyer (2006); Lompscher (2004); Rückriem (2009); Warmington (2008); Martin and Peim (2009); Peim (2009); Daniels (2004); Avis (2007); Hartley (2009); Blackler (2009) and Kontinen (2004, 2013). Avis (2009) in his paper, which includes comments on critiques by other writers, gives a comprehensive critique of Engeström's AT (Avis (2009, pp. 155-162). Avis suggests that if pushed to its limits Engeström's AT prefigures a critical and anti-capitalist stance (this relates back to the first level/primary contradiction). He argues that Engeström does not provide a consistent power-oriented critique of capitalism along the lines of canonical Marxism (p. 155), although he acknowledges larger social structures:

This insight fails to be translated into broader political engagement as the focus of his interventions are upon practices within a particular activity system or those adjacent to it, as is the case with third generation AT. Consequently the wider social structure within which these processes arise tends to be ignored. This leads to analysis that leaves these wider relations in place and fails to interrogate the manner in which they shape the terrain on which an activity system or cluster is set. It is this limitation that in part results in analyses and change strategies that effectively secure the interests of capital.

So, Avis (2009, p. 157) complains that Engeström's Developmental Work Research (DWR) focuses on peripheral contradictions rather than primary ones. Engeström, he says, uses Marxist categories 'heuristically, as part of an analytic technique that serves to distance their mobilisation from Marx's underpinning philosophical and political position'.

Avis claims that the interest in expansive learning could be aligned with political engagements that address the resolution of contradiction not only in the workplace but in the wider social formation. This could sit with an expansive understanding of practice, one seeking to locate work-based processes within a wider framework and that pursues non-reformist reforms. Such reforms, when successful, 'change more than the specific institutional features that they target' and 'alter the terrain upon which later struggles will be waged' (Fraser 2003, p. 79). Such a struggle is akin to the model of radical democracy propounded by Mouffe (2005) being a process towards which we continually struggle - an aspirational politics. The extent that this potential is present in this particular version of AT, is in its promise rather than in its enactment (Avis, 2009, p. 162).

Avis (2009, p. 162), reflecting on the work of the following writers, suggests that this potential is also present in the writings of those working alongside this version of AT but who are seeking to locate it more fully in its Marxist form and to recover its radicalism (Warmington 2005; Barker and Wiseman 2006; Jones

2006a, 2006b; Langemeyer and Roth 2006; Daniels, 2004). Langemeyer and Roth, concluding their discussion of CHAT and in particular Engeström, emphasise the importance of dialectical analysis:

We experience that our engagements to change and enhance practice are themselves quite contradictory. In the most challenging entanglements, we therefore need to generate each time anew – critical perspectives on these societal practices in which we participate, and on our own social-individual basis to act and to reflect on the problems and conflicts to be resolved. This is why dialectics play beyond its historical influence on CHAT an important role in practical and theoretical struggles for emancipation and why we should not abandon it to reductionist, functionalist or systemic views (2006, p.40).

This would serve to re-politicise and re-vitalise AT, recalling its radical potential whilst at the same time acknowledging the contradictory positions in which we are placed. Herein, claims Avis (2009, p. 162) lies a politics of hope.

Aside from the aforementioned critiques from Avis (2009), we have seen that CHAT/AT has been used in many organisations and on different levels of scale, large organisations and - as we will see - smaller ones. AT has the added bonus of being very similar to action research encompassing an engaging approach, lending itself to inclusion for everyone in the workplace (activity system). While a critique of AT could be that many of these organisations are ones that are already affiliated with the idea of reflecting on work practice and knowledge (Healthcare/education/information technology) elements used and discussed in change laboratories (CLs). In counteracting this argument, Engeström has shown that AT can also be used in organisations not commonly associated with deep reflection/knowledge based thinking/work practice. For example, in an interview with Lemos (2013, p. 723), Engeström, in explaining the wide uses of AT said that the very first CLs, conducted in 1995, were in the Finnish post offices.

The post offices were so small that all the mail carriers from the given post office could participate, so it was 100% participation. In addition, other similar projects using AT in Finland include two Finnish companies: the Finnish alcohol monopoly Alko and a paper and pulp production: Metsaliiton Teollisuus (Miettinen, 1996, p. 12). Other studies reporting on the use of AT include agricultural studies such as the one by Mukute (2009) from Africa. This study showed how AT was used to identify and analyse contradictions, model and implement solutions in the learning and practice of permaculture (the development of agricultural ecosystems intended to be sustainable and self-sufficient) at one school and its community in Zimbabwe, one of three sustainable agriculture workplace learning sites being examined in a wider study on change-oriented learning and sustainability practices (Mukute, 2009). Another study on agriculture by Hill et al (2007) describes how AT was used to effect change in the

apple industry in New Zealand. AT can thus be used in different sectors and, crucially, at smaller scales than major hospitals.

In summary, through the work of Yrjö Engeström and his research teams at the University of Helsinki, AT has evolved into an influential analytical framework for research into professional learning in work practices. As described in chapter six, in this study AT has been most beneficial as an influential analytical framework for research into professional learning in work practices, as it provides the step-by-step methodology and tools to help practitioners to seek transformations in their activity systems. In particular, academics conducting research into work-related learning have drawn on DWR, the ‘applied’ form of AT developed by Engeström, as a tool for intervention research and for promoting ‘expansive learning’ within organisations. The conceptual framework of DWR and expansive learning was laid out in Engeström’s (1987) seminal study/book, *Learning by Expanding* and has been developed since by many researchers including those mentioned throughout this chapter.

Engeström’s conceptual development of AT is rooted in a concern with the *collective* aspect of work or activity: in particular, the co-operation between actors within activity systems and between related activity systems. The central tenet of AT is that human beings do not live in a vacuum but are embedded in their socio-cultural context, and that their behaviour cannot be understood independently of that context (Engeström, 1987; also Engeström et al 1999 cited in Paavola, and Lipponen and Hakkarainen, 2004, p. 560). Human activity is mediated through the conceptual and material cultural artefacts people use. This concern is made explicit in several strands of Engeström’s research: in particular the conceptualisation of ‘knotworking,’ boundary crossing (Engeström et al, 1999) and his references to Victor and Boynton’s (1998) concept of ‘co-configuration’ (Warmington, 2011, p. 145), following through to expansive learning.

In the following paragraphs, excerpts that form a brief synopsis are taken from Engeström’s (2000a, 2000b; 2001; 2006; 2007a) concrete case study, (encompassing action research practices explaining the ‘how’ of AT at a practical level) conducted by he and his fellow researchers in Helsinki; it has been adapted for this thesis and is referred to as the ‘Helsinki study’.

3.13 HELSINKI HEALTH STUDY FINLAND

Engeström and his team of researchers were invited to the Children’s University Hospital in Helsinki Finland to conduct a DWR intervention. Since the 1980s the care of patients had been divided between the local health care clinics and the hospital. There were ongoing disagreements as to who was responsible for who and for what care to be provided to the patients i.e. children. It became apparent that children with chronic illnesses such as asthma or cystic fibrosis were not receiving the appropriate care. The challenge for Engeström and his team was: to

acquire new ways in which practitioners and parents from different caregiver organisations could collaboratively plan and monitor the child's trajectory of care, taking joint responsibility for its overall progress. In order to accomplish this challenge Engeström utilised five principles (discussed above) and four questions that will be discussed as follows starting with the first question:

3.13.1 Who are the subjects of learning: How are they defined and located?

Engeström claimed that the challenge could not be met by training individual practitioners as it was an organisational problem; the whole organisation had to adopt new skills and knowledge. Top-down instructions were not effective when the management did not know what the context of learning should be. First, Engeström organised a sequence of Boundary Crossing CLs for the three activity systems: the Hospital including the physicians, nurses and specialists, the health care clinics with the doctors, nurses and care assistants and the patient's family. The hospital physicians sat on one side, the health care practitioners sat on the other and the voices from the patient's family came from the front of the room. They held many CL sessions – some were heated, where they discussed disturbances and contradictions that arose regarding their responsibilities. In the first session they presented the case of a premature baby boy who was suffering from asthma. The subjects discussed this and the session ended with individuals speaking in different voices and taking leading subject positions.

3.13.2 Why do they learn, what makes them make the effort?

For situated learning theory (Lave and Wenger, 1991), motivation to learn stems from participation in culturally valued collaborative work practices in which something useful is produced. Engeström (1987) says this seems a satisfactory starting point when observing novices gradually gaining competence in relatively stable practices. Motivation for risky expansive learning processes associated with major transformations in activity systems are not well explained by mere participation and gradual acquisition of mastery. Engeström claims that Bateson (1972) suggested that expansive Learning III is triggered by double binds generated by contradictory demands imposed on the participants by the context.

In the CLs, Engeström and his researchers made the participants face and articulate the contradictory demands inherent in their work activity by presenting a series of troublesome patient cases captured on videotape to them. In several of these cases, the patients' (child's) mother was also present. This made it virtually impossible for the participants to blame the clients for the problems and added greatly to the urgency of the double bind. Despite overwhelming evidence, the acknowledgement and articulation of the contradictions was very difficult for the practitioners. The first statements to that effect began to emerge in the third session of the CL:

Excerpt 3 (*Boundary Crossing Laboratory, Session 3*)

Hospital Nurse: A chronically ill child who has several illnesses does not necessarily have a clearly defined physician in charge. The care is fragmented. The information is terribly fragmented in the patient's medical record. It is not necessarily easy to draw conclusions as to what has happened to this child in the previous visit, not to speak of finding information about visits to another hospital, for example what shared guidance and counselling practices the family would need. And one doesn't necessarily even have information on the current medications. They are merely in the parents' memory or written on some piece of paper. So the information on the care of the illness compared to the clinical situation and urgent care situation can be detective work (Engeström, 2001, p. 142)

In order to make sense of the situation Engeström conducted an historical check on the activity systems involved. Following this, he described the Finnish hospital systems since the 1980s; in the health centres the personal doctor principle and multi-professional teams have increased the continuity of care replacing the isolated *visit* with the long-term *care relationship* as the object of professionals' work activity. The notion of the care relationship has become the key conceptual tool for planning and recording work in health centres.

A parallel development had taken place in Finnish Hospitals. Hospitals grew bigger and more complicated in the post-war decades. Fragmentation by specialties led to complaints and was seen to be partially responsible for the rapidly rising costs of hospital care. In the late 1980s, hospitals began to design and implement *critical paths* or *pathways* for designated diseases or diagnostic groups. Sessions demonstrated that physicians' thought that critical pathways were achieving success with patients and the health clinic practitioners thought likewise as regards the care relationship tool.

As the CL sessions progressed all professionals could see that changes needed to be made, as patients' families were able to verify that the appropriate care was not being delivered to their children. Engeström explained that the care relationship and critical pathways were a response to particular sets of contradictions; these were rapidly being superseded by new and more encompassing sets of contradictions; the care relationship and critical pathway were representative only to internal contradictions.

3.13.3 What do they learn – what are the contents and outcomes of learning?

In practical terms and similar to action research, as explained by Engeström, the professionals in the CLs asked themselves 'what are we doing'? They employed

knotworking sessions i.e. tying and untying of knots, debating and discussing the contradictions. They tried to capture the idea of the new pattern of activity needed to achieve collaborative care of children with multiple illnesses across institutional boundaries; they did this with the parent's co-operation.

First, they formulated the idea of a care calendar (Engeström, 2006, p. 12) which was a simple template for listing the most important events of the illness and care of the patient for the past few years. The idea was to condense the often prohibitively voluminous historical information stored in the medical records, and in the patient's own recollections and interpretations, into one or two pages that may be easily reviewed in any encounter or planning situation.

Next, they designed the care map: a one-page template to represent graphically the different caregivers and institutions involved in the care of the patient. Ideally the doctor and the patient together construct the first version of the map, marking down also problematic or missing connections between the various parties. Thus, the care map becomes not only a memory tool but also a device for identifying and diagnosing gaps and ruptures in the network of care. The care map serves the socio-spatial expansion of the object (ibid, 2006, p. 12). The preceding tools culminated in discussions such as an idea of writing back to each patient after they had been seen either at the hospital or the health care clinic.

This was rejected, stating that it would be too time consuming. Eventually, they suggested the construction of a *care agreement*. The care agreement model is a one-page document template which asks practitioners and the patient to write down the diagnoses and the patient's main concerns, the division of labour in the care (what problems are treated where and by whom) during the next year, the procedures for informing one another, the date by which the care agreement is to be reviewed, and finally the signatures of the involved parties. The drafting of a care agreement requires exchange and negotiation between the caregivers and the patient. Requiring a renegotiation of responsibility and power, the care agreement serves the moral-ideological and systemic-developmental expansion of the object.

It has minimally three key players of care, namely the patient, the health centre general practitioner responsible for the patient, and the hospital specialist in charge of the patient's care; they negotiate an overall framework for the patient's care for the next year. They sign a mutual agreement that obliges them to inform each other of any significant care events and changes in the plan. It was decided that the patient's GP would be in-charge of the patient's trajectory of care including drafting the care agreement. If the patient goes to the hospital first, the physician or nurse drafts the care agreement to include a plan for the patient's care and division of labour between the care providers contributing to the plan of care.

The draft is to be given to the child's family and sent to the child's personal health care physician and to physicians in other hospitals/clinics where the child has been seen. The care agreement allowed for *care negotiation*, this could be done

either by phone or email or by face to face communication, if a third party was not satisfied and to formulate a mutually acceptable care agreement. It also allowed for *care responsibility agreement* whereby the parents of the child are consulted and sent the agreement. Finally, care feedback involved the GP or hospital physician/nurse automatically (without delay) sending the patients record to other parties of the care agreement after the patients unplanned visit or changes in diagnoses or care plan.

3.13.4 How do they learn – what are the key actions of processes of learning?

Engeström (2001, p. 151) states that previous organisational learning models were based on the assumption that the assignment for knowledge creation is unproblematically given from above – depicted by the management and was outside the bounds of the local process. In contrast, Engeström (2001) introduced conflictual questioning of existing practice, for example, the troublesome cases in the Helsinki study; this led to deepening analysis of cases as depicted in the cycle of learning (Figure: 3.11 above) which culminated in the design and implementation of the three tools: care calendar, care map and care agreement (Engeström 2001, p. 153). The four questions utilising Engeström's five principles are shown on the matrix below (figure 3.13).

In summary, this example, culminating in figure 3.12, has shown how CHAT can be tried and tested; the literature above describes the critiques and key aspects of Engeström's theory with the example from the Finnish hospital showing how the key aspects come into play. In outlining the research focus of this thesis i.e. the reconfiguration of CPD for practitioners, the idea is to take this approach and to apply it to the research questions and the findings of this thesis to give practitioners a voice and to strengthen their work practice but also to reflect a specific orientation to bringing about change. The learning challenge for practitioners is to have consistent relevant CPD training that responds to the changing landscape of practitioners. To reconfigure their CPD training, this thesis will address the broad contextual themes listed and discussed in chapters one and two. Engeström's AT will be adapted and applied which includes four questions, five principles, and DWR incorporating CLs where centre contradictions will be worked through; knotworking will be explored with the view to attaining co-configuration and transformations through expansive learning by suggesting similar conceptual frameworks like the care calendar, care map and care agreement implemented in the Helsinki example above.

	Activity system as unit of analysis	Multi- voicedness	Historicity	Contradictions	Expansive cycles
Who are learning?	<i>Interconnected activity systems hospital, health center, patient's family</i>	<i>Voices of specialized hospital care, general primary care and lay home care</i>			
Why do they learn?			<i>Historically emerging pressures: patients move between primary care and hospitals</i>	<i>Contradictions between new object and available tools and rules in the three activity systems</i>	
What do they learn?	<i>A new pattern of activity: knotworking based on the instrumentality of care agreement</i>		<i>Historical layering and co-existence of old and new concepts: pathways and care agreement</i>	<i>Struggle between old and new concepts: critical pathway vs care agreement</i>	<i>Expansion of the object from visit to trajectory: from doctor-patient dyad to network of care</i>
How do they learn?		<i>Dialogue and debate between positions and voices, focused on a vital object</i>		<i>Contradictions converted from need state to double bind to resistance to realignment</i>	<i>Learning actions from questioning to analysis, modeling, examining, implementing, reflecting . . .</i>

Figure: 3.13 Matrix showing answers to the four questions and five principles of AT (Engeström, 2001, p. 153).

Despite the contemporary criticisms outlined above (p. 129-135), this thesis suggests it is the most appropriate theory to analyse the relevant issues in relation to CPD. Practitioners' CPD is not ideal now and the application of CHAT could move it to a better place for the future, while keeping in mind the change over to Tusla. Practitioners engaging and utilising the tools of CHAT in CLs can have a collective and collaborative input into their future and ongoing CPD training.

The ultimate test of any learning theory is how it helps us to generate learning that penetrates and grasps pressing issues that humankind is facing today and tomorrow (Engeström and Sannino, 2010, p. 21). The theory of expansive learning currently expands its analysis both up and down, outward and inward. Moving up and outward, it tackles learning in fields or networks of interconnected activity systems with their partially shared and often contested objects. Moving down and inward, it tackles issues of subjectivity, experiencing, personal sense, emotion, embodiment, identity, and moral commitment. The two directions may seem incompatible. Indeed, there is a risk that the theory is split into the study of collective activity systems, organisations and history on the one hand and subjects, actions and situations on the other hand. This is exactly the kind of split the founders of activity theory set out to overcome. To bridge and integrate the two directions, serious theoretical and empirical efforts are needed (Engeström

and Sannino, 2010, p. 21). In aiming to investigate these observations, Engeström's AT has been adapted in this study. Chapter four discusses the methodology utilised to advance practitioners CPD training in the study.

CHAPTER FOUR: METHODOLOGY

4.0 INTRODUCTION

Chapters one and two set the context of the study by laying out the complex field of social care practice while addressing the various issues and challenges posed by the research questions. Chapter three identified the theoretical approach and why it was chosen. In this chapter we discuss the doing of the research and issues that need to be addressed, in particular the challenge of conducting an AT approach. The chapter is divided into two parts: part one discusses ontology, epistemology and the theoretical perspective used for the study; part two focuses on methods used to collect the data which consisted initially of the qualitative method of semi-structured interviews, followed afterwards by the questionnaire study.

4.1 RESEARCH DESIGN

Research design addresses the planning of a scientific enquiry; it refers to an overall strategy for finding out something and includes: research approach, research strategy and the research methodology (Babbie and Mouton, 2006). There is varying terminology and interpretations used to describe and discuss ontology, epistemology, research paradigms and theoretical perspectives. After reviewing the descriptions and terminology of Guba and Lincoln (1994, 2005); Denzin and Lincoln (2005) and Saunders et al (2007) I opted to use the approach of Crotty (1998) as it was best suited to the research approach, strategy and methodology that I wanted to utilise for this study. For example Crotty (1998, p. 8), describes ontology as dealing with the question of reality or existence of how we believe we exist and he explains epistemology as being concerned with the theory of knowledge, or 'how we know what we know'. Ontology and epistemology tend to be related or 'emerge together', indeed 'writers in research literature have trouble keeping ontology and epistemology apart conceptually' (Crotty, 1998, p. 10). Theoretical perspectives are philosophical stances that inform and provide a context for the methodology; these are embedded in the epistemology. Crotty's (1998) approach is outlined in table 4.1.

In order to be actively situated in the research process, a qualitative research approach was used whereby practitioners were given a voice and listened to. This yielded rich data from their interview findings. Candy, (1989, p.8), claims that 'while the epistemologies referred to here may for explanation be categorised, and particular aspects of each identified, few pieces of research are ever pure examples of any one paradigm, fitting unequivocally into one category to the exclusion of the others'. Arguably, one can derive a dominant perspective that is appropriate for the purpose of the research and relevant to specific research questions posed in a study and the investigation undertaken. In essence, when researchers undertake a research project to investigate identified problems or

issues, they devise a research process that is appropriate for their purpose and which appears most suitable to answer the research questions (Crotty, 1998). As (DeVaus, 2001, p. 9), notes ‘the function of a research design is to ensure that the evidence obtained enables the researcher to answer the initial question as unambiguously as possible’.

Epistemology	Theoretical perspective	Methodology	Methods
Objectivism	Positivism Post-positivism	Experimental research Survey research Etc.	Sampling Measurement and scaling Statistical analysis Questionnaire Focus group Interview Etc.
Constructionism	Interpretivism • Symbolic interactionism • Phenomenology • Hermeneutics Critical Inquiry Feminism	Ethnography Grounded theory Phenomenological research Heuristic inquiry Action research Discourse analysis Feminist standpoint research Etc.	Qualitative interview Observation • Participant • Non-participant Case study Life history Narrative Theme identification Etc.
Subjectivism	Postmodernism Structuralism Post-structuralism	Discourse theory Archaeology Genealogy Deconstruction Etc.	Autoethnography Semiotics Literary analysis Pastiche Intertextuality Etc.

Examples within Crotty’s knowledge framework.

Table 4.1: Classification table: Crotty, 1998, p. 5.

Crotty (1998) suggests that we consider four questions:

1. What epistemology - theory of knowledge embedded in the theoretical perspective - informs the research (e.g., objectivism, constructivism, etc.)?
2. What theoretical perspective - philosophical stance-lies behind the methodology in questions (e.g., positivism, interpretivism. etc)?

3. What methodology - strategy or plan of action that links methods to outcomes -governs our choice and use of methods) e.g., phenomenological research, survey research, ethnography, etc.)?
4. What methods - techniques and procedures - do we propose to use (e.g., questionnaire, interview, focus group, etc

Incorporating these four questions, and adapting Crotty (1998, table 4.1), this thesis devised the following schema (table 4.2) outlining the theoretical framework of the study.

Ontology	Epistemology	Theoretical perspective	Methodology	Methods
<i>of being</i> Relativist	Constructionism	Interpretivism Symbolic interactionism Phenomenology Hermeneutics	Interpretive Phenomenological approach	Semi-structured interviews Questionnaires

Table 4.2: Schema outlining the theoretical framework of the study

The following section explains the schema adapted from Crotty’s classification (1998) depicting the study’s research framework, starting with ontology:

4.1.1 Ontology

Ontology (the nature of reality): relates to the nature of reality and its characteristics (Creswell, 2012). Researchers embrace the idea of multiple realities and report on these multiple realities by exploring multiple forms of evidence from different individuals’ perspectives and experiences (ibid, 2012). Ontology implies that researchers question the reality of things in the world (Marsh and Stoker, 2002; Christou and Anastasiadou, 2008). Snape and Spencer (2003, p. 20) assert that:

Within social research key ontological questions concern whether or not social reality exists independently of human conceptions and interpretations; whether there is a common, shared, social reality or just multiple context-specific realities; and whether or not social behaviour is governed by ‘laws’ that can be seen as immutable or generalisable.

Taylor (2007) posits that societies in which we live influence and constrain how we act and think. Thus, through their subjective understanding, individuals can attribute different meanings to the same situation, and conversely, different reactions result out of similarly expressed views, which in turn lead to a state of

constant revision (Bryman, 2001, Niehaves, and Stahl, 2006) and various interpretations of social reality (Williams, 2000) accessible to a researcher through respondents (Ritchie and Lewis, 2003).

Western thought remains divided by two opposing ontological traditions. Heraclitus (c. 533-c. 475_{BC}), placed an emphasis on a changing and emerging world. Parmenides, (c. 515-c. 443_{BC}), who succeeded him, placed quite a different emphasis on a permanent and unchanging reality. Between a Heraclitean epistemology of *becoming* and Parmenides ontology of *being*, it is the latter that has held sway in Western philosophy. Hence, reality is seen as being composed of clearly formed entities with identifiable properties (in contrast to a Heraclitean emphasis on formlessness, chaos, interpenetration, and absence). Once entities are held to be stable they can be represented by symbols, words and concepts. Thus a representationalist ontology results in which sign and languages are taken to be accurate representatives of the external world. This epistemology orientates our thinking towards outcomes and end states rather than processes of change.

The ontology of constructivism is relativist (Guba and Lincoln, 1994 p. 110). This study is guided by the relativist ontology of *becoming*. For constructivists, '[r]ealities are apprehendable in the form of multiple, intangible mental constructions, socially constructed and experientially based, local and specific in nature . . . and dependent for their form and content on the individual persons or groups holding the constructions' (ibid, 1994, p. 111). Constructions, then, are not more or less true, in any absolute sense. Instead, they are simply more or less informed and/or sophisticated. Not surprisingly, constructions are alterable, as are their associated realities (ibid, 1994 p. 111). Based on Guba and Lincoln, *reality* for the researcher, practitioners/managers and their trainers is subjective and multiple and based on their own subjective views of it and the meaning they attribute to it. Individuals will have varying and diverse views, which will be based on their associated realities, though people will also believe that things are real, for example, the acknowledgement that child abuse exists or not, there is a possibility of constructing that too, everything can be included in a conservative/constructivist approach, so child abuse is not an independent reality.

The ontological assumption of constructivism is that access to reality (given or socially constructed) is through social constructions such as language, awareness and shared meanings (Neuman, 2003). For Blaikie (2000) constructivism entails an ontology in which social reality is considered as the product of process by which social actors together negotiate the meanings for actions and situations; it is a complex of socially constructed meanings. Human experience is described as a process of construction rather than sensory, material apprehension of the external physical world, and human behaviour depends on how individuals interpret the conditions in which they find themselves. As a result, social reality is not some 'thing' that can be interpreted in different ways; it emphasises those

interpretations. While reality is multiple and socially constructed, perceptions of reality may change throughout the process of study (Mertens, 1998).

4.1.2 Epistemology

While ontology deals with the nature of a phenomenon; by contrast, epistemology is where the researcher interacts with that being researched (Crotty, 1998). Ontology is about the relationship between the object of the study and the researcher (Sobh and Perry, 2006) and it focuses on how we acquire knowledge about a phenomenon (Marsh and Stoker, 2002; Ritchie and Lewis, 2003; Weber, 2004; and Taylor, 2007). Crotty (1998, p.8) suggests that ‘epistemology is a way of understanding and explaining how we know what we know’. Epistemology deals with the ‘the nature of knowledge, its possibility, scope and general basis’ (Hamlyn 1995, p. 6) ‘and is concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate’ (Maynard 1994, p. 10). Denzin and Lincoln (1998) claim that epistemology is asking us two different questions, namely: How do we know the world? What is the relationship between the inquirer and the known? Creswell (2012) suggest that researchers try to get as close as possible to participants being studied and subjective evidence is assembled based on individual views from research conducted in the field. Crotty (1998) outlines three main epistemological positions: objectivism, constructionism and subjectivism; they all deal with the relationships between subjects and objects.

Objectivism claims that things exist as meaningful entities independently of consciousness and experiences. That is, truth and meaning reside in the objects. Thus, meaningful reality exists as such apart from any consciousness. Under this epistemological point of view, the objective truth can be exposed because understandings and values are objectified in the people or things being studied, as with Parmenides above.

Constructionism sustains that the subject and object emerge together in the generation of meaning, which is a consequence of the mind and cannot exist without it. Under this epistemological position meaning is not discovered, but constructed. There is no objective truth waiting for us to discover. Truth, or meaning, comes into existence in and out of our engagement with the realities in our world. There is no meaning without a mind. In this understanding of knowledge, it is clear that different people may construct meaning in different ways, even in relation to the same phenomenon (Crotty, 1998, p. 9). Denzin and Lincoln (2005) point out that in constructionism, epistemology is subjective, as the researcher and participants are engaged in jointly creating understandings.

Subjectivism, a variant of constructionism, sustains that meaning is imposed into the object by the subject rather than coming out of ‘*interplay*’ between subject and

object as in constructivism. In subjectivism the object does not contribute at all to its meaning (ibid, 1998).

This research study adopts a constructivist epistemological perspective. It was built on a critical review of literature and guided to some extent by the researcher's own view points (positioning) and experience as a practitioner with the premise of investigating the current relevant CPD training given to practitioners/managers. The focus of the study is to engage with practitioners/managers to try to understand and co-construct their meanings and understandings about their work practice and CPD experience. For example, the main issues regarding CPD could have different meanings for each practitioner, for their managers, senior management and trainers.

The goal of the research is to rely as much as possible on the participants' views of the situation being studied while using broad and general questions so that they could construct the meaning of a situation, forged in discussions or interactions with others. The more open-ended the questioning, the better, as the researcher listens carefully to what people say or do in their life setting (Crotty, 1998, p. 43).

Viewpoints and opinions are not simply imprinted on individuals but are formed through interaction with others (hence social constructivism) and through historical and cultural norms that operate in individuals' lives (Creswell, 2007a, p. 10). Constructionist researchers thus often address the 'process', of interaction among individuals, while focusing on the specific contexts in which people live and work in order to understand their historical and cultural settings. Researchers recognise that their own background shapes their interpretation, and they 'position themselves' in the research to acknowledge how their interpretation flows from their own personal, cultural, and historical experiences. The researcher's intent, then, is to make sense of (or interpret) the meanings others (practitioners or managers) have about the world (CPD training). Rather than starting with a theory (as in post-positivism) inquirers generate or inductively develop a theory or pattern of meaning. Next, the third component of the schema (theoretical perspective) (cited in Table 4.2 above) is discussed:

4.2 THEORETICAL PERSPECTIVE

The theoretical perspective relates to the underlying philosophical assumption about the researcher's view of the human world and the social life within it. In addition, it reflects the philosophical stance informing the methodology and thus provides a context for the process and the grounding for its logic and criteria (Crotty, 1998, p. 3). Crotty (1998, p. 8) claims that the research should be distinguished with epistemological and theoretical perspectives in which a researcher could not claim to be both objectivist and constructionist at the same time. From a constructionist epistemology that incorporates the purpose of this

research and the questions posed, the theoretical perspective that underlies this study aligns itself with interpretivism while incorporating AT that in itself has affiliations with symbolic interactionism, phenomenology and hermeneutics.

4.2.1 Interpretivism

In investigating the current CPD training experienced by practitioners/managers in their work, 'Interpretivism' is an appropriate theoretical perspective in the context of unpicking their human knowledge. The interpretive approach to explaining human social cultural reality has its roots in the sociology of Weber who placed 'the study of sociology in the context of human beings acting and interacting' (Crotty, 1998, p. 68). Weber emphasises the interpretive aspect of understanding, and 'as far as human affairs are concerned, any understanding of causation comes through an interpretative understanding of social action and involves an explanation of relevant antecedent phenomenon as meaning-complexes' (Crotty, 1998, p. 69). From this perspective, human beings are viewed as social beings that interact socially with each other, and the outcomes of this interaction develop the fabric of society, the cultural world in which individuals live out their lives and identification for individuals within that society (Blumer, 1972). In this sense society is 'central to forming what the human being is' (Charon, 2001, p. 200) and interpretivism is concerned with an understanding of complex human behaviour and social settings (De Villiers, 2005).

Interpretivists believe that most of our knowledge is gained through social constructions such as language, consciousness, shared meanings, documents and other artefacts which have meaning in people's lives (Bryman and Bell, 2007). Researchers have their own understanding, own interpretations and worldviews about the phenomenon in question due to their own cultural and historical influences (Miles and Huberman, 1994). It is imperative that social scientists understand and interpret the social world from participants' perspectives and to recognise that their own backgrounds, including the researcher's, will influence interpretations of the phenomenon under study (Creswell, 2007a).

This study is interested in understanding the social world of the participants and relating their experiences to their cultural and social values and beliefs together with their work experiences. It can be difficult to understand these aspects without understanding the thoughts, feelings, beliefs, values and assumptive worlds, associated with the work practices, in which practitioners/managers operate, in centres. This requires an understanding of the deeper perspectives of the issues under investigation, achieved through face-to-face interviews with practitioners/managers; it also calls for the researcher to understand her own interpretations of the work and issues around CPD training.

The advantage of interpretivism lies in allowing a researcher to obtain rich, data from participants. This is illustrated in the current study, by obtaining in-depth information regarding the challenges presented to practitioners, the CPD training they had received, as well as their hopes for more relevant structured CPD training in the future. As suggested by Hesse-Biber and Leavy (2006) the researcher as a result of working part-time at the centre had built a relationship with the some of the participants, thus was able to comprehend their subjective worlds, which meant she was less focused on her own subjective interpretations.

An interpretive researcher is interested in gathering all relevant information that relates to the lived experiences of subjects and the phenomena in question (Denzin and Lincoln, 2000). The emphasis is on the contexts in which participants live and work, so that researchers can better comprehend the historical and cultural background of participants (Creswell, 2007b). This thesis was interested in collecting, among others, data related to the aspects of CPD training most useful for practitioners/managers and CPD training they deemed lacking in their work practice. Crotty (1998) lists three strands of interpretivism: symbolic interactionism, phenomenology and hermeneutics:

4.2.1.1 Symbolic interactionism

Symbolic interactionism has three main assumptions as defined by Blumer (1969, cited in Crotty, 1998, p. 72): (a) human beings act toward things on the basis of the meanings that these things have to them; (b) the meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows; and (c) these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he or she encounters (for example, by practitioners utilising a CL). In describing a, b and c above: in residential child care, if a child is admitted to the centre, who has been raped, this will be interpreted as symbolic of sexual abuse, if a child says he/she was bullied at home, this will be interpreted as emotional abuse, if a child is showing signs of being beaten, this will be equated to physical abuse and if a child presents hungry or dirty, staff will recognise this as symbolic of neglect.

4.2.1.2 Phenomenology

Phenomenology is described by Creswell (2007b, p. 57, 59) as: 'the meaning of the lived experience for several individuals about a concept or phenomenon' and in this study, this could be equated to particular experiences of CPD training for practitioners/managers and of social care practice more generally. For Creswell (2007b) 'Phenomenology is not only a description, but it is also seen as an interpretive process in which an interpretation is made of the meaning of the lived experiences.' (p. 59).

In concurring with this view, Titchen and Hobson (2005) and Smith et al (2009, p. 11) note that in contemporary social science, the term phenomenology is used more broadly to denote the study of individuals' perceptions, feeling, and lived experiences in everyday social contexts. It is:

A philosophical approach to the study of experience...[that] shares a particular interest in thinking about what the experience of being human is like, in all of its various aspects, but especially in terms of the things that matter to us, and which constitute our lived world.

Phenomenology describes the world as socially constructed with the observer being directly and indirectly observed. Managers directly observe practitioners and feedback is given in supervision. Indirectly, practitioners are observed in the quality of their work such as in how they write reports and how they present the files of the children they are key-working. While human interests drive science, the focus on meanings is about trying to understand what is happening. In phenomenology, researchers can construct themes from the data (inductively) (Gray, 2009).

4.2.1.3 Hermeneutics

As part of the interpretative research family, hermeneutics focuses on the significance that an aspect of reality takes on for the people under study and on defining shared linguistic meaning for a representation or symbol. The work of this study is centred on hermeneutics. Interpretation (as meaning) is the core of hermeneutics. People's reality is based on their interpretations and to understand another person we need to recognise and take into consideration their meanings. Connectedness is made through understanding children/young people by uncovering something of their connection to particular contexts, family and other background information (Graham, 2003). The researcher operates within two hermeneutic circles: being inside the world while at work and outside as a researcher, at the same time, which gives her an advantage.

The context of one's being and the social forces that shape it constitute one's world. Behaviour is influenced by one's perception of one's environment or world and to understand children/young people and influence their behaviour staff must gain insight into their perception of their world and recognise what triggers their actions. 'Meaning making' is specific to particular points in time. Therefore, as practitioners working with children/young people in their life-space it is necessary to consider the factors presenting in order to respond sensitively to them. Practitioners are concerned with understanding human experience as lived by the children/young people. Staff are the practitioners, so therefore they can be interpreted as being investigators who are central players in the research experience while partaking in an inductive (participative) paradigm using tactical

experiential knowledge (Graham, 2003). For example, on days that children know they have access with mum they can be very anxious before it. When access is over they can be aggressive. Through their learned competencies: knowledge, skills and values, staff know how to use various strategies (go for a walk, give the child timeout) to show their understanding while recognising the reasons behind the children's actions and allowing them to express them.

As practitioners, our knowledge has been built from academia, professional values and informed practice. We build relationships from this multidisciplinary learning, which is blended and integrated, culminating in competencies of values, advocacy, citizenship and professional practice. For example, values include inclusion, equality and anti-discrimination; advocacy is about promoting representation and partnership; citizenship means enhancing empowerment and social status with our residents and professional practice is where we as a team impart needs led care, delivered by all the team (Share, 2009).

In order to reach shared understanding as proposed in hermeneutic theory, subjects must have access to shared linguistic and interpretative resources (Marshall and Brady, 2001). Hermeneutic theory also posits that linguistic meaning is likely open to infinite interpretation and reinterpretation due to the interpretative ambiguity coming from presuppositions, to the conditions of usage different from authorial intention, and to the evolution of words (ibid, 2001).

Due to its interpretive nature, hermeneutics cannot be approached using a pre-determined set of criteria applied in a mechanical fashion (Klein and Myers, 1999). A meta-principal, known as the hermeneutic circle, guides the hermeneutic approach where the process of understanding moves from parts of a whole to a global understanding of the whole and back to individual parts in an iterative manner (ibid, 1999). This meta-principal allows the development of a complex whole of shared meanings between subjects, or between researchers and their subjects (ibid, 1999). Gray (2009) claims that in hermeneutics social reality is seen as socially constructed and is too complex to be understood through the process of observation; interpretations should be given more standing than explanation and description and the scientist must interpret in order to achieve deeper levels of knowledge and also self-understanding. For example, in residential care because of the complexity of issues as described in the themes in chapters one and two, the CL is an ideal forum where a shared understanding can be achieved. This is possible because of the multi-voiced collaboration and respect that is given to every participant as the discussion and debate continues by knotworking until agreement and co-configuration of the issues are resolved.

4.3 CONSTRUCTIVE/INTERPRETIVE EPISTEMOLOGY

The constructivist/interpretive epistemology is transactional and subjectivist. The inquirer and the respondents are interlocked in an interactive process, that is, each influences each other so that the ‘findings’ are literally created as the research proceeds (Guba and Lincoln, 1994, p. 111). Blaikie (2000) also shows that, in constructivism, knowledge derives from everyday concepts and meanings. The social investigator goes into the social world to understand the socially constructed meanings, and then re-interprets these meanings in social scientific language. At one level, these latter accounts are considered as re-descriptions; at another level they are developed into theories. These accounts develop in the process of research, which contribute to formation of the thesis methodology.

Specifically, this study set out to give practitioners/managers a voice; to investigate their challenges and work experiences, including the CPD they have been receiving, while also aiming to reconfigure their CPD. Creswell (2007a, p. 17) indicates that ‘in a qualitative study, inquirers state research questions, not objectives (i.e. specific goals for the research) or hypotheses (i.e., predictions that involve variables and statistical tests)’. In this study the research questions include a central question and associated research questions.

Central Question

How should the CPD training that social care practitioners receive, be reconfigured?

Associated Questions

1. How is the work in the social care sector in Ireland changing?
2. What type of CPD training is delivered to social care practitioners in Ireland?
3. What aspects of CPD training are the most useful to meet the needs of social care practitioners?
4. How can CPD training be reconfigured to respond appropriately to changing contexts and cultures of professional practice?
5. What has been the impact of relevant developments in CPD?

Twelve sub-questions were formulated from the associated research questions.

The methodological approach to this thesis is fundamentally shaped by Activity Theory (AT). It incorporates and supports all the necessary aspects of AT which, in itself, is a useful lens in qualitative research methodologies, and is supported by its own research methodology: Developmental Work Research (DWR). As in the analysis of the Helsinki case study, AT provides a method to understand and analyse a phenomenon, to find patterns and make inferences across interactions, to describe phenomena and present them through a built-in language and rhetoric.

In conjunction with section 4.3, the methodological approach incorporates figure 4.1 and table 4.3 showing how the research questions can be linked to the nodes of the activity system triangle which aided the intervention which was similar to action research as outlined in chapter six. After table 4.3, the thesis moves into part two: the practice of the methodology.

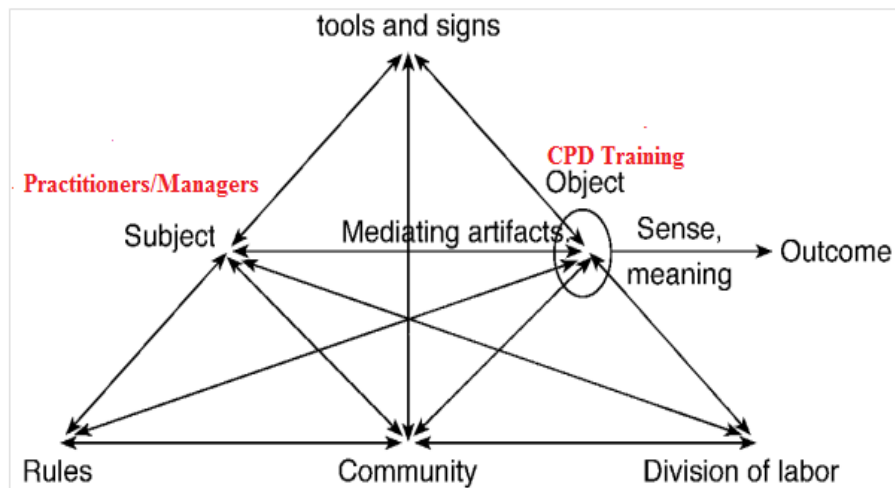


Figure 4.1 Second generation activity theory model: the structure of a human activity system (Engeström, 1987, p. 78).

Questions Corresponding to nodes of the activity system

Tools/signs	<ul style="list-style-type: none"> • Do you have professional supervision? How often? • Do you or your team engage in professional reflective practice? • Is your training competency based?
Rules	<ul style="list-style-type: none"> • Do you think you need ongoing training? • Do you think there are adequate resources provided for training? • Is your training beneficial and effective?
Community	<ul style="list-style-type: none"> • What training do you get in your profession? • What elements of training do you think are important? • What are the challenges in your training?
Division of labour	<ul style="list-style-type: none"> • Are you asked to suggest training that you need? • What changes would you like to see in your training? • How would you rate your supervision?

Table 4.3: Questions corresponding to the nodes of the triangle

4.4 THESIS METHODOLOGY

Methodology is the process of research, (Creswell, 2007a, p. 21). It is a research strategy that translates ontological and epistemological principles into guidelines that show how research is to be conducted (Sarantakos, 2005), and explains principles, procedures, and practices that govern research (Kazdin, 1992, 2003a, cited in Marczyk et al, 2005). This study utilised a phenomenological research approach, described below.

Creswell (2008) states that methodology describes three approaches to research design: qualitative, quantitative and mixed methods and claims that a study *tends* to be more qualitative than quantitative or vice versa. Mixed methods research resides in the middle of this continuum as it incorporates elements of both the other approaches (ibid, 2008, p. 3). Berg (2004) discriminates between these, arguing that qualitative research refers to the meanings, concepts, definitions, characteristics, metaphors, symbols and descriptions of things, while quantitative research referred to the measures and counts of things. Often the distinction between qualitative and quantitative research is framed in terms of using words (qualitative) rather than numbers (quantitative), or using closed-ended questions (quantitative hypotheses) rather than open-ended questions (qualitative interview questions) (Creswell, 2008, p. 3).

4.4.1 Three approaches to research

Of the three approaches, qualitative is the one used in this thesis.

- **Qualitative research** is a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. The process of research involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data. The final written report has a flexible structure. Those who engage in this form of inquiry support a way of looking at research that honours an inductive style, a focus on individual meaning, and the importance of rendering the complexity of a situation (Creswell, 2008, p. 13).
- **Quantitative research** is a means for testing objective theories by examining the relationship among variables (ibid, 2008, p. 13).
- **Mixed methods research** is an approach to inquiry that combines or associates both qualitative and quantitative forms (Creswell and Clark, 2007).

As described by Mack et al, (2005, p. 3), qualitative and quantitative research approaches differ in their analytical objectives; types of questions posed; types of data collection methods used; types of data produced; degree of flexibility in study design (see Table 4.4, below).

	Quantitative	Qualitative
General framework	Seek to confirm hypotheses about phenomena Instruments use more rigid style of eliciting and categorizing responses to questions Use highly structured methods such as questionnaires, surveys, and structured observation	Seek to explore phenomena Instruments use more flexible, iterative style of eliciting and categorizing responses to questions Use semi-structured methods such as in-depth interviews, focus groups, and participant observation
Analytical objectives	To quantify variation To predict causal relationships To describe characteristics of a population	To describe variation To describe and explain relationships To describe individual experiences To describe group norms
Question format	Closed-ended	Open-ended
Data format	Numerical (obtained by assigning numerical values to responses)	Textual (obtained from audiotapes, videotapes, and field notes)
Flexibility in study design	Study design is stable from beginning to end Participant responses do not influence or determine how and which questions researchers ask next Study design is subject to statistical assumptions and conditions	Some aspects of the study are flexible (for example, the addition, exclusion, or wording of particular interview questions) Participant responses affect how and which questions researchers ask next Study design is iterative, that is, data collection and research questions are adjusted according to what is learned

Table: 4.4 Differences between qualitative and quantitative research approach (reproduced from Mack et al 2005, p. 3).

The research findings in qualitative methodology are usually reported descriptively using words (Mutch, 2005). In an interpretivist constructivist perspective, the nature of inquiry is interpretive and its purpose is to understand a particular phenomenon, not to generalise to a population (Farzanfar, 2005). While the researcher acknowledges this generalisation, she pays particular attention to the residential child care setting. Researchers within the interpretive perspective are naturalistic since they apply to real-world situations as they unfold naturally, more specifically, they tend to be non-manipulative, unobtrusive, and non-controlling (ibid, 2005).

According to Ulin et al (2004) qualitative research methodologies often rely on personal contact over some period of time between the researcher and the group being studied. Building a partnership with study participants can lead to deeper insight into the context under study, adding richness and depth to the data. Thus, qualitative methodologies are inductive, that is, oriented toward discovery and process, have high validity, and are concerned with deeper understandings of the

research problem in its unique context (ibid, 2004). As mentioned above by Creswell, (2008) a study can be either inductive or deductive (discussed next) and Saunders *et al.* (2007), claim that a researcher should explain clearly which approach is being followed in his/her research project.

4.5 INDUCTIVE V DEDUCTIVE

In the following excerpt Marshall and Rossman (1999, p. 17) illustrate the theoretical use of both terms (inductive and deductive):

When researchers first begin to open up any new line of enquiry there will be no useful theories available from which to deduce propositions for testing. Knowledge has to begin with collecting facts and then trying to find some order in them. This is known as induction. Deduction is the technique by which knowledge develops in more mature fields of enquiry. It involves a sort of logical leap. Going a stage further than the theory, data is then collected to test it.

From the AT perspective, in the CLs, it can be argued that when practitioners introduce a new line of enquiry by questioning the current situation, they are engaging in induction and once the object is highlighted they switch to deduction where they examine the knowledge acquired by practitioners who have brought their issues to the CL to be tested and debated.

In addition, issues of trustworthiness and credibility, as opposed to the positivist criteria of validity, reliability and objectivity, are key considerations in the interpretive perspective (Ulin, et.al, 2004). Qualitative research that aims to explore, discover, and understand cannot use the same criteria to judge research quality and outcomes (ibid, 2004). Lincoln and Guba (1985) suggest that the fundamental criterion for qualitative reports is trustworthiness. How, they ask, can a researcher be certain that ‘the findings of an inquiry are worth paying attention to, worth taking account of?’

Qualitative research methodology treats people as research participants and not as objects as in the positivist research approach (Casey, 1993). This emphasis can be an empowering process for participants in qualitative research, as they can be seen as the writers of their own history rather than objects of research (ibid, 1993). According to Cohen, et al (2000), this approach to methodology enables the participants to make meanings of their own realities and come to appreciate their own construction of knowledge through practice. This process can be seen as enabling or empowering them to freely express their views, which they may not have a chance to do with someone outside of their workplace. While several research strategies of inquiry can be used by qualitative researchers, as is shown above in Crotty’s (1998, table 4.1, p.144 above), this study, utilised an

interpretative phenomenological qualitative research approach because, according to Fitzpatrick (2006, p. 464), it is inductive and descriptive (deals with the interpretation of human experiences).

4.6 PHENOMENOLOGICAL RESEARCH APPROACH

Of Crotty's (1998) three strands of interpretivism, this study leans towards the phenomenological approach, used as a diagnostic research tool to investigate the phenomenon of CPD for social care practitioners, from different perspectives, including from practitioners/managers and team leaders in the three research sites. Understanding the meaning of lived experiences marks phenomenology as a philosophy as well as a method, and in this study the procedure involves studying a small number of subjects (15 practitioners; 3 managers) to develop patterns and relationships of meaning (Moustakas, 1994, Elliot et al, 1999).

A phenomenological approach involves rich descriptions of the lifeworld or lived experiences of the participants (Creswell 1998; Schwandt, 2000, p. 189), which is what I want to understand from practitioners about their CPD. In phenomenological research, the views of participants are collected and what all participants have in common as they experience a phenomenon is fully described (Creswell et al, 2007). The purpose of phenomenology is to reduce the experiences of persons with a phenomenon to a description of the universal essence, a 'grasp of the very nature of the thing' (van Manen, 1990, p. 177). The phenomenological approach is most appropriate when little is known about a phenomenon (practitioners CPD training) or when a fresh look at a phenomenon is indicated (Fitzpatrick, 2006, p. 464).

It is noteworthy to acknowledge that the researcher's educational background and experience as a social care practitioner has influenced her subjective and reflective thinking on doing this study, because at work she saw first-hand how CPD issues were affecting practitioners. This gave her the impetus and provided the ideas to investigate this further. Therefore, she identified some specific categories and criteria of selection before the research began so the literature review, research questions, methodology, data collection and analysis was influenced by her knowledge and interest in this area of research. As Riessman, (1994, p. 135) notes: 'Locating ourselves in the work, instead of pretending we're not there, helps readers evaluate the situated knowledge we produce'.

In a phenomenological approach the researcher develops an understanding of a subject's or subjects' 'reality' however s/he, or they so perceive it (Leedy, 1997, p. 161). The phenomenological approach adopts a subjective style, in that the researcher and the research or study is linked (Hussey and Hussey, 1997, 2003). These realities may be expressed as an event, programme, relationship or emotion (Creswell, 1994, p. 12). Crotty (cited in Gray, 2009, p. 23) states that in

phenomenological research, the key is to gain the subjective experience of the subject, sometimes by trying to put oneself in their place. Hence, phenomenology becomes an exploration, via personal experience, of prevailing cultural understandings. Value is ascribed not only to the interpretations of researchers, but also to the subjects of the research themselves. Therefore in this instance there will be a lot of commonality, as the researcher is a practitioner herself. The next section moves on to discuss general methodological issues pertaining to analysis.

4.6.1 Phenomenological Data Analysis

Creswell (1998) opines that phenomenological data analysis proceeds through the methodology of reduction, the analysis of specific statements, and a search for all possible meaning. According to Creswell (2003) the choice of a suitable approach to conducting research is tied to three main considerations as follows:

1. The nature of the problem to be investigated
2. The personal experiences of the researcher, and
3. The audience for whom the research is intended.

These outlined issues are considered in the choice of methodology (discussed below in the next section). First, a discussion of what is involved in data analysis of a qualitative phenomenological study:

Moustakas (1994) embraces the values of qualitative research, as a focus on the wholeness of experience and a search for essences of experiences, viewing experience and behaviour as an integrated and inseparable relationship of subject/object. The transcendental emphasis includes these features. Moustakas (1994, p. 22) suggests that in a phenomenological study the researcher sets aside prejudgements as much as possible and uses systematic procedures to analyse the data. Setting aside prejudgements is *epoche*, a Greek word meaning to refrain from judgement. The process is called transcendental as the researcher sees the phenomenon ‘freshly, as for the first time’ and is open to its totality (ibid, p. 34).

In this study this was monitored and addressed by the researcher clearing her mind through the *epoche* process by recalling her own personal and professional CPD training experiences throughout the past 10 years, some which were positive, namely mandatory CPD while others negative due to the lack of relevant CPD. Through this bracketing process, the researcher reflectively meditates, by letting the preconceptions and prejudgements enter and leave her mind freely.

This way of analysing phenomenological data, according to Moustakas, follows a systematic procedure that is rigorous yet accessible to a qualitative researcher. The researcher describes her/his own experiences with the phenomenon (*epoche*), identifies significant statements in the database from participants, clusters these statements into meaning units and themes. Next, the researcher synthesises the

themes into a description of the experiences of the individuals, both textual and structural descriptions, and then constructs a composite description of the meanings and the essences of the experience. In addition, Moustakas (1994, p. 13) posits that phenomenological analysis has many benefits, for example:

1. Phenomenological analysis commences as soon as the first data is collected and the goal is to find common themes and broad patterns in the data.
2. It involves a return to individual or corporate experience in order to obtain comprehensive descriptions about a phenomenon and this is done through group interviews or focus groups.
3. The structure of an experience, i.e. the experiences and opinions of those interviewed during the data collection phase, is interpreted during phenomenological analysis.

This methodology creates space for research problems to be studied in the context in which they occur, allowing those who experience a phenomenon first hand to give an account of their own perceptions of these experiences before any theorising (ibid, p. 13).

In a phenomenological inquiry, the basic philosophical assumption underlying this inquiry has most often been illustrated by Husserl's (1962) statements cited in (Schwandt, 2000, p. 193) – “we can only know what we experience”. Thus, any inquiry cannot engage in ‘sciences of facts’ because there are not absolutely facts; we can only establish ‘knowledge of essences’. The essence is the central underlying meaning of the experience shared within the different lived experiences. This is done by the researcher looking into the individual point of view i.e. the realisation of subject consciousness perceived in the objects, to get to understand human phenomenon as lived and experienced, which Giorgi (1985) pointed out as the major characteristics of a phenomenological method (Schwandt, 2000, p. 193). The major data source for this is interviewing. Patton (1990, p. 62) opines that the purpose of interviewing is to “find out what is in and on someone else’s mind” and this is exactly what the target of the phenomenological approach focuses on, i.e perception of the lived experience.

Patton (1990, p.68) suggests two perspectives in phenomenological analysis of the perception of the lived experience: one, from the people who are living through the phenomenon, and another, from the researcher, whose has great interest in the phenomenon. In order to ‘return to the things themselves’ (Husserl, 1970, cited in Patton, 1990, p. 68), the researcher cannot impose the meanings for the learners, for example, because they are absolute sources of their own existence living through the learning environment. Husserl points out that it is impossible to detach personal interpretations from the things that are personally interesting. The researcher has to be aware of his/her own experience being infused into both his/her engagement in the interviews and the analysis of data (ibid, 1990, p. 68).

As stated by Patton (1990, p. 71), the entire data analysis process aims to examine the lived experience from the ones who produced the experience rather than imposition of other people's interpretations. It should be the interpretations of the participants in the phenomenon under study that define the commonalities of the lived experience in the phenomenon. It is not the researcher's own thinking of the phenomenon, the other researchers' experience of the phenomenon, or the theoretical descriptions of the phenomenon that are under analysis.

According to Klieman (2004, p. 8) and supported by Yin (2009) data analysis consists of: examining; categorising; tabulating and recombining the evidence obtained from the research to address the initial proposition of the research study. The complete process of data analysis requires that data is 'systematically organised, continually scrutinised, accurately described, theorised, interpreted, discussed and presented', in order to discover any important underlying patterns and trends (Ryan 2006, p. 95). For example, while the researcher was originally deciding on her topic of study she personally experienced and observed other staff making comments during handovers or at team meetings about how the lack of relevant CPD training affected certain work situations. The researcher then began to read the literature and from it was able to identify that there were gaps between the CPD training that staff should be getting and what they were getting. Through her investigations and research she established that this needed to be addressed. As the researcher works/lives with the rich descriptive data, the common themes or essences begin to emerge. This stage of analysis involves total immersion for as long as it is needed in order to ensure both a pure and a thorough description of the phenomenon. The researcher is aiming to identify and understand such concepts, situations and ideas as:

- A person's interpretation of the world/situation in which they find themselves at any given moment.
- How they come to have that point of view of their situation or environment in which they find themselves
- How they relate to others within their world
- How they cope within their world
- Their own view of their history and the history of others who share their own experiences and situations.
- How they identify and see themselves and others who share their own experiences and situations (ibid, 2004, p. 9).

The researcher felt that the benefits of utilising a phenomenological approach would give her the scope to unearth the responses to these situations which will be uncovered through the phenomenological data analysis processes of coding discussed in Content analysis later on, categorising and making sense of the essential meanings of the phenomenon. Far from using a theoretical model that imposes an external logic on a phenomenon, this inductive approach seeks to find

the internal logic of the subject. Table 4.5 describes a summary of some of the major distinctions between positivism and phenomenology (ibid, 2009, p. 23)

	POSITIVIST	PHENOMENOLOGICAL
Basic beliefs	The world is external and objective. The observer is independent. Science is value-free	The world is socially constructed and subjective The observer is a party to what is being observed. Science is driven by human interests
The researcher should	Focus on facts Locate causality between variables Formulate and test hypotheses	Focus on meanings Try to understand what is happening
Methods include	Operationalising concepts so that they can be measured Using large samples from which to generalise to the population Quantitative methods (deductive approach)	Construct theories and models from the data Using multiple methods to establish different views of a phenomenon Using small samples researched in depth or over time Qualitative methods: Semi-structured interviews; open-ended questionnaires; Activity Theory Change Laboratories: DWR (inductive approach)

Table: 4.5 Summary of positivist and phenomenological paradigms (Adapted from Easterby-Smith et al, 1991).

4.6.2 Activity Theory (AT)

In conjunction with the phenomenological approach activity theory (AT) brings in a set of understandings from the outside. The preceding paragraphs have indicated how I am taking a constructivist approach, rooted in interpretivism, in particular the phenomenological approach, now the challenge is to link this into the AT approach described in chapter three. AT (through its application of DWR in the CLs) will help the researcher to analyse and interpret meanings which will come out of understanding issues of concern at the centre, because when practitioners give meanings to things, they have to be able to understand them and they have to be linked to various constructs. The study will incorporate a variety of methods, to uncover the underlying meaning or structure of the perceptions of practitioners in this phenomenological inquiry.

4.7 METHODS

Methods are described by Guba and Lincoln (1994, p. 105) as the techniques or procedure used to gather and analyse data related to some research question or hypothesis. Crotty (1998, cited in Gray, 2009, p. 207) suggests that in the data collection phase of the research, phenomenology researchers rely on semi-structured in-depth interviews; while they may study one subject, typically 6-10 are purposefully selected and the researcher and subject(s) must work rather closely together to collect data. In this study, primary research consisted of 18 in-depth semi-structured interviews, 15 with practitioners and three with social care managers; secondary research consisted of reports, journals, websites, books and newspapers. Tesch (1990, table 4.6) distinguishes between phenomenological research and ethnography. While both are based upon description and interpretation, ethnographic research is focused on culture and phenomenology, on human experience of the 'life-world'. So, while the unit of analysis of phenomenology is often individuals, ethnographers make use of 'sites'. Phenomenology makes use almost exclusively of interviews, while ethnography's prime mode of data collection is observation (as a participant or outside observer), which is sometimes supplemented by interview data for clarification.

ETHNOGRAPHY	PHENOMENOLOGY
<ul style="list-style-type: none"> • Study of culture • Discovering the relationship between culture and behaviour • Studying 'sites' • As many informants as possible • Use of observation, and some interviewing • Unit of analysis: event • Reliability: triangulation 	<ul style="list-style-type: none"> • Study of the 'life-world' human experience • Exploring the personal construction of the individual's world • Studying individuals • Between 5 and 15 'participants' • Use of in-depth, unstructured interviews • Unit of analysis: meaning unit • Reliability: confirmation by participants

Table 4.6: Distinctions between phenomenological research and ethnography; adapted from Tesch, (1990).

As stated by Creswell (2007a, p. 21), in a qualitative approach the researcher collects open-ended, emerging data with the primary intent of developing themes from the data. If a concept or phenomenon needs to be understood because little research has been done on it, it merits a qualitative approach. In agreement with Creswell (2007a), others such as Sarantakos (1988, p. 128), Fontana and Frey (2000), DeVaus (2001, p. 2) and Fitzpatrick (2006) summarise that qualitative

research is exploratory and useful when the researcher does not know the important variable to examine. An exploratory study explores ‘what is happening; to seek new insights; to ask questions and to assess the phenomena in a new light’ (Robson, 2002, p. 59). This type of approach may be needed because the topic is new, the topic has never been addressed with a certain sample or group of people (as far as this thesis is aware the topic of CPD training has not been previously explored in relation to residential child care practitioners/managers), or existing theories do not apply with the particular sample or group under study (Morse, 1994). Furthermore, as far as the researcher is aware, a small scale intervention with regard to an aspect of CPD training has not been attempted by utilising AT methods in a residential child care centre, either.

The research basis for this study evolved as follows:

From her knowledge and experience, the researcher was guided to certain criteria for her literature review. This guided her to employ semi-structured interviews where she would have access to rich descriptive data. The interview data informed her about the need to engage in face-to-face interactions with practitioners in the CLs, in one centre, to conduct a research intervention using tools and concepts employed in AT. This was followed-up by a questionnaire study with the same participants in that centre. The inclusion and combination of AT in this study is depicted in table 4.7. The first method chosen for this study was semi-structured interviews; later on the follow-up questionnaire study was conducted.

4.7.1 Semi-structured in-depth interviews

According to Bryman (2008, p. 470) ‘qualitative interviewing is meant to be flexible and to seek out the world views of research participants’. Moore (1994, p. 29) suggests that interviews ‘provide scope for the discussion and recording of respondents’ opinions and views’ and May (2001, p. 120) states that ‘interviews yield rich insights into people’s biographies, expectations, opinions, values aspirations, attitudes and feelings’. They yield ‘good rich data’ (Edwards and Talbot, 1999, p.101) which was deemed to be essential for this study. Semi-structured interviews enabled an insight into an understanding of the concept of CPD training through a focus on the words of participants as well as the ‘establishment of a human-to-human relationship’ between the researcher and the participants (Denzin and Lincoln, 2003, p. 75).

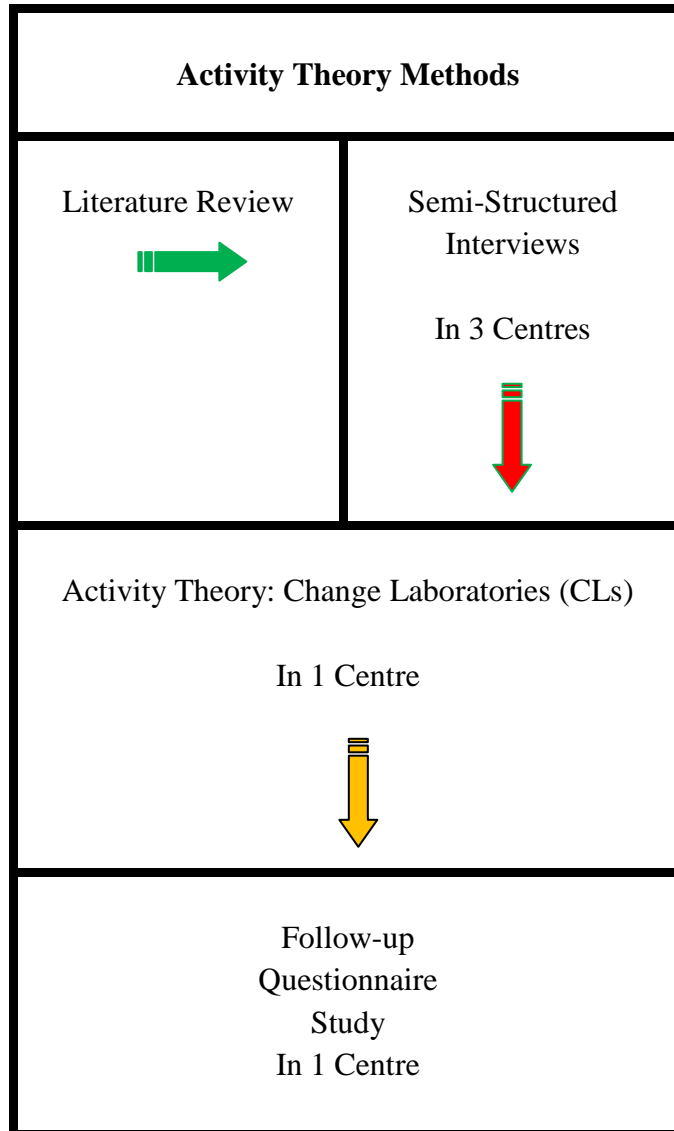


Table 4.7: Activity Theory Methods

For Van Maanen (1983) qualitative in-depth interviewing entails the relatively informal and interactional exchange of dialogue. The considerable advantage of using semi-structured interviews in this study lay in their flexibility. In-depth interviewing involved a thematic, topic-centred approach to asking questions that needed clarification, while at the same time allowed for a fluid and flexible structure. Van Maanen (1983) suggests this enables both the researcher and respondent to develop unexpected themes. As this was exploratory research, the use of semi-structured interviews was considered to be the most appropriate method, permitting the interviewer to pursue certain areas in more depth, while allowing the respondents to speak expansively on chosen topics. Interviews were tape-recorded which allowed for observations of nuances exhibited in the verbal and non-verbal communication of the participants as they answered the questions in their own terms. As stated by Haraway (1991), the researcher wanted to situate

herself in the research while giving a voice to the practitioners/managers who work at the frontline. Audio taping also facilitates the need to be responsive to the participant's answers so that it is possible to follow them up and it allows a more thorough examination of what people say (Heritage, 1984, p. 238).

4.7.2 Design of the Semi-Structured Interview: plan used

An original semi-structured interview guide, using open questions, was designed for the purpose of this research. Open questions are useful for exploring new areas or ones in which there is limited knowledge. Limited knowledge was known of the CPD training utilised by participants in two of the centres.¹⁸

Closed questions may make it difficult to establish rapport because the interviewee and the interviewer are less likely to engage with each other in a conversation (Bryman, 2001, pp. 145-147). Probes were used; probing questions have the purpose of completing, amplifying or expanding information given by the participant while stimulating and guiding the discussion and establishing a friendly atmosphere free of bias (Sarantakos, 1988, p. 229). The questions were divided into three main sections: section one introduced questions regarding the nature of the work including current work practices; the second section explored the elements of practitioners'/managers' work practice and the third section addressed the aspirations of practitioners/managers for future CPD training needs.

4.8 DATA COLLECTION AND ANALYSIS

First, terms used in the research are explained, before moving on to describe residential child care centres. Next, the data collection process is outlined including pilot interviews, sampling techniques, semi-structured interviews, questionnaires (follow-up study) and the data analysis.

4.8.1 Operationalisation of Research Terms

The following are brief explanations of terms identified in the research.

4.8.1.1 Continuous Professional Development (CPD)

The CORU (2013d) description of CPD is as follows:

The means by which health and social care professionals maintain and improve their knowledge, skills and competence and develop the personal qualities required throughout their professional life. CPD is an important

¹⁸

To protect the anonymity of children/staff at the centres, details about the location of the centres will not be disclosed.

component in the continued provision of safe and effective services for the benefit of service users.

In order to harness this new knowledge, practitioners need to document their learning, such as in a CPD portfolio where they can make notes of queries for further clarification with their supervisor. Also, they can show how they reflected on their practice while being accountable to the public and to their service.

4.8.1.2 *Social Care*

The IASCE definition of social care, cited in Share and Lalor (2009, p. 6) is that:

Social care practice is not just an ordinary job, nor is it something done on a voluntary or amateur basis ... The notion of 'professionalism' also implies that this is an occupation with some status and one that requires access to a specific body of skills and knowledge.

Operationalisation also entails moving from a general definition to a specific one. For example with practitioners, the researcher identified key grades/roles which can include deputy managers, team leaders and social care workers.

4.8.1.3 *Social Care Practitioners*

A social care practitioner is a person who:

Typically works in a direct person-to-person capacity with clients. He/she will seek to provide a caring, stable environment in which various social, educational and relationship interventions can take place in the day-to-day living space of the client (Dublin Institute of Technology, 2013).

4.8.1.4 *Residential care*

Residential care is not foster care but it can include respite care for children/young people. It refers to care that can be provided in a home in the community (for children in the care of the HSE) staffed by professionally trained care staff. The home or centre is referred to as a children's residential centre. Residential care may be provided in an HSE run centre; care may also be provided by voluntary organisations on a not for profit basis (HSE, 2013). In recent years, organisations also provide residential care for young people on a for profit basis such as by Gateway and Positive Care Ireland.

Williams and Lalor (2001, p 74) cite the following definition of the residential care task from the European Association of Research into Residential Child Care (Euroarrcc, 1998, p. 14) report on residential childcare in Ireland and Europe:

As involving an essential balance between meeting a child's need for physical care, emotional support and intellectual advancement and his/her need for therapeutic care and support in light of the specific difficulties that have led to him/her being in care in the first place.

4.8.1.5 *Reconfigure*

Reconfigure is a term used to denote substantial change. In this thesis reconfigure is used to show how changes can be made to the provision of CPD training. Reconfigure is described in the Oxford Advanced Learners Dictionary (2013) as: 'to make changes to the way that something is arranged to work'. In this thesis this equates to changes made through specialised training of staff to address an ongoing child care issue.

4.9 RESIDENTIAL CHILD CARE CENTRES – THE RESEARCH SITES

Practitioners from three residential child care centres took part in this study. In the centres practitioners care for children, male and female, aged 12-18 years. The three centres were located in housing estates in the community and the bungalows were rented for the purpose by the HSE. In each centre, there was a manager, a team leader and the practitioners. Each centre had a centre car for use by staff to transport children to appointments, school etc. Staff work from a monthly rota established in advance to allow for extra cover if required for annual leave. Centres employ full time and part-time staff. Full-time staff work a 39-hour week. Each child is assigned a key worker and co-key-worker. Duties of practitioners include provision of psychological and emotional support for the children/young people as well as the need to be competent at household management.

Centres can provide respite care as well as short-term or long-term care placements and in some instances centres are moving beyond the traditional notion of residential care by providing outreach work to families in the community. Team meetings are held on a weekly basis. Practitioners liaise with social workers and after care workers on a regular basis. Every child has their own bedroom that they can make as their own by adding personal touches such as photographs etc. Accommodation for staff is basic; in one centre staff slept in an office on a fold-out bed that doubled as a couch in the daytime. Centres have play stations and games and are child friendly while catering for all age groups.

Staff numbers can vary between 8-14 members, depending on the centre and the services that they offer, if they are a short-term or long-term unit. Where the researcher works, they introduced respite care and, since its inception, there has been a constant stream of children/young people who have availed of it. At the time of writing, due to the high intensity needs of the current children at the centre, outreach and respite work has been suspended until further notice.

These specific three centres were chosen as the study was carried out in a specific geographical location. Also, it was possible to gain access to these centres to do the semi-structured interviews/distribute questionnaires as the researcher worked in this area and had occasionally met some members from the other two centres at TCI trainings. Because the researcher was working in one centre and knew some colleagues from the other two centres, she was very sensitive to ethical issues and confidentiality as were management. The researcher gave a guarantee to all participants that all locations and information pertaining to same would remain undisclosed at all times including during the research process and in the future.

4.10 PILOT INTERVIEWS

For Heiman (2001) in qualitative research, a pilot study is a miniature version of a study. It allows a researcher to focus on specific areas that may have previously been unclear, or to test certain questions as well as procedures prior to the actual study. It can check if instructions are clear, whether the task can be performed given time constraints or any other demands and whether one has developed a workable, sensitive and reliable scoring procedure (ibid, 2001). This allows the researcher to make modifications with a view to quality interviewing during the main study (Strydom, 2005). During the pilot study the bio-data form was composed; this form lists basic information such as name, age, length of service; it is beneficial for recording information that assisted when writing up the findings of the interviews Appendix: 1 (p.413).

Pilot interviews were conducted with 10 participants including, a staff nurse, two student nurses, three social workers, two practitioners, and two teachers. The interviews took place in the researcher's own home, in a friend's house, in a centre, in a library and in a park beside where two of the participants lived. Each participant's comments and feedback were noted and recorded. Participants had been contacted in advance, and given Appendix: 3 (p.415) informing them about the study as well as Appendix: 2 (p.414), the interview guide. Research has shown that respondents may interpret questions in different ways to the investigator (Cormack, 2000). In addition, it was the researcher's first time to use this particular audio tape recorder and she wanted to practice using it, and ascertain how participants felt about being audio-taped.

Pilot interviews revealed that it took 25-50 minutes to complete the interview, a time span that all participants expressed satisfaction with. The pilot highlighted that some participants did not want to participate in audio-taped interviews. Instead, manuscripts were written up and completed from field notes after each interview was concluded. While participants deemed the questions to be appropriate to the study, it emerged that two other questions could be added to the interview guide; one on challenges experienced by professionals in their work and

another on what changes would professionals like to see in their CPD training Appendix: 4 (p. 417).

4.11 SAMPLING TECHNIQUES

At times qualitative research can use non-probability sampling for selecting the population for study (Ritchie et al, 2003).

4.11.1 Non-probability sampling

In a non-probability sample units are deliberately selected to reflect certain features of or groups within the sampled population. The sample is not intended to be statistically representative; instead the characteristics of the population are used as a basis for selection. This feature makes this kind of sampling suited to small-scale, in-depth studies (ibid, 2003). There are four reasons for keeping sample sizes small in qualitative research:

1. If the data are properly analysed, there is a point where very little new information is obtained from each new sample, as phenomenon need appear only once (this is termed redundancy).
2. The sample does not need to be large enough to provide statistically significant results.
3. Qualitative studies yield a substantial amount of information from each individual thus sample sizes can be kept quite small.
4. It would be impossible to conduct and analyse hundreds of interviews, observations or groups unless a researcher intends to spend a few years doing this (Ritchie, et al 2003). (It can be argued that by using specific computer packages, this process can be made easier).

A non-probability sample was deemed appropriate to the semi-structured interviews for this study, given the purpose of the study. May (2001) indicates that the goal of the sampling technique is to obtain an insight into the experiences and perceptions of the interviewee. The participants taking part in this study provided a snap shot of professional CPD training for practitioners from an Irish perspective, at this time. Bryman (2004, p. 87) acknowledges that ‘a purposive sample is the segment of the population that is selected for investigation’.

4.11.2 Purposive sampling

Denscombe (2003), Babbie (2008) and Bryman (2008, p. 168) summarise that with purposive sampling, a sample is chosen by the researcher on the basis of her/his knowledge of population, its elements and the purpose of the study. The power of purposive sampling lies in choosing information-rich cases for in-depth

analysis dealing with the central issues being studied (Berg, 2004). The benefit of non-probability sampling, according to Austin (2006) is that it is cost effective, quick and easy to generate. Disadvantages could include practitioners giving biased views, or giving information that they think the researcher wants to hear and/or giving information that the researcher already knows. This was a risk and the researcher took steps to prevent the likelihood of this happening. In preventing any bias on her behalf, she listened carefully, did not interrupt or did not prompt participant responses. At the same time, she asked participants to clarify or reiterate their responses and where possible back up their responses with examples from their work practice.

4.12(a) Semi-structured interview participants

The researcher gave her manager the revised interview guide Appendix: 2 (p. 414) which outlined the proposed questions and a copy of Appendix: 3 (p. 415) outlining the study. The manager asked the researcher to arrange times for the semi-structured interviews with relevant staff members. Managers in the two other centres were also contacted, firstly by writing to them and enclosing both appendices. This was followed up by phoning them the following week.

All 18 participants taking part in the study were Irish and ranged in age from 25 to 65 years of age. While having a mixture of male and female voices in this research study would have provided a rich and unique first-hand experience of practitioners' work and more specifically of their views on CPD training, however, there was only one male - a manager, despite interviews taking place in three different locations. As noted by Christie (1998) Williams and Lalor (2001); and O'Toole (2009, p. 143), 'social care practice can be seen as a non-traditional occupation for men. It is seen as a "caring" profession, and while some aspects of the work can involve control and surveillance, the emphasis on care positions it as a feminised profession'. Participants' educational qualifications include: eight participants have an ordinary degree in applied social care, four have an honours degree, one has a sociology degree, one has a certificate in social care and one has a nursing degree (see table 5.8 chapter 5). Three staff attained Masters degrees in fields related to their work.

4.12(b) Questionnaire participants (follow-up study)

Two years after the TCI intervention (described in chapter six) took place, I went back to the participants who took part. In doing this I used the findings by Schostak's (2010) which are displayed in (table 2.2.p. 52, chapter two) to see if participants' findings were similar and to see if their CPD had changed over a period of time. Utilising questionnaires, six of the original eight participants who took part in the TCI intervention study agreed to take part in this follow-up

research. They were asked questions about their past, present and future with regard to their CPD and work situation.

4.12.1 (a) Data Collection: semi-structured interviews

Interviews took place in privacy in the sitting rooms of the three centres; dates and times of same had already been agreed and confirmed. May (2001, p. 120) asserts that 'interviews yield rich insights into people's biographies, expectations, opinions, values, aspirations, attitudes and feelings'. Oakley (1981) advocated the participative use of qualitative in-depth interviews to best find out about people's lives (Letherby, 2003, p. 84). Moore (1997) refers to qualitative in-depth interviewing, as the relatively informal, interactional exchange of dialogue.

Kvale (1996, p.14) asserts that 'the qualitative research interview is a construction site for knowledge. An interview is 'literally an inter-view, an inter-change of views between two persons conversing about a theme of mutual interest' (ibid, 1996, p. 14). The considerable advantage of using semi-structured interviews in this study lay in their flexibility. In-depth interviewing involved a thematic, topic-centred approach in relation to asking questions, while at the same time it allowed for a fluid and flexible structure. Van Maanen (1983) suggests that this enables both the researcher and participant to develop unexpected themes.

Clarke (2003) suggests that in qualitative research interviews researchers should approach the social world from an 'experience near' perspective. With regard to this, the researcher, like the participants in her study, is a practicing practitioner and therefore is able to relate her working experiences to those of the participants. Some participants assumed the researcher was familiar with work issues that they had experienced which necessitated specialised CPD training. They appeared to take these issues for granted, as part of their work, including that of the researcher's work. The researcher probed these questions with them further, to gain a clearer understanding of their meanings of the phenomenon in question. By the researcher asking them to explain their statements, it clarified that she did not want to impose her thoughts and ideas or to interpret the data from her own perspective. This also highlighted that the researcher was aware of the dangers of researching her own colleagues in a familiar field. The researcher was trying to position herself and was aware of being an insider and the implications of the concepts of being 'near' and 'distancing' herself from the research.

Questions for the study were open-ended but semi-structured and related to the central question and the five associated research questions (listed on p 153 above). Although using an interview guide of questions Appendix: 2 (p. 414 and below) to focus the interviews, questions deviated from this when there was a need to probe deeper into the experiences discussed which related to the CPD training issues identified by participants.

4.12.1 (b) Data Collection: Questionnaires

Questionnaires were distributed to participants in September 2015. Over the months: September to December participants filled out the questionnaires which composed open ended questions regarding their past, present and future work situation, listed at 4.12.2 b.

4.12.2 (a) Interview Guide Questions

- (1) What are the main challenges in your work?
- (2) Do you think you need ongoing training?
- (3) What training do you get in your profession?
- (4) Are you asked to suggest training that you need?
- (5) Do you or your team engage in reflective practice?
- (6) Is your training competency based?
- (7) Do you have professional supervision? How often?
- (8) How would you rate your supervision?
- (9) What elements of training do you think are important?
- (10) Is your training beneficial and effective to your profession?
- (11) Do you think there are adequate resources provided for training?
- (12) What if any changes would you like to see in your training?

4.12.2 (b) Questionnaire Questions

Past

1. What did you think of the Change Laboratory's (CLs)?
2. Did the CLs change anything?
3. Did it lead to more?
4. What CPD have you got in the last 2/3 years, for example conference, presentation, paper etc?

Present

1. Are there positive/negative things happening around CPD?
2. Do you see it as top-down or do you think you have a role in it?
3. Is the work challenging?
4. Are you happy with your current work situation?

Future

1. Are you optimistic/pessimistic about your work for the future?
2. Do you think your needs are being met?
3. What do you think of the effort that CORU are putting into CPD?
4. How are you engaging with it?

4.12.3 Interview Process

Where the researcher works potential participants were either met or rang to arrange a convenient time with them. Interviews took place at various times and on different days over a three-month period. Phone contact with the managers in the other two centres confirmed suitable times to allow interviews to be conducted. This involved travelling to both centres. A day was agreed whereby starting at 9am the interviews began in the first of these two centres and finished at 6pm in the second centre. In all three locations, as mentioned above, interviews took place in a sitting room at the centres. When the participants who worked with and who were known to the researcher entered the room, she thanked them for agreeing to take part in the research.

In the other two centres the researcher introduced herself, welcomed them, shook hands and thanked them for agreeing to take part in the research. Thereafter, the researcher engaged in informal conversation with all participants before explaining the purpose of the interviews and the research study. Each participant was verbally informed about the consent form Appendix: 5 (p. 418) to partake in the interview as well as the bio-data form Appendix: 1 (p. 413) which listed the basic details about the participants. Participants were invited to read both forms before signing them. The confidential aspect of the research/interview was stressed to all participants.

Some participants read the consent form, while others did not. All participants agreed to sign the consent form and all filled out the bio-data form. When the forms were signed they were stored safely in a briefcase. At the first interview and for all interviews thereafter, a tape and interview schedule was coded using different coloured stickers on which was written: practitioner 1, practitioner 2 and so on. Participants were able to see this procedure being completed which reassured them their responses were confidential and could not be traced back to them or their centre. If participants agreed to be recorded with the Dictaphone, it was positioned in the centre of the table. When participants declined to be recorded, their manuscripts were written later and completed using field notes. Participants were guided through the interview by stating the nature of the issues they were being asked about. The order of questions was guided by the interview schedule that was ticked off after each question was answered. Participants were given ample time to elaborate on areas of interest.

When asking the second last question, each participant was informed that the interview was coming to an end. All participants were provided with an opportunity to make any comments or ask questions about the research at the end of the interview. Participants were thanked again for their time and valuable contribution. Following this, each coded tape, interview schedule, consent and bio-data forms was stored securely in a locked filing cabinet that was only

accessed with a key which belonged to the researcher. Data will be destroyed five years from the completion of this project (American Psychological Association (APA), 2002) or it could be lodged in the Irish Qualitative Data Archive (IQDA, 2014), with suitable protocols. Field notes recorded comments and observations if they occurred during the interview process. Participants, including centre managers, were all thanked for taking part in the research study; including the researcher's own manager. Thank you letters were sent to the other two managers, who assisted and took part in the study Appendices: 6a/6b (p.391; p. 392). On completion of the interviews, data was transcribed.

4.12.4 Transcription of Data: Semi-Structured Interviews

After each session of interviewing the semi-structured interviews were transcribed, rather than leaving them until all the interviews were completed. Legard et al (2003) advise researchers to audio-record the interview; this method allows a researcher to record interviews *verbatim* and with precision, including the language used by the participants, which includes their hesitations, silences and tone, in more detail than when the researcher takes notes only. As opposed to note-taking, audio-taping is neutral and less intrusive and it minimises bias. For example, interview participants may feel inhibited when the interviewer suddenly starts writing and the participants wonder whether what they have mentioned was of interest (Hancock, 2002).

In transcribing, it was noted that there was a repetition of some phrases in some of the interviews, for example, 'like you know', 'do you know what I mean' 'like' 'whatever', and 'you know'. Audio-recording omits cues given in note-taking such as that they should slow down or pause if the interviewer is writing or that they have said enough if the researcher is not writing (Legard, et.al, 2003). Interviews were transcribed in a timeframe of two and five hours per interview.

4.13 DATA ANALYSIS

Gray (2004) identified two main approaches for analysing qualitative data: content analysis and grounded theory. Content analysis attempts to identify specific categories and criteria of selection before the analysis process starts, while in grounded theory, no criteria are prepared in advance; all the measures and themes come out during the process of data collection and analysis. In other words, grounded theory suggests that theory emerges inductively from the data (Chesbro and Borisoff, 2007). Though it can be used in different types of research, grounded theory is often adopted to formulate hypotheses or theories based on existing phenomena (Glaser, 1992). In difference to this, and in agreement with Creswell (2007b, p. 17), the researcher used content analysis to analyse the data. She did this by using research questions and not hypotheses. She also utilised the established theory of AT which in turn grounded the thesis in a

theoretical framework. The researcher found that content analysis was a useful technique for allowing her to discuss and describe the focus of individual, group, institutional, or social attention. It is also useful for examining trends and patterns in research; word frequency counts can be used to identify words of potential interest (Stemler, 2001).

4.13.1 Content Analysis

Content analysis is ‘any technique for making inferences by systematically and objectively identifying special characteristics of messages’ (Holsti, 1968, p. 608). Qualitative data obtained from semi-structured interviews were analysed using inductive content or thematic analysis. The goal of content analysis is ‘to provide knowledge and understanding of the phenomenon under study’ (Downe-Wamboldt, 1992, p. 314). Researchers immerse themselves in the data to allow new insights to emerge (Kondracki and Wellman, 2002). This is also described as inductive category development (Mayring, 2000). Qualitative content analysis is defined as a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns (Bryman, 2001, p. 180). Content analysis offered a flexible, analytic and pragmatic method for developing and extending knowledge (Cavanagh, 1997) about CPD training for practitioners. This approach where information was gained directly from participants and where categories are derived from data during data analysis (Cavanagh, 1997) while compared to existing categories previously highlighted by the researcher, was advantageous for this study owing to the paucity of literature and knowledge available on the views of CPD training by practitioners/managers in Ireland (research and study conducted before the establishment of CORU or publication in 2014 of the book about CPD by Halton et al).

4.13.2 (a) Content Analysis Process/semi-structured interviews

The content analysis process comprised different stages. As is customary with the constructivist paradigm, an inductive data-driven approach was adopted, whereby the researcher began to search the data for codes. This was done by reading each typed transcript and manuscript carefully from beginning to end, as one would read a novel (Tesch, 1990), to derive codes (Morgan 1993; Miles and Huberman 1994, and Morse and Field 1995) by first highlighting the exact words (literally with a pen) from the text that appeared to capture key thoughts or concepts using the participant’s words. As they were worked through, attempts were made to limit these developing codes as much as possible. Next, notes were made of first impressions, thoughts, and initial analysis. As this process continued, labels for codes emerged that were reflective of more than one key thought.

Codes were sorted into categories based on how different codes were related and linked. For example, *time*, *staff*, *training*, *pay*, and *funding*. These emergent categories were used to organise and group codes into meaningful clusters (Coffey and Atkinson, 1996, Patton, 2002). Once all transcripts and manuscripts had been coded, all data within a particular code was examined through exploring relationships and connections between the codes. Some codes were combined during this process, eg the above codes were combined to form *resources*. Others were split into subcategories, such as *communication*, *staff*, *funding* and *paper work*. *Paper work* and *communication* were linked to *time* and *staff* and *funding* to *resources*. The final codes were examined to organise them into a hierarchical structure of themes, (all of the above codes were linked to theme one: the changing field of social care practice, discussed in chapter one and two) where they were explored to interpret the data by further re-examining the participants' responses while referring to the theoretical framework and other existing theory.

In extracting and using interview material, the researcher was careful about choosing excerpts from participants' interviews, to cite in the findings chapters (five and six). She quoted data that spoke directly and eloquently to her, confirming her insights and consolidating her thoughts about questions she had about CPD. Moreover, references that alluded to data highlighted in the researcher's review of literature and in the discussions of themes was also included in the cited excerpts. The researcher valued the participants' varied views and perspectives. Throughout the study, and most especially while analysing the data, the researcher was aware of monitoring and addressing her positionality and subjectivity; she was aware of her biases, given her internal/external position, and how this may have shaped the data. Equally, there can be constraints from being in an internal/external position in that despite the dissatisfaction reported from participants in the data, both the researcher and participants are in employment. It can be argued that if another person conducted the study, they may have viewed it differently. In acknowledgement of this she was conscious of representing participants' views objectively. Aside from reading it through the lens of social care practice, she aimed to stand back and outside and give a helicopter view of the situation for the reader.

4.13.2 (b) Content Analysis Process/questionnaires

In September 2015, the researcher contacted those who had originally taken part in the TCI intervention, with a view to finding out about their recollections of the Change Laboratories (CLs), also about their current, past and future views of their work situation and about their thoughts about the introduction of formal CPD by CORU. Two agency staff who had taken part in the intervention were no longer available or contactable. While discussing the content of the questionnaires with the six participating members at different times, the researcher pointed out the confidentiality of the study and assured them that all replies and details of same

would remain anonymous. Completed questionnaires were analysed as above with codes linked to themes with discussion occurring under the following headings:

1. When they reflected back on the process, how did they review it?
2. How has the CPD training changed – have they more control – is it a bigger menu. Now with CORU/Tusla have they more involvement in it?
3. What are their views of how it might impact on their professional development?

4.14 RESEARCHER'S ROLE IN THE PROCESS

Creswell (2007a, p. 22), in addressing personal experiences of researchers, asserts that the qualitative approach incorporates much more of a literary form of writing and experiences in conducting open-ended interviews and observations. In addition, qualitative approaches allow room to be innovative and to work more within researcher-designed frameworks. They allow more creative, literary-style writing, a form that individuals may like to use (ibid, 2007, p. 22). Rager (2005) points out that in qualitative research, the researcher is the instrument through which participants are studied and the researcher should be empathetic toward participants, at the same time. Wincup (2001) cautions that emotional involvement of the researcher in the study should be acknowledged in qualitative research, as most studies seem to disregard this aspect. Smit (2002) claims that part of the role of the researcher is to be aware of personal bias and preconceived ideas, since assumptions will lead a researcher not to see some of the data.

Nastasi and Schensul (2005) suggest that a researcher should be experienced and skilled when interviewing participants, gathering information and analysing data, and he/she should have good communication skills. According to Ehigie and Ehigie (2005) the researcher should be familiar with the topic and know when to probe deeper and get the participant to elaborate or broaden the topic of discussion. Patton (2002) notes that the researcher should be involved and immersed in the research as the real world is subject to change. The researcher developed interviewing skills firstly by conducting interviews when she was studying for her BA degree in Applied Social Care. For her master's degree by research in social care she conducted 32 interviews and lastly for her taught Masters degree she conducted 10 interviews. This experience afforded her ease and contributed to making her participants comfortable during these interviews. In addition, she reflected on her role during the research process and was sensitive to how her personal experiences would shape the study. Because of her subjective experiences, she was able to probe and follow-up on responses during the interviews. She wrote a subjective piece on each interview when she had finished conducting it and observed strategies to ensure quality of the research.

4.15 STRATEGIES TO ENSURE THE QUALITY OF THE RESEARCH

Table 4.8 lists the criteria to criteria commonly used in quantitative research. Guba and Lincoln (1989) proposed the *trustworthiness* criteria of credibility (paralleling internal validity), transferability (paralleling external validity), dependability (paralleling reliability), and confirmability (paralleling objectivity).

Naturalistic Terms/Qualitative	Conventional Term/Quantitative
Credibility	Internal validity
Transferability	External validity
Dependability	Reliability
Confirmability	Objectivity

Table: 4.8 Comparison of criteria for judging the quality of qualitative v quantitative research (Hoepfl 1997, p. 58).

4.15.1 Credibility of the data

Credibility involves establishing that the results of a study are credible or believable from the perspective of the participant(s) (Bryman, 2001) and can be achieved through ascertaining how compatible the findings of a particular study are with reality (Shenton, 2004). According to Merriam (1998) credibility, deals with the question, ‘How congruent are the findings with reality?’ Lincoln and Guba (1985) argue that ensuring credibility is one of most important factors in establishing trustworthiness.

In comparison, internal validity in quantitative research addresses what the researcher wants to measure. Strong internal validity means reliable measures of independent and dependent variables as well as being able to justify the links between them (Rolfe, 2006). In the constructivist/interpretive perspective credibility asks if participants’ constructions of reality have been accurately understood and reconstructed by the researcher (Lincoln and Guba, 1985, p. 296). To enhance the credibility of qualitative research, Merriam (2009, pp. 25-27) suggests: member checks, peer review, researcher reflexivity, prolonged engagement, and triangulation. Lincoln and Guba (1985, p. 296) also refer to the benefits of conducting member checks.

In this study, the strategies employed were member checks, peer review, prolonged engagement and reflexivity. Early familiarity was developed within the culture of the participating organisations before the first data collection dialogues took place. This was achieved by contact and consultation of appropriate documents prior to the study. Le Compte and Goetz (1982); Lincoln and Guba

(1985) and Erlandson et al (1993) are among the many who recommend 'prolonged engagement' between the researcher and the participant organisations in order both for the former to gain an adequate understanding of an organisation and to establish a relationship of trust between the parties, similar to that in anthropology or ethnography.

Prolonged engagement was achieved as the researcher had previously worked with some of the participants and during this time she was open to member checks of her work by asking the participants to comment on the initial interpretations (Miles and Huberman, 1994) which she had made to the original constructions of their phenomenon, derived from the semi-structured interviews. Prolonged engagement created a bond of trust between her and the participants. She engaged in member checking, to clarify her interpretations of meaning, while on her shifts. The practitioners/managers (participants) were accommodating with their opinions on same. In addition, the researcher engaged in peer-reviewed paper writing in journals and attended conferences and research symposiums; engaging with her supervisor also enhanced her credibility of the research. Reading and writing peer-reviewed papers as well as meeting peers face-to-face added to the knowledge and breadth of her thinking and her study. Peers would read extracts from her work and would comment on it and likewise she did the same for them.

According to Patton (2002) the credibility of qualitative research depends on the ability and effort of the researcher. The credibility of research findings may be maximised through the practice of reflexivity (Ritchie and Lewis, 2003). Within the context of individuals' understanding of themselves and others, reflexivity is usually taken to mean 'the action of the mind by which it is conscious of its own operations' (Chambers Etymological Dictionary, 2005). Bolam et al (2003) define reflexivity as the active process of reflection that the qualitative researcher engages in to document how the research process, in general, and he/she, in particular, constructs the object and reaches conclusions.

Reflexivity allowed the researcher to examine her background, values, culture, and experiences that might influence interpretation of the research. Sinacore et al (1999) further consider reflexivity to be the 'practice of observing and locating one's self as a knower within certain cultural and socio-historical contexts ... It promotes self-awareness, scholarly accountability, and recognition of a range of human truths' (p. 267). The researcher was aware and went through a dual process of using her personal experience to understand and critique the knowledge that was introduced to her in which she appraised and made sense of her personal experiences using that knowledge.

This process involves cognitive, affective and experiential processes. The researcher is aware that she has to reflect more because of her insider/outsider status in the research process. For example while reflecting on data discussed

during and after the interviews, the researcher became aware that she equated a good professional supervision session to her work supervisor identifying to her what she was good at and what areas needed further work such as reviewing and researching key-working skills.

After reflecting on others' perspectives on supervision she realised that while it was ok to identify areas that needed more work, but also the broader picture needed to be looked at. This could be done by thinking critically and discussing areas of need with a view to them being addressed, for example, by the provision of courses on family therapy to enable practitioners to learn more about how engage with families of young people in care. This led the researcher to understand that from then on that while supervision was about identifying strengths and weaknesses, also it was about coming up with a step by step plan about how to address these needs which will ultimately benefit the professional practice of practitioners as well as the service. There was learning taking place that inevitably impacted on the research itself. An issue like this raises thoughts on insider/outsider research.

Unluer (2012, p. 1) claims that it is crucial for social researchers to clarify their role, especially for those utilising qualitative methodology to make their research credible. Unluer (2012) also advises that researchers who undertake qualitative studies take on a variety of member roles when they are in the research setting. These can range from complete membership of the group being studied (an insider) to complete stranger (an outsider) (Adler & Adler, 1994). While there are a variety of definitions for insider-researchers, generally insider-researchers are those who choose to study a group to which they belong, while outsider-researchers do not belong to the group under study (Breen, 2007, cited in Unluer, 2012, p. 1).

Bonner and Tolhurst 2002 cited in Unluer, (2012, p. 1) identified three key advantages of being an insider-researcher: (a) having a greater understanding of the culture being studied; (b) not altering the flow of social interaction unnaturally; and (c) having an established intimacy which promotes both the telling and the judging of truth. Further, insider-researchers generally know the politics of the institution, not only the formal hierarchy but also how it 'really works'. They know how to best approach people. In general, they have a great deal of knowledge, which takes an outsider a long time to acquire (Smyth and Holian, 2008, cited in Unluer, 2012, p. 1).

According to Unluer (2012, p.1), although there are various advantages of being an insider-researcher, there are also problems associated with this positionality. For example, greater familiarity can lead to a loss of objectivity. Unconsciously making wrong assumptions about the research process based on the researcher's prior knowledge can be considered a bias (DeLyser, 2001; Hewitt-Taylor, 2002

cited in Unluer, 2012, p.1). However, social research is concerned with human beings and their behaviour, involving a great number of players, each of whom brings to the research process a wide range of perspectives, including the researcher's own perspective. May (as cited in Porteli, 2008) stated that this situation can produce a more balanced and in this sense a more 'objective' account of the gradual development.

Unluer, (2012, p. 2) posits that insider-researchers may also be confronted with role duality. They often struggle to balance their insider role (instructor, nurse, geographer, etc.) and the researcher role (DeLyser, 2001; Gerrish, 1997). As an insider, the problem is not just that the researcher may not receive or see important information. Another risk may be that the insider-researcher gains access to sensitive information. To conduct credible insider research, insider-researchers must have an explicit awareness of the possible effects of perceived bias on data collection and analysis, respect the ethical issues related to the anonymity of the organisation and individual participants and consider and address the issues about the influencing researcher's insider role on coercion, compliance and access to privileged information, at each and every stage of the research (Smyth and Holian, 2008, cited in Unluer, 2012, p. 2).

The goal of reflection is to promote a better understanding of self and others within a collaborative context (Sinacore et al., 1999). The CHAT model of the activity system facilitates reflexivity on the part of the researcher who employs it. Especially when researchers play a participant-observer role in their study of an activity system, they are impelled by the model to consider their own roles in the activity as alternately 'subjects/actors' and members of the 'community of significant others' co-engaging the activity's object (Foot, 2001, p. 33).

4.15.2 Transferability

In table 4.8 above, the conventional equivalent of transferability is external validity which refers to the extent a study is able to generate statistical generalisations from a random group to a wider population (Hoepfl, 1997; Sarantakos, 2005). In qualitative research, the equivalent term is 'transferability' and refers to the extent to which the results can be transferred to other contexts or settings (Guba and Lincoln, 1989). For example, the findings of this study in the residential child care setting may possibly be transferred to other similar settings around the country. Also a theme that emerged from the data and discussed in chapter five was: *The pros and cons of using TCI for addressing challenging behaviour*. TCI is widely used in residential child care settings.

It can be argued that qualitative researchers do not share the same level of concern for generalisability as quantitative colleagues, yet the researcher would agree that, while her study is not completely generalisable to the general population, as far as

she is aware there is a good chance it could be transferable and applied to other centres. Qualitative external validity concerns itself with comparability (the ability of other researchers to extend knowledge based on the 'richness and depth' of the description) and translatability (the extent to which other researchers understand the results given the theory and procedures underlying the study) (Altheide and Johnson, 1994). According to Payne and Williams (2005) transferability depends on rich descriptions of the data collected and a full report. This demonstrates reliability and validity in the researchers' account, and allows the reader to decide whether the findings can be transferred to other settings.

This study, as recommended by Shenton (2004) has described in detail the context of the study while mentioning three research sites; it gives a description of the sample in the study, the number of participants in the study, their gender, the data collection methods used in the study, the number of interviews and the duration with participants. Another researcher can utilise the same methods, used here, in their study to ascertain the extent to which the same results can be obtained.

4.15.3 Dependability

According to Guba and Lincoln (1989) and Ritchie and Lewis (2003, p. 271) dependability refers to the extent to which the research findings can be replicated by other researchers. The researcher argues that this study is dependable because anyone who works in a child care centre/social care setting could do this study. One of the purposes for doing this study was to establish the CPD training needs among staff and how to address them. To enhance dependability, in this study, in which the methodology is detailed, the researcher followed a very clear and logical method where she could see a link between the data and the findings. The challenges are that another researcher would need to get access to the research sites and may need to have insider status to replicate the study. In aiding dependability, there is a specific process that must be undertaken, which encompasses points one to six below:

1. The researcher was the only researcher involved in the whole study from start to finish, endowing her with logical coherence and the capacity to become familiar with the research data and discourse of the study.
2. The use of the audiotape for interviewing gave a true representation in participants' own words about their experiences and insights about training. Also it provided the scope to analyse the verbal and non-verbal communication during interviews, which sometimes gave vital clues to the thoughts and emotions of participants.
3. Transcribing the interviews verbatim gave a true richness of the narrated experiential accounts of CPD training.

4. Having an effective and efficient data management system in place accounted for good data storage and retrieval, the essence of data management for two reasons. First, Wolfe (1992) noted that data can easily be ‘miscoded, mislabelled, mislinked, and mislaid’, with the lack of a clear working schema (p. 293). Second, a useful data storage and retrieval system allows researchers to track available data; effectively use data at different points of a project; and record the analyses made, so that the study can be verified and evaluated by its readers and other researchers (Huberman and Miles, 1994).
5. Participants’ data was stored securely so that it would not be mismanaged in any way. Data inputs were backed up on internal and external computer hard drives and on a USB key at home as well as on the hard drive of the college computer. Computer backup of files took place on a daily basis as this was considered an important aspect of the research process. Records of tape recordings of interviews, manuscripts and transcripts and all correspondence in relation to study were/are kept safely - stored in a locked secure cabinet.
6. Presenting excerpts from the participants’ own words from the interviews gives a trustworthy report of their experiences, which can increase the dependability of the data to the greatest possible degree. Dependability of data was further increased by utilising concrete case studies from Engeström’s, Helsinki study, which discussed the health care case in a children’s, which has parallels with this study on practitioners CPD training.

4.15.4 Confirmability

Confirmability is the equivalent of objectivity (table 4.8 above) in conventional research (Bryman, 2004). In quantitative research, objectivity addresses reliable knowledge, checked and controlled, undistorted by personal bias and prejudice (Kvale, 1996). Confirmability refers to the degree to which the results are reflective of the experiences of the participants (Shenton, 2004). According to Sarantakos, (2005, pp. 92-93), in quantitative research, the concept of value neutrality requires that researchers ensure personal bias does not influence the process, while in qualitative research, the concept of normativism asserts that research is not value-free and that the researcher should disclose this inevitable bias rather than pretend it does not exist (Sarantakos, 2005, pp. 92-93).

As Hammersley and Atkinson (1983, p. 15) note: ‘There is no way in which we can escape the social world in order to study it. Put simply a relationship always exists between the researcher and those being researched’. Reflexivity, according to Altheide and Johnson (1994), admits that the observer ‘is a part or parcel of the setting, context, and culture he or she is trying to understand and represent’ (p. 486). Seale (1999) advised that reflexive work includes: a story of the research project; fieldwork experiences; keeping a research diary or detailed field notes; documenting how the researcher approached the study both theoretically and

practically; and the researchers' personal predilections and biography. As stated by Lincoln and Guba (1985, p. 331) 'confirmability is a neutral criterion for measuring the trustworthiness of qualitative research; if a study demonstrates credibility, auditability and fittingness, the study is also said to possess confirmability' (ibid, 1985, p. 331). Miles and Huberman (1994) consider that a key criterion for confirmability is the extent to which the researcher admits his or her own predispositions. Shenton (2004, p. 63) asserts that to achieve confirmability, researchers must take steps to demonstrate that findings emerge from the data and not their own predispositions.

The following are some strategies for addressing confirmability in this study: The researcher tried to remain as objective as possible while conducting this research. In order to reduce her personal bias, she has explained why she used a qualitative method and constructivism/interpretivism rather than other methods in her study. Also, she has described the methodology that she adopted for the study and outlined how the data for the study was collected and analysed. Shenton (2004, 74) explains that an ongoing 'reflective commentary' by the researcher and an 'audit trail' enhances the confirmability of the study. Detailed methodological description enables the reader to determine how far the data and constructs emerging from it may be accepted. Critical to this process is the 'audit trail', which allows any observer to trace the course of the research step-by-step via the decisions made and procedures described (ibid, 2004, p. 74). The audit trail for this study can be easily reviewed here. Moreover, the researcher was aware from the outset that because she was a practicing practitioner that she came with a body of knowledge in relation to the residential child care setting. She was aware that this might impact her interpretation of the research. In order to remain alert to this, a non-biased approach was fostered in interaction with her research supervisor.

4.16 METHODOLOGICAL POINTERS

The previous section provided an insight into the data collection and analysis. This section moves on to discuss a number of methodological pointers that emerged during the research study which are worthy of further attention. Important pointers include: access, ethics, and power relations in the study.

4.16.1 Access

Initially time delays were experienced in gaining access to conduct some interviews. While the researcher easily gained approval to conduct interviews in the centre where she worked, she experienced some difficulty in contacting one manager in particular in one of the other two centres; she made several phone calls but the manager was either at training, on leave or not on duty when she rang. She did leave her phone number but the manager did not ring back for a while; she persisted with it as described in the field note:

Tried the number again today, but was told the manager is at a meeting, and will get back to me when it's over ... If there is no contact, I will try again tomorrow, this will be the 5th attempt, hopefully ... (Interview field notes 17th January 2011)

During the data collection, other restrictions prevailed with regard to interview access. For example, when the researcher arrived at the first centre, the manager and two staff were leaving to go to a training session from 9.30-11.30am. The manager had forgotten to inform the researcher about this when she rang to make the arrangements about the interview. By the time she arrived at the second centre, it was 3pm, and participants who came into the sitting room to be interviewed were conscious of not being delayed because they had to collect the young people from secondary school at 4pm.

The researcher acknowledged and accepted that the data collection process required flexibility and extra time due to the demanding nature of the work in the centres. She used the time delays experienced as a result of access and timing issues by transcribing the interviews from the participants in her place of work as well as familiarising herself with data. The frustrations that were experienced by access and time delays were minimal and once resolved they were overshadowed by the researcher's excellent experiences in which she had full co-operation from all participants in the three study sites. Time delays were also experienced in getting the completed questionnaires back from participants due to their time consumed by work pressures and meeting deadlines. Also, the researcher experienced delays in trying to locate the two agency staff who originally took part in the TCI intervention; however, it was not feasible to locate them at that time.

4.16.2 Ethics

Ethical concerns command a principal role in all research into sensitive topics (Kimmel 1988; Homan 1991; Gregory 2003; Benn 2006; Long and Johnson 2007). Throughout this study high ethical standards were strictly observed. As explained on p. 21 above: at the time of commencement of this study, the reviewers deemed that formal ethical approval was not required. From the outset of the study the researcher was aware of and made herself familiar with the requirements of the *HSE Guide to Good Research Practice* (2006) and the *HSE Research Ethics Committee* (2008), also with the requirements of the Institute of Technology Sligo *Code of Practice for the Quality Assurance of Postgraduate Research* (2008). These requirements highlighted for the researcher the importance of ethical issues and helped to ensure that the study always adhered to high ethical standards. As described above, at all times the researcher was aware of sensitivity to participants. During the interview and questionnaire study she informed participants that no identifying data would be presented in the context of

research sites/locations and pseudonyms were always used to protect anonymity of practitioners, for example when writing field notes. In addition, only the researcher handled data and she took great care to lock and store it safely. The following were also adhered to:

4.16.2.1 *Respect for Autonomy*

Beauchamp and Childress (cited in Lindsey, 1984, p. 3) define autonomy as ‘a form of personal liberty of action where the individual determines his/her own course of action in accordance with a plan chosen by him/her’. In research contexts, autonomy requires that the individual’s decision to participate is both voluntary (without coercion) and informed. The concept of informed consent assumes that in order for individuals to make informed decisions on whether to voluntarily participate in the research; they will require information that increases their awareness of the project’s risks and benefits.

Informed consent was an explicit part of this research process where all participants were informed about the nature of the study and its affiliations. This included providing the participants with as much information as possible before consent to participate was given and clearly emphasising the voluntary nature of participation. The written consent forms also incorporated these rights (that is, to information and voluntary participation), the researcher continued to stress the voluntary nature of participation throughout the study.

Holloway and Jefferson (2000, p. 88), warn that the decision to consent ‘cannot be reduced to a conscious, cognitive process, but is a continuing emotional awareness that characterises every interaction’. Similarly, May (2001, p. 59) defines ethical decisions in research as those that distinguish between efficiency and that which is morally right or wrong, between ethical principles and expediency in the research process.

4.16.2.2 *Non-Maleficence*

The principle of non-maleficence demands that the researcher be sensitive to what constitutes 'harm' (Ford and Reutter, 1990, p. 188; Punch, 2005, p. 75; Bryman, 2008, pp. 118-125). The potential for harm can be inherent in the interview process, which seeks access to the intimate details of the participants’ lives for the sake of understanding and elucidating their experiences. Sensitivity to research participants was ensured and no harm came to any participants who decided to take part in this research; neither was there discrimination in terms of who was interviewed for the study (Ford and Reutter, 1990).

4.16.2.3 Beneficence

While non-maleficence refers to the potential risks of participation, beneficence relates to the benefits (Ford and Reutter, 1990). Benefits may be limited for participants and although they may benefit from their involvement in the study, the ultimate purpose of the research was to give a voice and to hear their views about CPD training in their professional practice. Publication of the data may demand the balance of risks and benefits, favouring participant(s). In the longer term participants' data may contribute to professionalisation of the workforce and to further research.

4.16.2.4 Good practice in research

The anonymity and privacy of participants was respected at all times. Throughout this research, from the start of the interview process, participants were informed about the confidential aspect of the study. As discussed above, participants were assured that no identifying information was required and the information given would be treated with the strictest confidentiality. Research professionalism was also maintained in relation to integrity of individual viewpoints, respect for human rights and diversity at all times. Alderson (2004) accentuates the importance of 'respect' throughout the research process, which includes treating participants as competent and knowledgeable as well as respecting their privacy and confidentiality rights. The rights and welfare of participants were also of paramount importance where for example, all participants had the right to withdraw from the interview process at any time (Ford and Reutter, 1990).

4.17 POWER RELATIONSHIPS

The power relationship was one of equality, at all times. This was aided by the researcher's own identity being an equal practitioner. It was further enhanced by the researcher's independent status and the relaxed mode during the semi-structured interviews, which helped to create and maintain an equitable stance. From the start and throughout the study, the researcher was conscious of the importance of building rapport through, interpersonal relations, understanding life world, interpreting, being sensitive, and creating a positive experience for participants (Kvale, 1996, p. 30).

The researcher was conscious throughout the research of the potential power balance between researcher and participants and she ensured that no research participant was 'othered' or oppressed in any way (Oakley, 1981; Young, 1990). This was minimised by the researcher adhering to continual alertness, mindfulness, thoughtfulness, and empathy. Personal and professional sensitivity were adopted throughout. This study was committed to the ethic of *care* and the

associated values of: honesty, authenticity, respect, transparency, and to humility (Etherington, 2007).

4.18 STRENGTHS AND LIMITATIONS OF THE STUDY

4.18.1 Strengths

The methodological strength of this study is based on the qualitative approach which the researcher adopted when gathering the data and utilising the research. The person-centred style encompassing face-to-face semi-structured interviews, gave participants the forum to generate rich dialogues (May, 2001) where they expressed their concerns, reservations and aspirations about future CPD training in their work. It is also true that CPD is currently an important topic.

The study was further strengthened, by the numerous techniques (discussed above) that were used to increase the trustworthiness of the study. The inclusion of various locations for conducting the interviews was a further strength to the study. For example, familiar with procedures and CPD training in the centre where she works, it strengthened the study to hear the experiences from the forthright participants who work in the other two centres. The cross-sectional design added strength to the study as it gave added bonus of interviewing and capturing the essences, at one particular time, of participants who worked as practitioners/managers, in three different centres. Participants taking part in the follow-up questionnaire study further strengthened the study.

4.18.2 Limitations

While a longitudinal design may have opened a wider window on work experiences and CPD training trends over a longer period, this inadequacy was ameliorated by asking questions about work practice and CPD training of participants who had worked in this profession for up to 18 years, where they witnessed many changes to CPD training in that period. This was complemented by a small-scale follow up study of those who had participated in the CLs.

While not feasible for one researcher to relay the various work experiences within the scope of this study, they could be investigated in more detail in a further study at another time. To redress this deficit, challenges and work practices were discussed in various chapters throughout this study.

This study could have been more broadly defined. Participants could have been chosen from cohorts of professionals to generate data on a regional/national or even an international scale. Financial and time constraints meant this was not possible; no funding was received for any part of this study. Another limitation of this study was that some interviews took place in the participants' work places. This posed minor problems at the time as some participants were generally under

stress to resume work. Participants may have been more relaxed had it been possible to site the interviews in a neutral venue that suited participants and the interviewer. Owing to shift work schedules this was impractical.

While rich descriptive data was generated from individual interviews, in this qualitative study that explored a cohort of participants at one time, however, focus groups involving set numbers of professionals from different regions may have provided a more diverse data contribution. For example, the nature of the focus group may have produced a free flow of communication, which could have made the conversation richer and also more varied as participants progressed naturally from topic to topic; perhaps more views may have been expressed in this way.

4.19 CHAPTER SUMMARY

This chapter described the different decisions and processes undertaken throughout the research journey including the study's theoretical schema shown in Table 4.2 above whereby constructionism – interpretivism/phenomenology were utilised. Content analysis was used to analyse data from semi-structured interviews. Access and ethical issues relating to the study were discussed. A qualitative approach was used to supply rich data garnered from semi-structured interviews and from six qualitative open-ended questions discussing the phenomenon of CPD training for practitioners/managers. Qualitative strategies discussed to ensure quality of the research included, credibility, transferability dependability and confirmability. The next chapter presents the findings from the semi-structured interviews and from the questionnaires

CHAPTER FIVE: FINDINGS – SOCIAL CARE CPD

There should be more training other than Therapeutic Crisis Intervention (TCI) – even basic stuff like Fire Safety training or how to deal properly with kids who are self harming. Kids coming into care have changed, it's all abusive stuff now resulting from abuse of alcohol and drugs, we are not prepared for how to deal with this; our work is changing from simple life story work to kids who go out at night and don't return for days on end, we have no means of locking them up, all we have is basic TCI stuff that we do here every day but when you go to TCI they have buzz words to describe what we do.

We don't even get in-house training, the only mandatory here training here is TCI; it's nice to go out to it and meet people from other centres, it's the only chance we have to meet them; you don't even get to meet all the staff here, with how shifts are arranged; it would be good say once a week if all members of the team involved in the programme of care met up, even just for an hour; even a team meeting to explain family support. We work a lot with families now but have had no training; we should be networking; we are supposed to be part of a multi-disciplinary team. In high profile cases on TV you hear about social workers and their burn out but you never hear of social care staff and their burn out. Social care staff has no support, no backing from unions or anyone.

(Practitioner 10¹⁹ female aged 26, four years work experience)

5.0 INTRODUCTION

The preceding words exemplify what it is like to be literally thrown in at the deep end without any explanation or proper CPD training, but still expected to perform in a highly skilled and sometimes dangerous job. Apart from not having had relevant CPD training, practitioners have also to contend with and update themselves on the types of changes in their work practice. This chapter reports on the semi-structured interviews, introduced in the previous chapter, as outlined in detail earlier in this account, together with findings from the questionnaires completed (Sept-Dec. 2015) as a follow-up with six of the original eight participants who took part in the TCI intervention discussed in chapter six. They set the scene for a discussion of changes to CPD training by presenting the findings from practitioners/managers about their lived experiences of their work, current CPD training, and the issues they are concerned about for the future. The follow-up questionnaires provide an outline of changes – if any – that have been experienced since the original data-gathering.

¹⁹ Social Care Practitioners are referred to as practitioner1, practitioner2 and so on to preserve anonymity of participants

The research is a response to the dearth of information on social care practitioners that exists in the professional CPD training literature and allows practitioners the opportunity to give their own voice and insights into CPD training in their Irish contexts. Interviews were structured around the 12 sub-questions (p. 173 above).

The findings presented here are based on a synthesis of all 18 readings of interview transcripts/manuscripts. In an attempt to aid clarity and legibility the central question and five associated research questions are listed, then there are outline key features of the study population tables and discussion on data followed by the themes that emerged from the data which includes excerpts from interviews/manuscripts. The chapter concludes with the responses to the research questions and a summary of the key findings from the interviews/questionnaires.

5.1 RESEARCH QUESTIONS

These comprise the central research question and five associated research questions.

5.1.1 Central research question:

How should the CPD training that social care practitioners receive, be reconfigured?

5.1.2 Five associated questions:

1. How is the work in the social care sector in Ireland changing?
2. What type of CPD training is delivered to social care practitioners in Ireland?
3. What aspects of CPD training are most useful to meet the needs of social care practitioners'?
4. How can CPD training be reconfigured to respond appropriately to changing contexts and cultures of professional practice?
5. What has been the impact of relevant developments in CPD?

5.2 INTERVIEW FINDINGS

The following tables give a breakdown on key demographic features of the interview sample, for example, gender, age, job status, years of service and location of work.²⁰

5.2.1 Personal Profiles

Gender

²⁰ Location of Residential Child Care Centres (centres) will be referred to using a letter, for example, K, L and M to protect anonymity of children/young people/staff

Of the 18 participants, there was only one male, a manager²¹. This reflects research stating that there is a shortage of male workers in social care (O'Toole, 2009, pp 137-150). For example, figures generated by CSO (2012) for social workers and related occupations (there were no figures specifically for practitioners) shows that in 2006 there were just 4,580 (27 per cent) males in comparison to 12,628 (73 per cent) females working in the sector; this did not change much in five years given that in 2011 there were 4,824 (23 per cent) males and 16,498 (77 per cent) females working in the sector; in fact the female dominance intensified. Low numbers for males entering this sector is not unique to Ireland, in Scotland, the *Sector Skills Assessment 2010 - Scottish Summary Report* (2010, p. 3) cites figures showing that in 2007 the social services workforce was 198,680, of which just 30,300, 15 per cent, were male.

Gender	No.
Female	17
Male	1
Total	18

Table 5.1: Gender Profile

In addition, a workforce survey carried out in Ireland by the National Social Work Qualification Board (NSWQB, 2006, p. 22) reported 388 male social workers employed in 2005 (16.8 per cent of the workforce) compared with 1,928 (83.2 per cent) female social workers (Halton et al, 2014b, p. 69).

Age

The majority of the 18 professionals in this study were aged between 30-59 years of age; fourteen participants were aged over 30 years old. Of the 552 social care participants who took part in Byrne's CPD survey (2014, p. 8) (81 per cent) were female and aged between 30 to 39 years (39 per cent). In Halton's study (2011) 82 per cent were females in the 26-35 and 46-55 age brackets.

There is some evidence that younger people are employed more broadly in the childcare related occupations in Ireland. The discussion paper, *Developing the workforce in the early childhood care and education sector* (2009) found that:

The age distribution of employment in childcare related occupations is skewed towards younger age cohorts. Almost half of the workforce is younger than 35, while only 7 per cent is older than 55. Over one half of

²¹ Social Care Managers are abbreviated to manager(s)

employment in the nursery nurse and playgroup leader category and almost 60 per cent of that in other childcare related occupations is in the 15-34 age cohorts. Education/special needs assistants are concentrated in the 35-54 cohorts, with more than 60 per cent in this category. There has been a shift towards older age cohorts in all childcare related occupations, with the share aged 15-34 declining from 61 per cent to 47 per cent between 1998 and 2008 (ibid, 2009, p. 18)

The ages of staff in this study indicate that practitioners are mature and possibly older than the overall practitioner in the workplace, and generally experienced, which can be an asset when working in such demanding and volatile settings with vulnerable children/young people. As table 5.2 shows, the majority of staff in this study are in mid-career.

Age	No.
20-29 years	4
30-39 years	8
40-49 years	3
50+ years	3
Total	18

Table 5.2: Age

Years of service

Most professionals in the study had completed at least six years of service (Table 5.3). In contradiction to research both in the UK from the Training Organisation for the Personal Social Services England, (2004) and Colton and Roberts (2006, p.14) and from Irish settings: Williams and Lalor (2001, p. 79) and McEvaney et al, (2013, p. 178), who all cite high staff turnover in residential child care settings, the findings from this study indicate that staff have been in their posts for long periods of time. This could also be related to the operation of a less diverse social care practitioner market in regional as opposed to urban areas in Ireland.

Years of Service				
	0-5	6-11	12-17	18-23
Female	4	6	6	1
Male				1

Table 5.3: Years of service – overall

Respondent	Years of service	
	Social Care Practitioner	Additional as Team Leader
1	12	
2	5	4
3	9	
4	5	
5	10	
6	4	
7	4	
8	8	9
9	8	5
10	4	
11	12.5	
12	12	
13	12	
14	10	
15	10	
average	8.3	

Table 5.4: Years of service - practitioners/team leaders

Table 5.4 indicates an average of 8.3 years worked per practitioner. Three practitioners progressed to team leaders after building up their experiences for five or more years. While high turnover of staff was reported in other centres in

Ireland (McEvaney, et.al 2013, p. 178), this table shows that in the centres taking part in this study there is a lot of experienced staff, with four years being the shortest length of service.

Managers

No. of Managers	
Female	2
Male	1

Table 5.5: No of Social Care Managers

Table 5.5 indicates three managers: two female; one male. In some residential child care centres they have deputy managers but in these three there was just the one manager. The data contradicts the norm regarding women in managerial positions. Lavin (2014) reports a glass ceiling in Irish society for women climbing to the top of their careers. They are consistently under-represented on boards of management and in politics and earn less than men in general. In 2010 women were only 22 per cent of business leaders and 15 per cent of Dáil members. While initiatives, such as gender quotas, help women get to the top they fail to address on a broader scale why so many men can climb higher than women and why those women fall behind men mid-career. In social care practice it may be different as women may be likely to succeed in the ‘care sector’.

Social Care Managers – total years of service		
1	Male	18
2	Female	18
3	female	5

Table 5.6: Years of service managers

All three managers had five years or more service experience (Table 5.6). In all three centres the managers were promoted to their positions after working for some time in each centre; all three managers worked in residential child care before coming to work in these present centres, bringing with them a diverse range of experiences from different areas of the social care sector.

Centres

While there were other employees working in each of the three centres, table 5.7 shows the number of participants who took part in the study on the days when the semi-structured interviews were conducted.

Work Location				
	Centre K	Centre L	Centre M	Total
Female	6	6	5	17
Male	0	0	1	1
Total	6	6	6	18

Table 5.7: Work locations

Educational qualifications

It can be garnered from table 5.8 that it provides a good basis for CPD at quite an advanced level, given that there is a good combination of education and experience. This area of work with children in care is established since the 1970s and is complying with standards and regulations, among others: the Child Care (Placement of Children in Residential Care) Regulations 1995 and in 2001 the National Standards for Children’s Residential Centres. **By** contrast, the early childhood care and education sector is in its infancy, with HIQA in 2012, publishing the National Standards for the Protection and Welfare of Children; while HIQA only recently published the National Quality Standards: Residential Services for Adults and Children with Disabilities (2013c).

Qualifications on the National Framework of Qualifications (NFQ)	
ODASS: Ordinary degree in Applied Social Studies: Level 7	8
HDASS: Honours degree in Applied Social Studies: Level: 8	4
DND: Disability Nursing degree: Level: 7	1
MDASS: Masters degree in Applied Social Studies: Level: 9	3
Sociology degree Level: 7; Certificate in social care: Level: 6	2
	18

Table 5.8: Educational Qualifications

Training (April 2011)

Table 5.9 shows the type of CPD training that was available to staff in the three centres. One centre in particular did not have any training for two years or more while the other two had regular TCI and fire training. Because of no new training being offered by the HSE, staff in centre M decided to try and source free training by inviting professionals to give talks at the weekly team meetings as well as staff sourcing and funding other training that they required. At the time of writing, there was no official data that had reported on the effectiveness or not of this initiative. Interviewees at centre M explained that historically they had had a training officer employed for many years in their centre but, due to the recession, this person was no longer in employment there.

Training Offered			
	Centre K	Centre L	Centre M
TCI	Yes, but no refresher for 2 yrs	Yes, twice yearly	Yes, twice yearly
Fire Safety	No	Yes	Yes
Children First	No	Yes	Yes
Strengthening Families	No	No	Sourced/paid for by staff
ASIST	No	No	Yes
Restorative justice	No	No	Sourced/paid for by staff
HSE Corporate Training	Yes given after commencement of employment	Yes given after commencement of employment	Yes given after commencement of employment

Table 5.9: Training offered

5.3 THEMES

In line with the constructivist approach, the next section outlines and discusses emergent themes emanating from the research questions asked at the interviews, and ongoing themes highlighted from the follow-up questionnaires, linked to the five overarching themes of the study.

5.3.1 Lack of staff/resources

As a consequence of the changing field of social care practice combined with the recession, a major issue for practitioners was lack of staff and resources. They pointed out that their CPD training mainly consisted of mandatory TCI refresher training and fire training, although manager2 said: ‘all staff here need refreshers in TCI but have not had any’. Owing to a lack of resources, participants in one residential centre began sourcing their own training by trying to get professionals to come to their team meetings to give them free talks on relevant topics pertaining to issues that arise in their work practice. Practitioner 7 said: ‘resources are not adequate but we are doing our best to source our own in-house training by getting professionals to come in to talk to us for free’.

For the three managers it was challenging trying to balance the needs of young people and staff as well as managing their centres together with the lack of staff and resources. Manager3 invoked Engeström’s (2006) thinking when he mentioned: ‘it’s challenging giving staff the tools, when you don’t have them, so that all staff can work together towards the one goal’.

Practitioners also said they have been paying themselves for their training, which they engage in on their days off work. Lack of resources and deficiencies in their training was summarised by four practitioners (4, 5, 6 and 14) who claimed that resources could be better spent, citing they have no extra support apart from them making an appointment, through their manager, to see an occupational therapist employed by the HSE. Practitioners claimed that there is no appreciation of their work; they do not have proper supervision and they are not given time for reflective practice, the only support they have is each other as a team; they had no external supports available to them. While again highlighting their dissatisfaction with TCI, practitioner3 said: ‘resources are not adequate as the only training we get is TCI which is boring’, practitioner4 said: ‘Too much time and money is spent on TCI and the restraint part is not being used’. Manager1 said: ‘Although I know nothing about budgets, the quality of the training provided is of poor standard’. Manager3 said: ‘we could do with more team based training’. The opening quote to this chapter by practitioner 10 gives a descriptive view of resources and the situation for practitioners working in centres.

In discussing the lack of resources, manager 2 said, ‘we are short staffed here and are relying on a skeletal staff, there was no relief panel and we had to employ agency staff where necessary’. Three participants (practitioners’ 12, 13, and 15) resigned themselves to the fact that due to the present economic recession there is no money now in the HSE for CPD training or resources. A point made by practitioner 9 gives a picture representative of all the centres:

The HSE don't listen to their staff, they provide the training before they ask the staff. We need a member of staff to take on what training is needed, it has to be what is needed here, not what the HSE propose.

Practitioners' interviews have illustrated a lack of adequate resources in the centres and that the HSE do not listen to their staff, instead they provide whatever training is available and do not ask for feedback.

Although four years have elapsed (2011-2015) since the original interview study, the follow-up questionnaire has indicated that little has changed in the intervening period. Practitioners 1, 2 and 5 said that the changeover to Tusla was difficult with very little support, with a lack of support externally with staff having to fight for any help or support that they got. While they had been granted the services of a psychologist for a few months this service was discontinued due to financial constraints. Practitioners had found the services of the psychologist to be beneficial and highlighted that similar professions had such a service as routine.

From these excerpts we can see that practitioners were dissatisfied with the level of support they received during the change over from the HSE to Tusla. As described by P1, they are doing a difficult job but still have little external support and have to fight for any support given, as described by P2. While there have been many advances in residential child care, it can be argued that these 2015 findings in relation to resources are reminiscent of the study by Williams and Lalor (2001) who discussed obstacles to professionalisation of the residential child care work.

5.3.2 Changes in relation to work practice

Coupled with a lack of resources, practitioners reported on changes that affected them in their everyday work practice. Noting a lack of specific relevant CPD training, practitioner 7 said: 'it is very challenging dealing with young people who self-harm, as we have had no training in how to deal with it apart from what we learned in college'. Although practitioners consulted the internet for information, this did not help them to know if they were using the correct procedures with children who had different reasons and different needs for engaging either in self-harming and/or in suicide ideation.

Other challenges for practitioners were discussed: practitioner 4 found it was challenging 'getting young people to engage in the programme of care that is in place for them'. Concurring with this practitioner 13 said: 'after 13 years in the job I still find it challenging when children are placed in care that are too old rather than if they were placed at a younger age where there could be some chance of doing something with them'. Practitioner 12 claimed 'it is challenging enough working in residential care but even more challenging trying to deal with aggressive behaviours of young people as a result of drug/alcohol abuse'.

Practitioner15 said: ‘my biggest challenge is keeping young people safe in the centre because they keep absconding’. A challenge for practitioner 11, a female aged 50 with 12.5 years work experience was: ‘balancing family life with working long hours; keeping up with legislation; the changing norms of young people in care, dealing with trauma from abuse, especially sexual abuse, self-harm and suicide as well as addressing the usual challenging behaviour’. As the above indicates, issues in relation to abuse, aggressive behaviour, self-harm and suicide are key issues that practitioners have to contend with in centres.

While the above practitioners highlighted their dissatisfaction about changes in their work practice, we can see from the following excerpts from questionnaire participants that staff are still experiencing challenging changes, some of which are new to their practice. When asked if they were happy with their current work situation, they gave the following responses.

The questionnaire responses indicated that staff are not happy with changes that have occurred within the organisation, mainly since January 2014 with the changeover from the HSE to Tusla. With reference to this question, P2 pointed out that ‘they are happy with the work they do with young people’. It is worth remembering that most staff who took part in the study have four or more years experience in this work. However, they are not happy with the management structure or the way the Tusla organisation operates in bringing in change. Practitioners said they were not supported either by Tusla or by their Unions.

Themes highlighted include the national reconfiguration of residential child care services, which P2 claimed had resulted in a feeling of isolation. This is in stark contrast to residential child care services in the larger institutions where isolation was not an issue as every service required was on site at all times. Other key themes highlighted centred on staff not being happy with their roster. Some part-time staff were continuously asked for over three years to make up their contract hours by working on day shifts each day for a few hours, which they found onerous. Also, at the time of questionnaire study there was talk of management introducing 12 hour shifts and live nights²² which most staff were against, to be compliant with the Working Time Act.

As well as these issues, questionnaire participants commented on how the environment for working with children was changing. For example, P1 summed this up by saying:

I’m annoyed at how official things have become when trying to work in a friendly homely like environment that it’s supposed to be because it has now become really institutionalised, with the added effect of a big brother style monitoring structure. While that’s supposed to be put in place to

²² Live nights are where the practitioner stays awake all night, usually on 12 hour shifts

ensure there is quality care it feels too heavy in its approach in assessing that. It's gone to the stage now where the young people have to sign documents after the key worker has done a session with them which make things very official. In our own homes we would not be signing documents every time we had an informative talk with our children (P1).

Participants also mentioned not being happy about how the new structures affecting them. They mentioned that the new service is neither effective nor efficient with regard to finances. They are now required to fill in more forms, there is an increase in paperwork required as well as computer work but they are not given any extra help or resources to do this work. On top of all that they had just been told about the changes that are coming with regard to CORU and formal CPD, P6 made the following remark about this:

I like the work but the system is becoming increasingly bureaucratic due to the national reconfiguration of the service. Also the new CORU/CPD thing is happening but I think that for it to work for people, they have to have openness to it and I get a sense that this is not happening. There seems to be a lack of clarity on how it will impact on work. It could be that if you don't get your points through the training they put on you could have to source them yourself (P6).

Clearly all six practitioners are unhappy with their current work situation. Including the impending registration with CORU, practitioners have highlighted numerous complex issues including changeover from the HSE to Tusla; national reconfiguration of residential child care service; 12 hour shifts; inequality of rotas; increased monitoring and extra work with no help or extra supports. It can be argued that in a residential child care centre this will result in less time for doing one to one work with vulnerable children/young people.

In the questionnaires, practitioners were asked if they were optimistic/pessimistic about their work for the future? All six said they were pessimistic. In their responses practitioners talked about being worried about the welfare of staff needs (P1) because of the concurrent changes introduced since 2014 and while she recognised that they have to give it time, she said 'we have no choice but to go with it'. In expressing her disillusionment P2 mentioned the fact that now practitioners are dealing with faceless people. Before the change practitioners were familiar with the management structure, the whole way up to the Minister for Children but the changeover brought new people and many older experienced people had resigned. Because of the difficulties brought about by changes which have been introduced, as well as the uncertainty about future changes, staff are very anxious about the future (P2). Also what makes it difficult is that as stated by P5: 'the lack of information coming from external management about it'.

P4 made the point that: ‘making us a national service may disassemble all local links to the detriment of the service’. With reference to this, practitioners commented on the need now to send all invoices to various people who have to sign them, which causes them to be delayed. Due to a back-up of invoices and time delay, this can cause disruption in services, such as if the coal bill is not paid on time the local delivery service will not deliver fuel the next time. In the past such problems did not arise and there was a relationship built with local suppliers. Centres can only do business now with services who have special contract numbers. A disadvantage of is that businesses in local area may not be used in favour of outside businesses in order to be compliant with new requirements. A point highlighted by P3 was a loss of a sense of belonging that she previously had. This caused her to suggest that the centre may close. Also, there were links to Williams and Lalor (2001) study again here when P4 said:

My experience is that the views and expertise of residential social care workers are not ever taken into account. I don’t think the role of the social care worker is seen as being important at all.

In expressing her pessimism about the demands of the extra workload, P5 said: ‘It’s more demanding with the focus on paperwork, no time for the children; a lot of accountability’. These sentiments were echoed by all participants who recognise that in their current work practice, paperwork is demanding but do not know how they will possibly cope with the requirements of the new regime. Moreover, the most important aspect of all these changes is that staff in this centre recognise that children who have suffered pain and trauma need a lot of time and attention, individually. When staff are required to spend hours doing paperwork they simply do not have the time, as P4 said, to spend with the children. This is the core of their work and it is being diminished.

These excerpts show that staff are very clear that they are not optimistic about their future careers. They cite the difficulties in adapting to a myriad of proposed new changes after experiencing and still having difficulties with the change over to the new agency which entailed new structures that are still not consistent or fully operational. A major change is that staff are dealing with people in head offices that they do not know nor have never seen, these people too are new to the job and are learning as they go along. Interruptions have occurred and there have been breakdowns in services due to difficulties with payments. It is evident there will be substantial continuous changes in work practices. A lack of support and resources coupled with an increase in workload and an adjustment to new practices and processes makes for a bleak perception of the future for a workforce, already under pressure in this volatile job that changes and evolves on a continuous basis.

5.3.3 The pros and cons of using TCI for addressing challenging behaviour

Along with a lack of resources and changes in relation to work practice, another emergent theme for practitioners was their discontent with TCI for addressing young people's challenging behaviour, reflective of changes in the nature of the client group. Practitioner12 claimed 'it is challenging enough working in residential care but even more challenging trying to deal with aggressive behaviours of young people'. Participants said their only recourse for addressing challenging behaviour, apart from their own communicative skills built up over years of experience was TCI, which is part of their behavioural management policy; the 'official' response to such issues.

While some practitioners used and found TCI theory to be effective, many expressed dissatisfaction with the physical restraint part of TCI, identifying what they perceived to be some key deficiencies. For example, practitioner4, a female aged 27 with five years work experience, said: 'TCI is no good at equipping you to deal with stuff that crops up on a daily basis in a children's centre, we need more training to deal with young peoples' challenging aggressive behaviour'. Practitioner8 said: 'ongoing training in TCI is provided but there must be something else out there that could be incorporated into it; it would be great to have something different to it'. Based on these statements, there are positives and negatives in the TCI approach; it could be a matter of practitioners themselves reconfiguring TCI, which would give them more control over it.

Practitioner2, citing a personal responsibility for training, saw: 'gaps in TCI training where it is not addressing the restorative aspect'. She suggested ways that TCI could, for example, show how staff could encourage a young person to make reparation to one of the residents or staff he/she has verbally/physically abused. This practitioner outlined changes she would like to see in future training:

To see thinking outside the box, staff being encouraged and supported to do training. I've been battling for years to get management to get another model other than or as well as TCI but no, it's still only TCI. Also we are not supported to do research; HIQA are more about improving approaches without training. Training is a personal and not a service goal but if we source it, the manager is very supportive of getting it for us.

TCI has long been a controversial issue in residential child care centres, owing to the different views on it. With regard to physical restraint, in the TCI workbook, Holden et al (2009a, p. S1) discuss the controversy about TCI restraints and they ask does physical restraint keep children safe? They cite Nunno et al. (2006), for whom restraints are amongst the most controversial interventions used in the mental health, juvenile justice, special education, and child welfare systems. They point out that these procedures are considered high-risk and dangerous to children

and the adults who apply them. The primary reasons cited for use of restraints with children and youth are for safety and containment and the prevention of physical harm. They note that, unfortunately, using restraints to prevent harm often results in injury or worse, and not only are injuries commonplace, but, tragically, there have been fatalities to a number of children as a result of physical interventions (ibid, 2006).

Holden et al (2009a, p. S1) ask: is physical restraint therapeutic? They cite Zaslow and Breger (1969) and Cline (1979) who claim that some proponents advocate the use of physical restraints as a therapeutic component of care and treatment based on attachment theory (that holding promotes positive attachment with children with certain disorders such as autism, reactive attachment disorder, and borderline personality disorders). Also, they cite Day (2008), supported by Kennedy (2008), who claims there is no empirical evidence to support the therapeutic use of physical restraints; in fact the research suggests that restraints may be physically, psychologically, and emotionally risky.

In discussing the ethical issues associated with restraints, Holden et al (2009a) note that restraints pose a number of risks to children (e.g. further trauma, injury, death, suffering, and humiliation). As a routine intervention, professionals must seriously question the ethics of this practice.

Holden et al (2009, p. S1) ask why physical restraint is still included in our training and part of our practice? They note that the use of physical restraint is a complex issue and has been part of our practice for centuries (Masters, 2008). It is a practice that has been institutionalised and is part of the residential care culture. Today, there is sufficient information there for organisations to drastically reduce, if not eliminate, the need for high-risk interventions (Nunno et al, 2008; Paterson et al, 2008). If an agency makes a commitment to substantially reduce or eliminate restraints and adopts a plan or model to do so, it can be successfully accomplished. Also, the HSE (*Best Practice Guidelines in the Use of Physical Restraint* (Child care: residential units), (2006, p. 5) suggests that there are many ways of managing challenging behaviour which constitute good practice and they recommend that residential units working with children and young people adopt a systems approach to support and promote good practice. Such an approach was not in operation in any of the three centres participating in this study.

This was borne out by practitioner7 saying: in the last four years, the only training I have had is in TCI and while the therapeutic part of TCI could be kept, another package is needed to complement it'. In addition, practitioner10 said: 'training is needed but the only training I had in the last two years was one refresher TCI training session'. Practitioner9 claimed she received:

No CPD training at all, only TCI, which she claims ‘does not equip practitioners to deal with the challenging problems that are presented in centres’, she also claimed that ‘people are bored with it’; she suggested that: ‘young children who are a danger to themselves and to staff should be locked up for everyone’s safety. TCI was invented before young people started taking drugs/alcohol’; also ‘having TCI exams make us look silly in comparison to other professionals, yet we work at the frontline’.

Practitioners described their CPD training as only partially beneficial and effective. Almost half (eight) of the participants commented on TCI with practitioner1 saying: ‘while some training is effective and beneficial, CPD training other than TCI is needed’; practitioner5 said: ‘TCI is basic and something like counselling is needed in this demanding job’. Practitioner6 said: ‘TCI theory is effective and beneficial but doing restraint is a last resort’. Practitioner7 echoed this by saying: ‘TCI is not at all suitable for mainstream residential child care’.

Practitioner15 said her CPD training:

is only beneficial and effective sometimes, I do not believe in TCI; we never use the restraint part of it here; the restraint is no good; how could we possibly be thinking of restraining the big fellas that we are caring for, also by restraining young people I believe that you break your relationship with them.

Manager1 said: ‘it is a waste of resources having some training, such as TCI taking three days to do when it could all be done in one day’.

This data clearly indicates that practitioners are not satisfied with current CPD training, and while they use the therapeutic part of TCI they do not employ TCI restraints, which are in themselves controversial and contested. While citing that their CPD is only partially beneficial they desire changes and have called for CPD training other than or in addition to TCI.

In discussing changes that they would like to see in future training, almost half the participants (seven practitioners and manager1) commented on the need for changes to TCI training so that it could be improved. Practitioner1 said: ‘I have been battling for years but have not been listened to, telling management that I want to change the TCI model’. Practitioner3 wants: ‘other relevant training as well as TCI which would enable staff to pass on skills to young people’.

Practitioner9 claimed that ‘TCI needs to be revamped; the whole team needs to train together and the training given should be devised by staff experienced in residential child care’. Practitioner10 said: ‘more training other than TCI is needed to deal with children coming into care now who have changed due to abuse of alcohol/drugs’, while manager1 said ‘TCI restraint is not practiced; it’s a

waste of time and money doing it; I would like to see relevant management training provided to managers without having to travel long distances to attend it’.

As the excerpts from practitioners’ interviews show: there is disconnect between their professional roles and CPD; crucially the training offered had not changed despite the substantial changes that had taken place in the work environment and with the client group. Practitioners were particularly dissatisfied with TCI as a way to address challenging behaviour and claimed that it was not adequate to address the challenging behaviour that they were experiencing. There is also the strong critique in the TCI literature. TCI emerged as an important theme from the interviews and that is why the CLs (outlined in chapter six) focused on it.

The responses to the original interviews focused strongly on issues surrounding TCI. In the updated questionnaire study, practitioners were asked if their work was challenging. Despite the challenges associated with TCI restraint being highlighted as a main issue for participants in the earlier interview study, the follow-up study questionnaire participants did not spontaneously mention TCI. This might be because practitioners are no longer required to engage in the restraint elements of TCI.

When asked if their work was challenging, five out of six questionnaire respondents agreed that it was. They acknowledged that working in residential child care is always challenging because of the nature of the job, as the behaviour of young people keeps evolving, there are different dynamics and there is the risk of assault (P2). Participants also reported new challenges. Key themes include challenges focusing on the changeover from the HSE to Tusla and the general changes to the structure of the evolving service (P3), requiring more computer and paperwork; more monitoring and HIQA inspections; and the possibility of joining CORU in 2016/17 (P5), all of which has left staff feeling under pressure. Practitioner1 said: ‘It is all very challenging, there is too much pressure; everything is changing. Sometimes I feel I’m not at all on top of it and I feel I am not able for so much that is going on (P1). On the point mentioned by P5 about changes to the changed structure of the service, P4 added:

Yes but not always with the young people. I find it’s with the service. It can be extremely challenging at times. This is increasingly highlighted due to ongoing issues around sourcing people to pay bills/fix things and services being cut off and for staff issues around the rota.

While the original research showed that the work was challenging – going back to the participants, all six have indicated that they still find their work challenging, even more so now, and it is not only caring for children/young people that is difficult but the aforementioned changes which have created extra challenges for staff.

5.3.4 Lack of effective CPD training

All practitioners said that ongoing relevant CPD training was needed. As of yet there is no CPD training framework for practitioners/managers in the Republic of Ireland. Given this situation, the challenge for the social care profession is to come up with an agreed set of competencies. The values proposed by social workers, a profession that works closely with practitioners and that has similar values, can be seen in their proposed *Code of Professional Conduct and Ethics for Social Workers*. Commenting on the type of training that they do in the absence of a competency framework, practitioner2 said: ‘our current training is more skilled based’; Manager2 said: ‘the training is more practical based’.

Practitioners recognised that their work is changing; they are increasingly engaging in family support and outreach work with families in the community. While their role has changed, practitioners said they had not received any relevant training to reflect this. Practitioner1 said: ‘we need training because now we are effectively family support workers who are not paid at that rate; although, we are working with families of children in care’. Practitioner 2 and 4 summarised that they needed training but it needed to be relevant and specific to working with young people in residential care. Training designed by practitioners themselves may be helpful.

Similarly, managers 1 and 2 expressed that they have not had any specific management training; manager 2 said ‘yes, but I need management training in how to manage staff – supervision, post-crisis response and resources. I go to the same TCI as staff here, if they are not happy with me, they won’t discuss it there, a different forum is needed for them to say how they feel about me’

Recognising this, practitioners 3 and 6 expressed that relevant CPD training was needed as so many things were changing that they needed to be informed about. Only mandatory residential CPD training (TCI, Fire Safety) was available and in some cases this was not given. Practitioner7 said: ‘I would like to have done First Aid training but did not get it’. Practitioner9 said: ‘we need relevant, focused, interesting CPD training but not rubbish training’. She claimed: ‘people are bored with TCI training whereby staff have to attend this after working a long shift which is not helped by having to do exams, while other professionals at the frontline don’t have to do exams like us’.

As regards receiving CPD training - it depended on the centre that participants worked in but most practitioners/managers received one or both mandatory CPD refresher trainings: TCI and/or Fire safety training. Some practitioners stated that TCI was the only CPD training they had received for the past few years. Practitioner 9 said ‘kids come in at 2am in the morning, full of drink and possibly drugs, and staff don’t know what they have consumed and don’t know what to do

with them as we have not had any specific training in this area'. Due to the lack of any new relevant CPD training, practitioners had begun to source and pay for their own CPD training.

Practitioner7 said: 'I've done Applied Suicide Intervention Skills Training (ASIST) and Parenting Plus training which I did in my own time and paid for myself'. Likewise practitioner2 also said: 'I am paying for a course I am doing about the restorative part of TCI'. This highlights the emergence of a new trend among practitioners whereby they identify deficits in their training and respond by sourcing and funding further training and education themselves. This also raises questions as to whether or not centres should provide an education fund to staff that could facilitate further development. It can be argued that the answer to this question regarding staff training was summed up by practitioner11 who said: 'TCI is all we get every six months, that's it'.

While thirteen participants said they had been asked to suggest training that they need, only two practitioners 7 and 11 (who both work on the same team) received the training that they had asked for which was given free during team meetings at their centre. Practitioner7 suggested getting a psychologist from the local hospital to come to the centre during one of their team meetings as the child she was key-working was self-harming and she wanted to know how to address the situation. Similarly practitioner11 was key-working a child presenting with Obsessive Compulsive Disorder (OCD) and suggested getting the psychiatrist from the local hospital to come to a team meeting to explain to them how to deal with this situation; he did so twice.

Managers/practitioners were very despondent in their aspirations for suggesting training that they required. Four practitioners (12, 13, 14, 15) identified that they had asked for training but anything they suggested was not given to them except when practitioner15 asked for drugs/alcohol training, it was provided immediately, leading her to assume that it already had been planned for that centre. Two participants (practitioner3 and manager1) said that when they were asked to suggest CPD training they needed, neither suggested any as they knew they would not get what they would want/like. Manager2 said: 'she is not asked but she still writes a 'wish list' which she submits to her manager asking for training the staff'. Three practitioners (2, 7 and 11), who all work in the same centre commented that they got the ASIST training which was provided free to them, whereas the other two centres have applied for it but at the time of writing had not received it, resulting in practitioners paying for it if they wanted it.

Manager2 said: 'our centre has had no training at all in the last two years due to budget cuts'. Manager3 said: 'we have tried to be resourceful by sourcing our own 'free' training'. Practitioner10 said: 'our CPD training is not effective or beneficial because at present despite having asked for it we have got no training

and we have X number of children who are self-harming and abusing drugs'. Practitioner 5 said:

Our training is not relevant, it's for nurses and the likes and we are put in with them. Burnout is high in this job, we have children for 24/7; changes should include our need to be motivated; we need some kind of counselling training or something where we could off load stuff

Practitioner6 said: 'relevant training addressing drugs/alcohol/self-harm is needed because the training given is too general'. Practitioner12 sought 'more consistent training of staff in centres so there would not be conflicting views on how to manage situations'. Manager2 said: 'there should be relevant training other than taking days out here and there for say court room skills and legislation training which is more for social workers and not for practitioners'. For Practitioner14:

Some training is ok and relevant like Fire Safety training and TCI, but what do we need to know say about facts about domestic violence, court room skills or legislation that we have been at in the past and are not at all relevant.

Similar to the domestic violence training mentioned above, if legislation training was offered to social workers and if spaces were available on it, practitioners were asked to go to it. Practitioner 4 summed it up by saying: 'at times it feels like it's keeping the trainers in a job, that's because it's not at all relevant'.

Overall there appears to be discontentment among managers in relation to CPD training. Their general thoughts are that it is outdated and no longer meets the needs of changing clientele that practitioners are now working with. As a result, it can be argued that there is a strong demand for appropriate, ongoing CPD training to be identified and delivered to practitioners and a need for a competency framework designed by and for practitioners, reflective of those developed by/for social workers and many other professional groups, from fire fighters to early years' practitioners. The interview responses state clearly that there is a need for change. Practitioners/managers recognised that they needed to be moving with what is happening on the ground and have taken it upon themselves to source free training when management did not provide it. They want CPD other than mandatory TCI and Fire safety training. The sentiments are reinforced by the data from the follow-up questionnaire study.

Participants were asked: What CPD have you got in the last 2/3 years, for example conference, presentation paper etc? All participants had received Therapeutic Crisis Intervention (TCI) Children First and fire safety training. It was interesting to hear that some participants had attended training in Domestic Violence; Facilitation; Cultural diversity and CPR; Self-harm; Meitheal and

Supervision training. In comparison to the previous period, this range of training indicates that there has been evidence of change in that there is an increase in the provision of practitioners' CPD training from when practitioners engaged in the interview/CL phase of this study. While this change began in 2011, the provision of CPD has definitely increased since the changeover to Tusla in January 2014.

In addition, in line with the professionalisation theme participants were asked if there are positive/negative things happening around another change: the introduction of CORU formal CPD structures. Only one practitioner from the cohort who took part in the questionnaire study had attended a local CORU information session and she said she was not impressed with what she had heard. The others only knew what they had heard from others but were not enthusiastic to learn more about it either. They see CORU as yet another change coming when they were just trying to cope with the myriad of changes already introduced.

As stated by P1: 'From what I heard it could prove to be cumbersome to incorporate it into an already stressed work schedule as there appears to be a lot involved'. Other negative comments focused on the accountability aspect of introducing formal CPD. Practitioners feel they are already accountable and that CORU are trying to make them even more accountable which they reject, saying it will cause fear in an already stressful job. Aside from these fears practitioners said they are aware that there is little motivation for further training in their job as there are very little job promotions/advancements, especially in the centre where they work(P2). Another point highlighted by P3, along with mentioning the negative aspects of extra work and more writing involved in CORU requirements, was the cost of annual registration fees, she said: 'It's really about money making'. P6 echoed this and, while commenting on the CORU requirements of the need to acquire points, said: 'Negatives are: it seems to be a costly method of acquiring points which has yet to be discussed with us in detail'

These questionnaire excerpts suggest that there is a negative orientation towards the introduction of formal CPD structures. Only one person had attended an information session about CPD. Most have said they know little about it and what they know appears to be what they have heard from others. This has left them wondering how they will cope with the extra work involved given their already stressed work schedules (P1). Also, they are trying to come to terms with the other numerous changes and concerns that they were preoccupied with at the time they took part in the questionnaire study. It may be concluded that broader structural issues have not been positively addressed, so that enhanced CPD is now seen as a threat/burden.

Continuing with the professionalisation theme practitioners were asked: Do you think your needs are being met? Participant responses indicated that overall their training needs were met at the centre. Only one practitioner, P1, was not satisfied with the level of training received for using the computer. P2 would have liked to get court room/report writing skills training. While P3 mentioned that only over the last two/three years were her training needs met; she commented that she has friends who work in another centre but still do not have the level of CPD that she is receiving now. While most practitioners were satisfied with their CPD training needs, they reiterated dissatisfaction with the needs of the service, with P3 saying: 'the needs of the service are not well met'. This point was addressed more by P4 who said the following:

My training needs are but other to that no, my needs are not met. I've raised the issue as regards my work rota. I've spent 11 years trying to get a 39 hour contract and I still haven't got it. I do believe that it's up to the individual to get their needs met. The organisation does not take account of individual needs or people working in sometimes stressful situations very seriously.

Five out of six participants are saying that their training needs are being met; they are satisfied with the level of training that they have received over the past 2/3 years. Regarding training over the past 2/3 years, we can ask if practitioners have more control of their training now. In analysing this one can see a balance with the overall situation being better now, but it is difficult to say if it is as good as it could be. There are various issues to consider and it is not the practitioners but the management/organisation who decides on who does what, where and when. Also, in discussing training, one can ask if the training is benefiting the practitioner and to improve their work practice or for the organisation? The answer to this can vary and depends on individual centres; in comparison to the past, as described by P3, in the past two years they have had 'a good amount of training' and, in some cases, the training is now more personalised.

5.3.5 Dissatisfaction with lack of support for reflective practice

Under the overarching theme of professionalisation, dissatisfaction with adequate space and support for reflective practice was highlighted by interview participants. Nearly all participants engaged in some form of reflective practice, mainly done as part of a team during daily hand over meetings and at weekly team meetings by twelve participants, (practitioners: 1, 6, 7, 8, 9, 10 11, 12, 14, 15 and two managers: 2 and 3). In comparison, only two participants practiced personal reflection (practitioner2 and manager1) who indicated that it is not common practice. Manager3 commented that there was not enough emphasis placed on reflective practice: 'we're looking at it; it's part of the post-crisis response stuff;

we don't do it enough, we should be doing it more, we are supposed to be reflective practitioners but we don't do enough'.

The main reason that participants gave for not engaging in reflective practice was that due to their busy work schedules, as Practitioner12 said: 'I have no time to do reflection' and as experienced by the researcher of late there is extra paperwork required as a result of the reconfiguration of residential child care centres. In the questionnaires, while practitioners were not asked directly about reflection or reflective practice, they did not refer to in their responses to other questions. The researcher is aware that practitioners do engage in reflection of their work both informally and formally at handovers, team meetings, at external support time and at their formal supervision.

5.3.6 Dissatisfaction with Supervision

A further issue highlighted was professional structured supervision. The majority of participants said they have regular professional supervision, only one, practitioner5, said: 'I don't have supervision even though it is provided in the centre where I work, I would prefer to have external supervision'. Practitioner8, said: 'I don't find it helpful at all, sure we are all talking about the same thing every day to my supervisor so what would be different in supervision?' Manager3 said: 'yes, we discuss things – what happened since the last meeting, it's not reflective as such'. Most practitioners said 'they have supervision every 6-8 weeks but it can sometimes run to 12 weeks. Reflecting on this practitioner14 said: 'it should be done more regularly but other things take over.' Social care managers generally have supervision every month. It is acknowledged that practitioners receive supervision. However, questions are raised in relation to the priority given to it, for example, the comment by P14 above.

Based on the interview comments above, it can be argued that what is needed is trained supervisors to conduct supervision with social care practitioners. On their website IASW (2016) 'recommends that professional supervision for social workers is provided by social workers equipped with the necessary skills and knowledge to provide quality supervision'. Professional supervision should enhance a practitioners' practice (Morrison, 2003, p. 30; Hawkins and Shohet, 2007, p. 59; Murphy et al, 2010 cited in Lyons, 2010a, p. 173 and Lyons 2010c, p. 35).

At their supervision, participants said they reflected on their current work situation and what they had been doing up until supervision. In doing this they were reflecting on case work as opposed to, for example, how the work was affecting them personally. Practitioners were eager to point out that they were not enthusiastic about their supervision. Only two (practitioner 1 and 2) alluded to it 'being good'. Most participants (practitioners: 1, 3, 4, 5, and 8 as well as manager1 and 2) summarised that there should be an external supervisor, who has

knowledge of but is independent to the centre coming in to conduct the supervision. Practitioner5 said: 'there is no time for reflection and it's not a good idea that my colleague supervises me'. Manager1 said: 'I am asked to take down the notes of the meeting and there is no time for reflection'. Similarly, two managers (2 and 3) summarised that supervision time is taken up by going over the crises that happened in residential care with no time for reflection.

In any instance supervision is not prioritised and there appears to be anxiety among staff in relation to the relationships and the environment in which supervision takes place. Practitioners have expressed unease at their colleagues supervising them and their understanding of supervision appears to be that it is a tedious activity that fulfils a tick box approach. Some practitioners have thus called for external supervision. Only one practitioner who took part in the questionnaire study mentioned supervision. It can be argued that practitioner 3 spoke for all the others when she said 'I have supervision'. Because they did not mention it, this would suggest a change in levels of satisfaction with supervision

5.3.7 Inadequate skills for adhering to accountability

In centres a main factor associated with accountability is adherence to clear lines of communication. For example, it is vitally important at handovers each day that the two practitioners going off duty together with the manager should relay to the two incoming staff about any events/chores/issues that need attention. Also it is important that management should consult with the social care manager, who in turn consults with the practitioners on relevant CPD training required to address issues and for clarification on issues and on work needing to be done. If this clear line of communication is in operation, it will filter down to the children/young people via the practitioners/centre manager. For these reasons and as practitioners are aware that lines of communication can be blurred, in their interviews all participants pointed out the gaps in their CPD training with regard to the issue of communication skills training. This was cited by practitioners as the most important element of their training. Three practitioners (practitioner 1, 3 and 7) identified that it would be important that they get communication skills training in how to deal with children who were self-harming. They went on to say that they have asked for it but so far had not been given this up-to-date training. Summaries of thoughts from three participants (practitioner 1, 7, 14 and manager2) claimed that while TCI is ok, other communication training is needed to be added to it to make it more effective in building relationships and addressing behavioural difficulties of children/young people. Practitioner2 said:

Behaviour management and building relationships training would be important which are not done here. Communication skills training, especially focusing on non-verbal communication training is needed for

when the child first meets you. Behaviour management training here is done under TCI but it would be nice to have something different than TCI.

As discussed above by practitioner14, practitioners were asked to go to domestic violence and legislation training that was not immediately relevant to their current work practice. It can be argued that these comments suggest a breakdown in communication between practitioners/managers and senior management regarding CPD training. This may reverberate from practitioners to the children in their care and can impact on accountability in the centres. In line with accountability, proper procedures need to be in place for practitioners to address complex issues presented by vulnerable children/young people now coming into care.

All practitioners and managers said that they are finding it challenging to cope with the amounts of paperwork now required. This adds to the burden of bureaucracy, which can be a struggle for staff, but is necessary in line with CORU and HIQA, and for the provision of an accountable, transparent, quality-assured service. The data from the questionnaires revealed that the requirement of additional paper documentation and the burden of bureaucracy has not lessened; if anything it has intensified for practitioners, especially in relation to the new bodies: CORU and Tusla.

In commenting further about CORU, participants were asked: what do you think of the effort that CORU are putting into CPD? All but one participant said they knew very little about CORU's efforts. Issues they mentioned included the need for clarity about awarding themselves points. Again, as above, they thought this would mean extra work and more paper work. P1 said:

It appears to be a lot of extra work just for the sake of ticking another lot of never ending tick boxes that can be turned into graphs and pie charts. There is a growing amount of paper work and tick boxes to be done. They want all this accountability without giving us the necessary time/extra supports to do it.

Practitioners 1 and 5 mentioned the money aspect, referring to the cost of registration and that if they did not pay, they may not be hired. In addition, practitioners are aware of the primary function of CORU: to address risk:

They are there mainly to protect the public. While I'm not on top of the efforts they are putting into it I think their effort, and what they have clearly said is that it's the public they are protecting. They are not protecting us' (P3).

Although as of the time of the study, practitioners acknowledged they had little information or knowledge about CORU, nonetheless they were reluctant to get involved with it as they see it as 'placing extreme expectations on people who are

already quite stretched and stressed in work' (P4). Also they did not agree with self-allocation of CPD points and questioned about how effective CPD training would be locally, as a result of the changes to it (P5). While P6 saw it positively that CORU were providing guidelines for collecting CPD points she questioned:

If there will be a shift in learning as a result of having joined CORU and going to all this training whereas I can see how there will be impacts on being away from our post attending extra various training so we get the points they want us to have, unless they provide the extra staff to cover us being away training.

Five of the six participants have said that they know very little about CORU and practitioners⁶ and 1 have reservations as to how time away from the centre at training in order to gain necessary points may have impacts on their work unless extra staff is provided to allow extra cover for this. The excerpts show that participants are aware that CORU's primary aim is to protect the public; also participants acknowledge the financial costs for staff and realise if they do not pay their registration fee they are not allowed to practice. In extending the questioning about CORU questionnaire participants were asked: How are you engaging with it? All six participants confided that they are not engaging and are reluctant to engage with it. P2 summarised it for the others when she said: 'I'm not engaging yet but when I do, I'll be doing it because I have to not because I want to'

The excerpts point to reluctance by practitioners to engage in CPD set out by CORU as they appear to see it as extra work imposed on them as described by P4. Even though P5 attended an information session on CPD run by CORU she claimed she was not impressed with what she had learned at the information session. What appears to be coming across from these participants is that it continues to be a top-down approach. They were not asked for their opinions but were told by CORU about what their expectations should be, the voice of practitioners was ignored. This was an emerging theme under overarching theme five: greater focus on interagency/collaborative work, discussed next.

5.3.8 Voice of practitioners ignored

In terms of interagency/inter-collaborative working, the majority of interviewees expressed a lack of coordinated communication between them and senior management, saying that they are not asked for their opinions on issues even though they work at the frontline with children/young people. Practitioners said their voice was not heard; they were not listened to when they asked for something or when they made suggestions to senior management.

Manager1 said, 'I feel alone and isolated here, being the only manager in this area; communication is an important element for all social care professionals'. Practitioner14, said: 'the most challenging thing is the non-involvement of staff in making decisions: management do not involve staff here as they should'. Acknowledging this, practitioner's comments above (p. 199) alluded to the need for a new method/model of CPD training that would improve communication by making reference to how the HSE inadequately provides CPD training.

In order for proper interagency work to begin it would be important that all professionals involved in a child's care should be in regular contact and views should be especially sought from all practitioners who are working with the child on a 25/7 basis for the duration of their placement at the centre. Also there needs to be a concerted focus on relevant issues affecting staff for the future; this process could be convened in a Change Laboratory (CL). In order to elicit practitioners' thoughts about the current state of their CPD, in the questionnaires they were asked: Do you see it as top-down or do you think you have a role in it?

Responses from practitioners indicated that it remained top-down. While they have been sometimes asked about CPD that they required, they said they seldom get it except if management were intended putting it on anyway. Practitioners are aware that everyone has a role to play in their own professional development (P6) and the CORU regulations puts the onus on each person to procure their CPD. P2 said: 'I don't even see it as top-down. The onus lies solely with each person. While they may ask you about what training you would like usually you won't get that unless it's in their interest to put that training on but at least now we know we have the option to ask for something unlike previously when I started working in this job' (P2). P3 claims that practitioners should have a voice and an input in their CPD and CORU should ask them but said: 'We should have an input, we have had no role or at least if we did I wasn't told about it, the way I understand it is that we had no role in it, they told us what's happening, we had no say in it'.

Practitioner 4 also pointed out that:

It's top-down because having worked in the area for the past 11 years I've found that our opinions were not taken into consideration. We can give it all we want but we never have the deciding factor. Management needs to put in place ways to facilitate staff completing training necessary for CPD without having to work excessive hours.

Five of six participants express the view that a 'top-down' attitude to the provision of CPD remains, with practitioners being told about what is coming into place without prior consultation as to their views or inputs, for example, about joining CORU (P3). This suggests the necessity to focus on getting others to listen to the voice of practitioners by trying to improve this ongoing; it was previously

highlighted as an emerging theme under theme five from the interview study. People are not satisfied with the changes that CORU are bringing in and are not satisfied with the impending increases in workload and changes in structures such as the introduction of 12 hour shifts to be compliant with the Working Time Act and the structural issues in the nature of the work and the demands of the service users are still the same.

It can be argued that there are many changes to contend with as well as having to be competent in caring for and addressing the various problems, including new ones in comparison the past, such as children who have been sexually abused and traumatised. Budgets, time, giving people time off for CPD, group support in the form of consultations with psychotherapists/psychologists or individual supports – these are not within the control of practitioners: they remain dependent on what is provided/offered to them by management.

Moreover, while CPD is important, people's appreciation of the work is determined by other factors. Looking back on it now, CPD will not solve all problems; it is difficult as the questionnaire data has shown the impact of seeking to introduce enhanced CPD at a time when there are cutbacks and practitioners are trying to adapt to the new regime as a result of the changeover from the HSE to Tusla. Even the Activity Theory (see chapter 6) approach cannot deal with all those questions, what it can do is provide a forum where the questions can be discussed and where everyone will be respected and can have their input. As the data from the questionnaires above has clearly shown, practitioners now have more CPD training and they are more involved, but are still unhappy (or are more unhappy) with other aspects of their work.

5.3.9 Responses to the Research Questions

Q.1 How is the work in the social care sector in Ireland changing?

As described in theme one, historically, in Ireland, children were cared for in large institutions by people who had no education or experience of caring for children but who were supported on site by professionals such as doctors nurses and psychologists. Data from the interviews of the cohort of 18 professionals, comprising three residential child care centres (bungalows in communities) taking part in this study has shown that 17 were female; the average age group was 30-39 and most had four years or more service predominantly working in residential child care centres. Staff scored high on educational standards: eight had obtained ordinary degrees in applied social studies, while three had master's degrees in same. While staff possessed the educational requirements to enter the profession, the interviews revealed that as time passed their CPD training and development did not match their changing roles and had reflected changes in the field of social care, such as the need for clearer accountability and transparency or changes in

the nature of the client group. Many staff were long-serving and felt isolated due to a lack of adequate supports and insufficient resources. They found it difficult to cope with new issues that children were presenting with, such as self-harm, being traumatised by sexual abuse and abusing drugs/alcohol simultaneously, as well as trying to address the major ongoing issue of aggressive behaviour which sometimes developed into a physical and/or sexual abuse.

Q.2. What type of CPD training is delivered to social care practitioners in Ireland?

When exploring the answers from interviewees to this question the data revealed that practitioners mainly only received mandatory TCI and fire training only and one centre did not have this refresher training for two years. As discussed above, there was a lack of adequate supports and resources with a shortage of staff and relevant CPD training. Practitioners were aware that CPD training should have been kept up to date with changes in the field of social care practice and changes in the nature of the client group. Staff pointed out that consistent, relevant CPD training would have numerous benefits for the children in their care. Because mainly the only CPD training that staff had was TCI/Fire training, many discussed this and in particular the restraint part of TCI and how dissatisfied they were with having to still practice and be examined at refresher days on the techniques which were not implemented at one of the centres. Evidence of change was noted by questionnaire participants who reported on having received various CPD as well as mandatory CPD in the past 2/3 years.

Q.3. What aspects of CPD training are most useful to meet the needs of social care practitioners'?

In answering this question staff discussed their lack of CPD training while iterating that they sometimes felt isolated and needed to be brought up to speed with relevant CPD training to address issues affecting them such as alcohol/drug training, doing outreach work with young people and their families and self-harm training as well as training for the effects of trauma from sexual abuse. Above all further education/training to include proper communication training was needed so as to set the foundations for accountability and transparency on all levels in the centre both for/with young people, with staff and for compliance with inspections. Building relationships was cited as important when working with young people as was the importance of dealing with young people presenting with aggressive behaviours amongst other issues. Many interviewees mentioned the need to have another form of training to complement the therapeutic aspects of TCI training.

Q.4. *How can CPD training be reconfigured to respond appropriately to changing contexts and cultures of professional practice?*

First, in order to reconfigure CPD, the voice of staff, the people on the ground working 24/7 with the children/young people needs to be heard. This was evident as interviewees pointed out that they felt ignored; their views were not considered; they were dissatisfied with their professional supervision sessions with a majority calling for external supervision. Also, they were dissatisfied with time allocated for reflection of the work and how it was affecting them. Data from practitioners' interviews pointed clearly to a gap in interagency working. This collaborative work needs to be established and maintained if CPD is to be reconfigured properly; everyone needs to be saying the same thing in the future. According to the interviewees, this was in its infancy and not happening as regularly as it should have been. There is a need to involve practitioners in interagency work in conjunction with the other professionals caring for the child/young person and with teachers in local primary/secondary schools.

Q5. *What has been the impact of relevant developments in CPD?*

The follow-up questionnaire study spanned a period of three years and reflects the impact of the recession, the changeover from the HSE to Tusla and the introduction of the new CPD regime by CORU. It gives a snapshot of the initial response to the new CPD regime. Practitioners reported a feeling of not being in control, they were not impressed by the process and are asked to do a lot of extra work and are not getting extra supports in the line of more staff or resources, and are not offered extra pay. Practitioners highlighted their worries about the implementation of numerous pending changes in relation to work practice as discussed above, for example, CORU registration, while they are struggling to cope with a myriad of current changes such as changeover from HSE to Tusla.

Beginning with theme one: *changing field of social care practice*, it was evident from responses to questions posed under this theme that there remains a lack of staff. The researcher as a practitioner has witnessed agency staff regularly being recruited; there are no relief panels of staff and in some instances the agency cannot fill the demand for staff, depending on the issues arising and need for staff cover at centres. Also, there is still a lack of resources and in one centre where external support had initially being offered questionnaire participants discussed the discontinuation of this service due to financial constraints.

Theme two explored changes in the *nature of the client group* where all six participants expressed that their work is still challenging as they try to address familiar challenges such as aggressive behaviour of young people. As well as that there are now new challenges such as trying to care for children, some very young who are affected by trauma resulting from being sexually abused, being neglected,

abandoned and presenting with mental health issues such as depression, self-harming and suicide ideation which can be linked to substance and/or alcohol/drug abuse.

Under theme three *professionalisation of the workforce*, questions were asked about training and CPD where there was evidence of increased training. As well as mandatory training, practitioners have received a variety of relevant training, citing that over the last 2/3 years their training needs have been met. However, staff presented a negative orientation towards the introduction of formal CPD structures by CORU. Staff seemed to know little about this yet but from hearing about it from others they feel it will mean a lot of extra work, pressure and stress and they said their job is already stressful because of all the recent changes to work practice in the social care sector.

Theme four looked at *accountability/risk culture*; questionnaire participants acknowledged that while they are aware that CORU are implementing stricter regimes for adhering to accountability and transparency of work practice, it will mean extra work and more, including more paperwork for them, which will increase the already bulging burden of bureaucracy, while at the same time they are not given any extra help or support to implement these new requirements.

The final theme five examined: greater focus on *interagency/collaborative work* and it was clear from the questionnaire data that there have been few changes since the interviews were conducted for this thesis. Questionnaire participants commented that still the voice of practitioners is being ignored. Participants cited examples of this, for example, saying that they were not consulted about CORU's intention to implement changes, but were told it was happening. The majority of participants expressed that a top-down approach is still being adopted. Therefore based on the update of data from participants, there is still a need for a structure and procedures (such as CLs) so there can be a staff-centred focus on relevant issues affecting them for the future, and which will contribute to the reconfiguration of their CPD. Moreover, the questionnaire data has shown that there are several new issues needing to be discussed and debated.

Table 5.10 below shows the overarching and emergent and ongoing themes of the study.

OVERARCHING THEMES				
The changing field of social care practice	Changes in the nature of the client group	Professionalisation of the workforce	Accountability/risk-culture/discourse	Greater focus on interagency/collaborative work
EMERGENT THEMES IN THE STUDY/INTERVIEWS				
Lack of staff, and resources Changes in relation to work practice	The pros and cons of using TCI for addressing challenging behaviour	Lack of effective CPD training Dissatisfaction with lack of support for reflective practice Dissatisfaction with Supervision	Inadequate skills for adhering to accountability/Burden of bureaucracy	Voice of practitioners ignored Focus needed on relevant issues affecting staff for the future
ONGOING THEMES HIGHLIGHTED FROM QUESTIONNAIRE DATA UPDATE				
Still a lack of staff/resources Changes include: <ul style="list-style-type: none"> • Child and Family Agency (Tusla) • CORU – CPD • Dissatisfied with Rotas • 12 hour and live night shifts • Working Time Act More computer input External support discontinued	Old challenges still present and new challenges include children/young people traumatised/sexual abuse	More training now but staff still not happy with their situation	Ad hoc communication trails still in place. The paper trail and bureaucracy has increased as a result of increased accountability meaning more work for staff who have no extra staff to support them to keep up to date with it	Voice of practitioners still ignored Focus still needed on relevant issues affecting staff for the future

Table 5.10: Overarching, emergent and ongoing themes of the study

5.4 CHAPTER SUMMARY

This chapter explored the original data from the interviews as well as the follow-up changes surrounding CPD from the questionnaire study. The previous chapters showed us how the need for CPD evolved from it being initially provided to practitioners onsite working in large institutions, to being provided to practitioners in bungalows working in communities. Over the years the client group kept evolving and there were changes in practice resulting from legislation and the publication of various government and academic reports. Interview participants reported that they had mainly received mandatory CPD in the form of TCI and fire safety training. They were calling for more staff/resources and new CPD to help them cope with the challenges presented by the changing clientele. Other challenges presented by interview participants included the need for a proper communication system for working with children/young people and the need to have their voice heard.

The updated questionnaire study showed that it is difficult to bring about change in CPD even though everyone agrees that it needs to be done. Questionnaire participants did report to having received CPD other than mandatory CPD for the past 2/3 years and especially since joining Tusla in 2014. Participants complained about the stress resulting from the many changes that have occurred all at once. These changes occurred in the context of a severe financial recession where there was a moratorium on staff recruitment and on resources. As well as this there has been the changeover from the HSE to Tusla and the ongoing national reconfiguration of residential child care centres. All these changes have placed severe demands on practitioners and they have incurred a major shift in the need for more paperwork. Also, further changes lie ahead: registration with CORU and the requirements of formal CPD.

It could be argued that practitioners may have been more positive about small amounts of change rather than big changes. A way to have their voice heard can be if they take part in Cultural Historical Activity Theory Change Laboratory (CHAT) CL sessions (described in detail in chapter three). The CL will provide the space and allotted time where staff can discuss their contradictions and knotwork them until co-configuration with outcomes are found regarding objects of concern in their centres. Practitioners can talk to management about holistic CPD training to address their current and ongoing issues. This approach could involve the family of the child and where appropriate the child/young person. The whole team would be working together for the benefit of the child and their centre. In this way, CPD training would be keeping up to date with changes in the nature of the client groups and be relevant for staff in each centre. Also, they would be taking ownership of it.

Furthermore, as outlined in theme four addressing accountability and the emergent risk culture, the CL has the potential to provide the arena to discuss actions needed to be accountable and transparent in line with HIQA and local monitoring, as well as discussing tactics to address risk culture of children/young people. CLs can be an ideal place to incorporate an interagency collaborative approach to the work. Other professionals can be invited to attend and while staff will learn from them, also, they will be more attuned to the work that practitioners are providing.

While interview participants were asked various questions listed on page 173, their replies centred and reflected on TCI indicating this was a key issue for them, and thus for me. Because of this, it was decided to examine this issue in more detail in chapter six.

6. INTERPRETING AND APPLYING ACTIVITY THEORY

6.0 INTRODUCTION

The findings from the interviews identified a broad range of issues; one that stood out clearly was the issue of TCI and, in particular, TCI restraints. Because of the importance of this, the researcher decided to focus her attention on trying to construct an intervention, with a view to highlighting and addressing this issue for practitioners for the future. The intervention is modelled on Engeström's Cultural Historical Activity Theory (AT) approach, explained and depicted in chapter three. Adapting Engeström's approach, this chapter applies AT to the smaller-scale setting of a residential child care centre. This is a challenge; Engeström and his team deal with large institutions, it will be interesting to see if I can bring this in without all the support that Engeström and his teams had. Kerosuo et al (2010, p. 117) indicate that in Engeström's large scale studies, researchers and practitioners would form multi-professional working groups. Data for this small scale PhD study was collected solely by the researcher. The question is: can the AT process be scaled back, yet still be effective? This chapter says it can be done.

6.1 OVERVIEW OF CHAPTER

First, the chapter opens with an analysis of centres, followed by a description of setting up a CL in one centre. This is followed by an explanation of TCI including its application in centres. Next, the social process of change and learning in centres is discussed followed by a description, discussion and analysis of a CL intervention. Finally, as mentioned in chapter five, due to the passage of time since the interviews, it was decided to return to participants with a questionnaire, asking them about their recollections of the Change Laboratory's (CLs) to see did they make a difference. Section 6.4.11 below discusses their responses.

The chapter describes and compares actions, scripts and activity systems in Engeström's study with actions, scripts and activity systems in this study. It explores disturbances and contradictions. Finally, it looks at innovations and visions through Engeström's term horizontal dimension.

6.2 ANALYSIS

As part of the HSE/Tusla, centres represented in this study are responsible for the placement of children aged 12-18 in State care when either their home care or foster care placements break down. Each centre can accommodate up to four children at any one time. Daily activity in centres is managed by a manager and two practitioners. Centre managers are answerable to their Social Work Manager (SWM) who works from a central office. As well as being responsible for alternative care, SWM's also have responsibility for child protection and welfare.

From the perspective of this study, the *activity system* represents the cultural resources at hand to create innovative CPD training. Engeström's activity system model can consist of two or more activity systems. In this study there are two activity systems (figure 6.1): one is the residential child care centre that includes the practitioners/manager, the other is the management activity system that includes the SWM, social workers and trainers. Object 1 could be specific CPD training concerns or, as depicted in figure 6.2, concerns about TCI restraint for practitioners/manager at the centre; object 2 is where they discuss this with management/trainers in the other activity system and object 3 is the collective meaningful outcomes from such discussions.

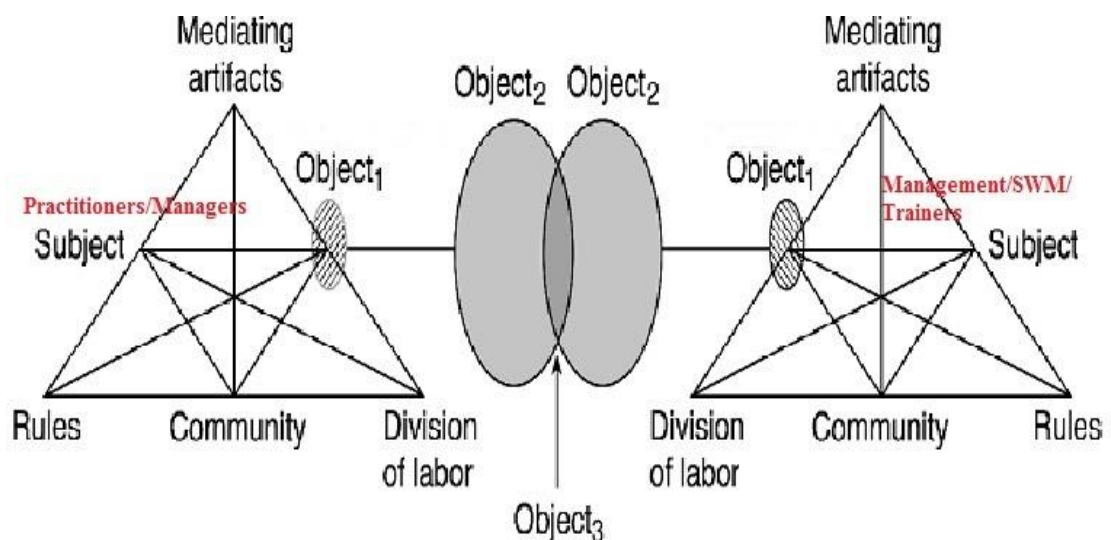


Figure 6.1: Two interacting activity systems as minimal model for the third generation of AT, adapted from Engeström (2001, p. 136).

As described in chapter three, an activity system is not stable but rather is in a constant state of flux because of internal *contradictions* within and between its elements. A contradiction is a structural tension between opposing forces in a societal activity (Engeström, 1987). Contradiction is also used as an analytical concept to examine latent tensions and contradictory demands *between* activity systems. For example, there is a structural tension (Figure 6.2) in relation to practitioners being expected to implement a particular model of TCI restraint. This is due to staff having experienced the negative effects of previous restraints on children, such as the fear of a child being physically touched had they been physically abused before being placed in care. Staff have also experienced negative effects from conducting the physical restraint such as physical exertion and stress from trying to control a child/young person during the restraint, as well as trying to deal with the aftermath of the procedure.

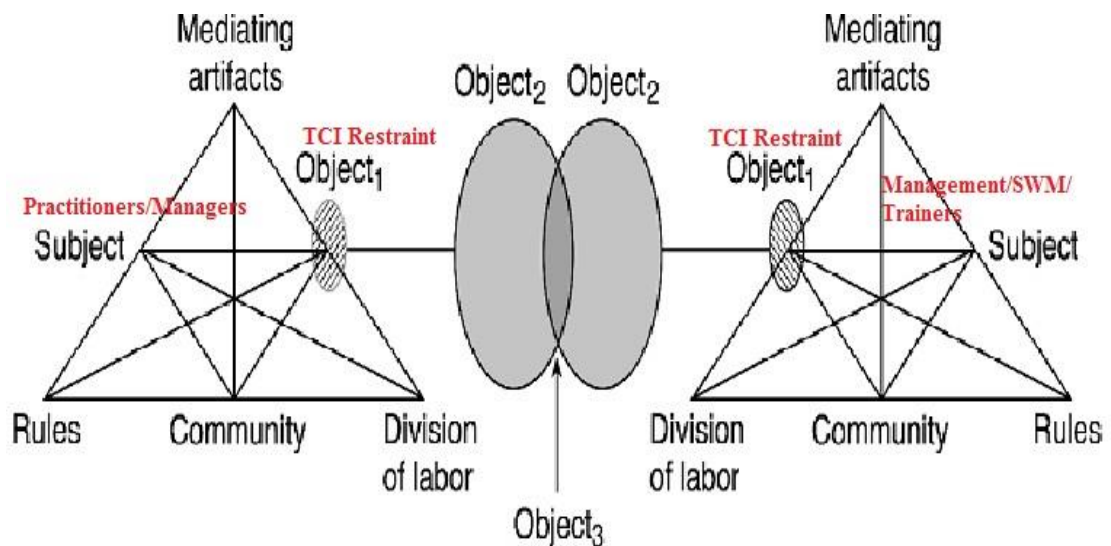


Figure 6.2: Centre and management activity systems with TCI contradiction (object) adapted from Engeström (2001, p. 136).

In this centre, a limited number of staff have been, and continue to be, trained in restraint, despite outcomes that show it is not effective. At the same time staff are required to develop new skills/competencies, but are not trained in relation to these (for example, in the area of self-harm).

When working through contradictions, the process of *expansive learning* actions (Figure 6.3) is used. This starts with questioning of present practice and leads to the consolidation of new practice. This process can enable change and innovation as outlined in chapter three.

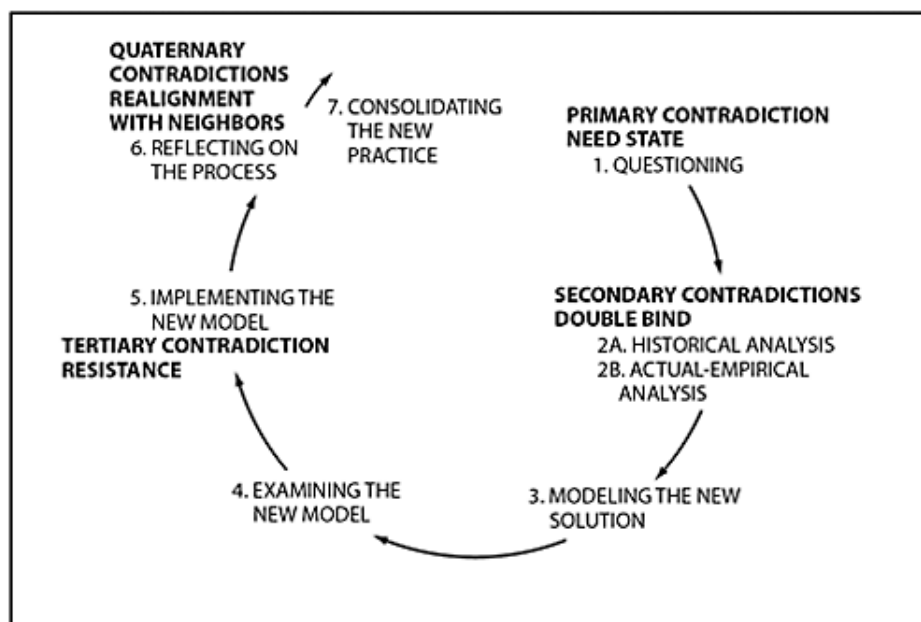


Figure 6.3: The model of expansive learning actions (adopted from Engeström and Sannino 2010, p. 8).

As in Engeström's AT interventions, the Developmental Work Research (DWR) process including the CL (schematically depicted in figure 3.7: the *Prototypical layout of the Change Laboratory*) was the initiation of the expansive learning process in the following intervention. CLs are characterised as promoting the creation of change and learning through the model of expansive learning actions (Kerosuo et al, 2010, p. 116; Warmington, 2011, p. 147). As the researcher was working alone, it was not feasible to conduct a full-scale CHAT analysis intervention on all study findings; consequently, she conducted an element of CHAT by focusing on the issue of TCI restraint that had emerged as a key issue in the interview process. The intervention is an example describing a social process of how new ideas could be developed and put into practice in a centre.

6.3 INITIAL STEPS: SETTING UP THE CHANGE LABORATORY

Practitioners and managers in the three centres were aware of the researcher's PhD study and of her research. From time to time they enquired about the study and its progress. In particular, one manager was interested in the latest update on research findings and on the general progress of the study. The researcher began telling the manager about the new found theory: AT, what it entailed, and gave an example of a study in Helsinki where Engeström et al used an intervention to bring about change and progress in an organisation, through utilising DWR/CL sessions. The manager was interested in this and, after much debate and discussions over a period of time, eventually agreed to try this process out at the centre with the intention to discuss the TCI restraint contradiction. A consensus was reached that a good time to introduce a CL would be after a weekly team meeting (TM) when most staff were present at the centre.

First steps of a CL session involve participants/managers initiating questions and thoughts about current issues/contradictions and about their practice in general. This gives a voice to all staff; also there was the hope of inviting management to allow them to voice their opinions on the matter. As with the group described by Kerosuo et al (2010, p. 117) the task of this group was to analyse the TCI restraint tensions in their work practice and find a solution to it. Later on, the same procedure could ensue with regard to all the study findings, with the hope of possibly finding a solution and implementing a new CPD training model for staff at the centre. The following paragraphs briefly describe the concept of TCI, in order to understand the debates that are discussed further on in the intervention.

6.3.1 Therapeutic Crisis Intervention (TCI)

All practitioners and the manager at the centre are familiar with TCI, which is mandatory training for residential child care staff employed by the HSE. It involves an initial five-day foundation training course followed by two refresher training days per year. TCI was developed in the late 1970s in Cornell University,

(Holden et al, 2009a), as a prevention and intervention model for managing behaviour in residential centres. According to Holden et al (2009a) the TCI system helps organisations to prevent crises from occurring; de-escalate potential crises; manage acute physical behaviours; reduce potential and actual injury to staff/young people; and teach young people adaptive coping skills.

The primary objective of the TCI training programme is to assist practitioners to help young people to develop new responses to their feelings, needs and environment that will assist them in their social and emotional development. TCI gives staff a range of behaviour support techniques to intervene at the first sign of distress; to apply principles, skills and techniques that provide for safe and effective methods of crisis prevention and management (ibid, 2009). During training three core competencies are assessed:

1. Prevent and de-escalate potential crisis with young person
2. Safety and therapeutically manage crisis situations and
3. Be able to process with the young person to help improve coping strategies.

In line with these core competencies, in TCI there are three levels. Level 1 comprises non-physical de-escalation techniques; Level 2 includes protective physical interventions without the use of physical restraint, i.e. breakaway techniques or breaking up fights; Level 3 involves physical restraint (the standing hold, seated restraint, supine and prone restraint and the small child restraint). In the centre taking part in the intervention, only TCI Level 1 and 2 non-physical interventions and de-escalation techniques are employed. The two other centres taking part in this study are still employing TCI Level 3 physical restraint. The levels employed are reflected in each young person's Individual Crisis Management Plan (ICMP) (ibid, 2009). It is important too, to note the potentially devastating unintended consequences in any given situation and the safety of children/young people and staff is paramount.

Staff must weigh the risk of using any physical intervention against the risks involved in failing to when warranted. All incidents of physical intervention are recorded on a significant event record form (SER) which details: what led up to the incident, the people involved, the incident itself, the preventive strategies used, de-escalation techniques used, any injuries sustained, and any follow-up carried out with the young person. This form is signed by staff members involved and forwarded to: the supervising social worker, the social work team leader, SWM for alternative care and the HSE monitoring officer.

The ICMP is an integral part of TCI (Holden et al, 2009a); this is created based on information supplied by the young person's social worker at referral point and taking into account any previous identifiable concerns/known patterns of dangerous behaviour. With this information a risk assessment is completed and

initial ICMP formulated which is reviewed and updated as necessary. The young person can be included in the process of developing an ICMP as appropriate; this assists staff in providing the best response to the young person in crisis and helps the young person develop better coping skills in the long-term. The young person's ICMP must accompany all 'red flag' incidents (ibid, 2009a).

A critical incident monitoring committee oversees practice in this area, examines red flag incidents and ensures that TCI is properly and fully implemented. A red flag incident is one that involves any physical intervention, any event where a young person or staff member is injured or any event where the young person, staff or others are at immediate and serious risk of injury or harm. In preparation for a meeting of this committee the centre manager must submit red flag incidents on a monthly basis. Supervising social workers also receive a copy of the ICMP.

At each TCI refresher day, staff who sign up to do all levels are instructed to perform these techniques and are graded by the trainers; a written exam on theory and techniques takes place on one of the two refresher training days. A tension/contradiction in this centre was that staff had not performed the restraint part of TCI for many years, yet felt they had not been listened to by senior management when they repeatedly asked why they had to 'waste time' continuing to learn about and perform TCI restraint techniques on training days. There is also an issue of cost effectiveness in a service short of financial resources.

Data from the semi-structured interviews in relation to TCI, together with input from participants present at the CLs, was used as 'mirror' data in the CL sessions. According to Engeström, R. (2014, p. 124):

Participants are provided with a mirror, which entails ethnographic data on the activity to be jointly examined during the intervention. In constructing the mirror, the most commonly used method is video recording and active interviewing in online activities (using video also), as well as interviewing people outside the activities.

The mirror data was textual not video, based on the findings from the semi-structured interviews where many practitioners mentioned their dissatisfaction with TCI Level 3 physical restraint. Altogether five CL sessions and two follow-up sessions were conducted. At the first CL session a practitioner was asked to volunteer to scribe the minutes of the meeting, thereafter the scribe voluntarily rotated. In this study, the data of the CL sessions is used to illustrate the social process of promoting change and learning in the centre: a process of identifying key issues in CPD and then exploring a process whereby such issues might be acted upon in a bottom-up way, modelled on AT. Table 6.1 provides an outline of the CL sessions that were ultimately conducted in the selected centre.

CL	Date	Persons present	Key issues discussed
1. CL	26.2.13	Manager and 7 practitioners	Questioning, criticising or rejecting some aspects of the accepted practice and existing wisdom of current situation
2. CL	12.03.13	All practitioners	Analysing the situation in order to identify causes or explanatory mechanisms by tracing its origin and evolution (historical genetic analysis), or by constructing a picture of its inner systemic relations (actual-empirical analysis)
3. Boundary Crossing CL	2.04.13	Manager, all practitioners, SWM, one trainer	Modelling the new solution, new model of activity
Additional Meeting	8.04.13	Manager, team leader, two practitioners and researcher	Discussing details about the upcoming PowerPoint presentation
4. CL	16.04.13	Manager and all practitioners	Experimenting and testing the new model in order to grasp its dynamics, potentials, and limitations
PowerPoint Presentation	23.04.13	Manager all staff and staff from other teams (30 people approx)	PowerPoint presentation on TCI and presentations by other teams
5. CL	28.05.13	Manager and six practitioners	Implementing the new model through practical applications
6. Boundary Crossing CL	18.06.13	Manager and eight practitioners including two agency staff	Reflecting and evaluating the process
7. CL	26.11.13	Manager and all practitioners	Consolidating and generalising its outcomes into a new, stable form of practice

Table 6.1: Change Laboratories/TCI intervention at the centre

6.4 THE SOCIAL PROCESS OF CHANGE AND LEARNING

In Figure 6.4, the social process of change is analysed with the help of the conceptual model of expansive learning actions (Figure 6.3). While the process of change and learning was based on the script of expansive learning actions, the script was broken up and reformulated by the practitioners. The special characteristics and key points to be observed are that the first, second and third learning actions are intertwined and bidirectional, whereas the other four learning actions proceed unidirectionally (adapted from Kerosuo et al, 2010, p. 121).

The social process of change and learning at the Centre

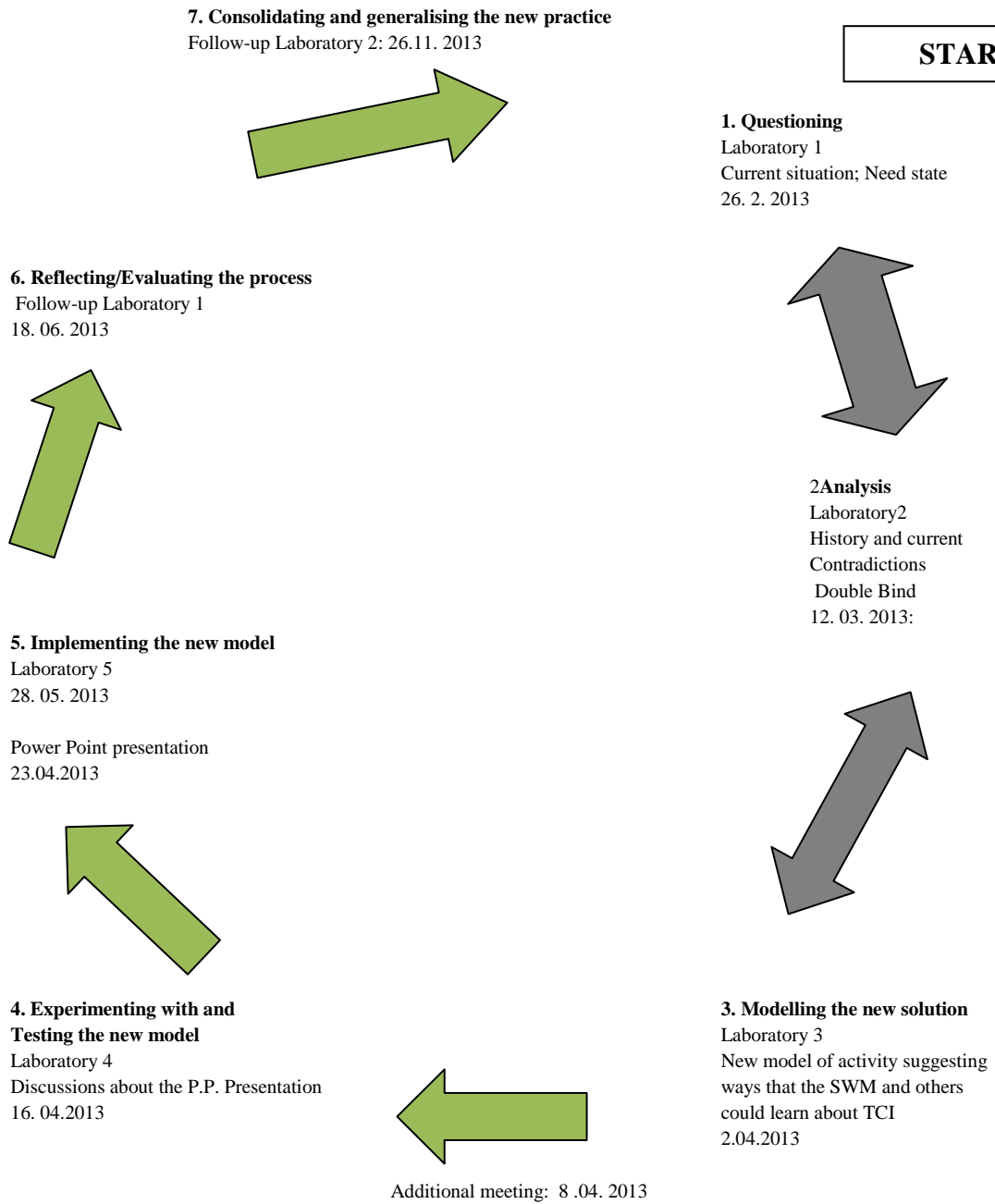


Figure 6.4: The social process of change and learning as expansive learning actions in the centre.

6.4.1 Setting the scene for change and learning in the Centre

The expansive learning actions of questioning the current situation, analysing contradictions and modelling new solutions took place as early as the first CL session and continued to be the subject of discussion in the second and third sessions. The first session introduced the current contradiction that constituted 'mirror' data relating to TCI restraint, which practitioners had long been familiar with, though the mirror can also reveal what might not be known.

The critical tensions revealed in the mirror were: (1) practitioners/managers said they were not listened to by senior management who received their emails but had not responded; (2) time was wasted doing TCI techniques that required staff to be examined; (3) HSE was wasting tax-payers' money paying trainers to keep doing the techniques with the staff and (4) TCI restraint was not practiced at the centre.

6.4.2 First Change Laboratory (CL 1)

As indicated in table 6.1, seven staff and the manager were present; two staff were on annual leave. The scheduled team meeting (TM) had already dealt with everyday issues and concerns about the present resident and with issues relating to the centre, including the rota. It had been scheduled to run from 10.30am until 1pm, but ended at 11.20am. From previously consulting with the manager and in anticipation of this, it was decided to introduce the idea of a CL at this time.

The researcher began by briefly explaining about CHAT and what was involved in CLs, elaborating on DWR including knotworking, contradictions, co-configuration, expansive learning and transformations (Engeström, 2001, p. 152). All participants were encouraged to be open and join in with their thoughts, comments and ideas regarding the tensions to be highlighted at this session as well as in future CLs.

Disturbances (Helle, 2000) arose when some practitioners objected and resisted the need for specific CL sessions, citing that matters for discussion could be dealt with during the weekly TM time. The researcher explained that while TMs discussed several important and pertinent issues, the CL was a designated structured space in which discussions/knotworking sessions could take place with regard to tensions/disturbances/contradictions that only concerned the needs of staff, for example: the need to discuss among others the four tensions outlined above. Moreover, it was pointed out that while the CL can address and discuss tensions, it can also propose alternative ways of working and improving practice.

While conscious that it was not an ideal time to introduce a CL session, nonetheless, the present time seemed adequate. The manager discussed that there had been only one child at the centre for two weeks now and work had not been as

busy as it sometimes had been of late. The researcher explained to the team that following advice and discussion with the manager, it was decided to try to utilise this time by introducing the first CL and once staff were familiar with them, it could be decided to have them at a different time and appoint representatives to attend. At present, having all staff assembled for the TM provided the ideal opportunity to initially explain and lay the foundations for future CLs.

Once clarified, it was then agreed by all present that there was potential for conducting CLs. The researcher agreed to chair the first CL as well as the next one but suggested that the chair position could be rotated from then on. The researcher requested a practitioner to volunteer to scribe for this session while taking down the minutes and bullet pointing issues that were raised. In line with Engeström's AT, the researcher explained that at the end of each CL all professionals involved would be asked to evaluate the acceptability of this new way of working (Daniels, 2004 p. 196).

While the CL began with a collective questioning and criticising of some elements of the current work practice as a whole, including present tensions/contradictions in the activity system, the researcher suggested that for this CL they focus on TCI physical restraint. Engeström and his teams (1996) emphasise that analysing current internal contradictions helps participants to pay attention to essential sources of tensions in an activity (Kerosuo, et al, 2010, p. 118). A feature of the CL is that the roots of the tensions are traced from the history of the activity: this was done by modelling the past activity system, through to the present system. Both are discussed in Excerpt 1, starting with practitioner13 commenting on the past activity system (ibid, 2010 p. 117):

Excerpt 1 (Change Laboratory, session 1)

Practitioner13: When I started working, nearly 13 years ago, TCI training and strategies would have been welcomed as we had absolutely no way of addressing challenging behaviour; now there is a TCI manual devoted to it and staff are shown how to use the techniques; also staff are examined in it and it suggests that they can do restraints on children/young people.

Manager: Yes and the crux of it is that we actually do not do restraints.

Researcher: On that note, could we propose that TCI trainers, the SWM and other senior managers be politely asked to attend a CL so that knotworking sessions could take place to expand the object, i.e. highlighting and discussing the four tensions highlighted above, which we will discuss now.

This proposal was unanimously supported. Each of the four tensions was debated and discussed and, once individual tensions were mentioned, staff started to reflect on them immediately:

Practitioner3: We can say so that the TCI tension has been surfacing and resurfacing for ages; there has been much to-ing and fro-ing for years about us having to do the training for it and why waste time at training when we don't do restraints?

Manager: I will contact the Social Work department to invite the SWM, social workers, team leaders, trainers and any other senior management that would be available, to come here to the centre or at a neutral venue of their choice for a forthcoming CL session.

Researcher: thank you...very good...

Practitioner4: This will be interesting....

In keeping in line with Engeström's idea of evaluating each CL session, the following occurred:

Researcher: what are your thoughts so far on our first CL?

Manager: It's going down well...

Practitioner6: We seem to be making progress, but am I the only one here who is sceptical about management coming here to discuss this with us?

Practitioner5: Yeah, I wonder as well...

Researcher: Ok, can we agree to have another CL in two weeks time but if there is anything that occurs in the meantime we can note it and discuss it further at the next CL?

Having unanimously decided to debate and discuss the object (TCI restraint) further, at the next CL, this brought proceedings to a close. After the CL had ended the scribe gave the notebook containing the bulleted minutes to the researcher who corroborated them with her own notes about the proceedings of the CL while it was fresh in her mind; she continued to do this for all future CLs.

This initial CL went well. Once they had been given the information and clarification had been established regarding the purpose and process of the session, practitioners appeared to be delighted to have this opportunity to discuss an issue that concerned them all. They relaxed and the questioning and criticising

began to flow, thus achieving what it set out to do: to get practitioners to focus and critically discuss the TCI restraint contradiction.

6.4.3 Second CL

This took place on the 12th March 2013. A slightly different group of people were involved. The manager, who was at a meeting, instructed the team leader to relay to all present that the SWM had responded and had agreed to attend a CL along with the social work team leader and two TCI trainers.

Researcher: This is good news; any other thoughts from the last CL?

Overall, practitioners said that the previous CL had given them reason to reflect on matters concerning them. They found it was good to have the time and a space to discuss matters solely concerning staff as opposed to everything else:

Excerpt 2 (Change Laboratory, session 2)

Team leader: we actually need time like this; we are always discussing the children; it is good to reflect and analyse our own situation as workers for a change, and this is a good time to do it because we are quiet with having only one child here for a while now.

Researcher: Given that you all seem to have reflected somewhat on your work, what do you think of recording a few notes, like a little reflective learning journal each day/night of your experiences and thoughts and we could debate/discuss them at the next or in future CLs?

Practitioner1: I think we have enough to be doing in here without that at night but in theory it's a good idea.

This idea was analysed and debated and in the end there was apparent agreement that using a journal could be a good way to learn. Practitioners said they would try to begin to document their thoughts in a journal. Moon (2014, p. 18) states that learning journals come in all shapes and sizes, including tapes and videos and in electronic forms and blogs. She says that there are many purposes for learning journals and that in a review of over a hundred papers on journal writing, around eighteen purposes for the practice emerged (Moon, 2006). Moon states that among other learning, that from learning journals encourages meta-cognition, the understanding a person has about her/his own mental processes. Crausaz (2014) provides information on setting up journal clubs that could be of benefit to practitioners in advancing their learning, development and sharing of knowledge.

In this CL there was no concrete news on the object (TCI restraint). Practitioners shared that the previous CL had opened up the idea of reflection for them. This

was then discussed in conjunction with discussion on the use of reflective journals. Practitioners could see and agreed that new learning could be achieved if they were to use a journal for their work, to make notes on issues of concern or clarification during their shift. The session was then brought to a close with plans to have a third CL on the 2nd April.

6.4.4 Third CL

The third CL was a boundary crossing CL that took place as usual after the TM at the centre. The SWM and one trainer attended; with apologies from the other trainer, two social workers, one team leader and the area manager. All staff, including the manager, attended. The researcher opened the CL by welcoming the SWM and trainer and gave a brief overview of Engeström's activity theory (1987) by explaining DWR and CLs. The discussion began as follows:

Excerpt 3 (Boundary Crossing Change Laboratory 3)

Researcher: Why do practitioners at this centre have to continue doing restraint techniques and be examined on same at TCI training days when you don't practice restraint here at the centre?

Practitioner 1: I have a shoulder injury thus I am not in a fit state to perform the restraint, if it was being done.

Practitioner 2: I understand that in order to perform the restraint properly two qualified practitioners (who have been trained and checked by TCI trainers) in performing the restraint need to do it.

Practitioner 3: It is a waste of time and money having practitioners go through the ritual at every TCI refresher training day by doing the restraint techniques and them never used again at the centre.

Team leader: I'm only 5 foot tall and while I have always done the techniques at TCI training and would consider myself as qualified, I would not be tall enough or strong enough to restrain the children/young people that have been here in the centre over the years as they have been much taller and stronger than me.

Trainer: As ye know, I am new to this role and coming as I do from a psychotherapy background, I had no previous knowledge of TCI. Jane (her predecessor) gave me the PowerPoint slides and explained about TCI being used as the training programme in residential centres.

Practitioner 4: And what do you think of it now that you have been to a few training sessions and have experience of it?

Trainer: I've studied some of the techniques and I'm getting to know them better. I had taken part in them a few times with Jane before she left, and I think I am grasping them but I do forget; I try to remember them from the last time that I did them.

Along with the others, the SWM had been listening attentively to the discussion:

SWM: I know that TCI is HSE policy; however I can now see how you are justifying your difficulties with it, although some of it I assume can be effective?

In answering this, the manager and practitioners said that the principles of TCI theory are quite good. Also, TCI teaches practitioners about protective techniques that can be used if children's or young people's behaviour becomes aggressive or violent. Staff use TCI theory (without using the buzz words that are referred to in the TCI Manual), on a daily basis in their work, and have found it to be effective and beneficial. Level 3 restraint has not been used at the centre and while acknowledging that the SWM has only been in his post for the past two years, prior to this the staff at the centre have been asking senior management if they could desist from doing the restraint training techniques during training days.

Manager: For the past 7 years I have made contact with senior management about changing this, however, nothing has changed.

Practitioner 5: Restraint cannot take place for many reasons, among others if a child is overweight, is under the influence of alcohol/drugs, or has a medical condition.

Practitioner 6: It would be impossible to do the restraint properly given that while two qualified practitioners are required to do it. If this was happening, who would be taking care of the other children while the two staff on duty were doing the restraint, if it was performed after the manager had finished work at 5pm?

As explained in the principles of AT (chapter three, p. 122-123), in AT terms when everyone gets a chance to have their voice heard it is described as an object orientated, multi-voiced dialogically driven discussion (Engeström 2001). The tensions and contradictions relating to TCI restraint were discussed and analysed. As the CL progressed it was observed and became obvious that the SWM appeared to know little about the application of TCI in general.

Researcher: Have you experienced the use of TCI yourself in your work?

SWM: Actually I'm not too familiar with TCI because I did a social science degree in college prior to doing social work and at that time, (I

know it's different now) I didn't have placements that students now undertake during their degree studies. Since becoming SWM I hadn't a chance to attend a training session even though I would like to go and have often thought I would...

Practitioner 3: Would the SWM, social work team leaders and senior managers like to come to the next TCI refresher training day and see first-hand what goes on?

There was much deliberation about this suggestion and about how to model a new way of helping the SWM and other senior management to learn about TCI; in particular about Level 3 physical restraint. It was noted that as the TCI refresher might not be scheduled until the following autumn, it would be difficult to know if the SWM would be able to attend. Another suggestion was put forward:

Researcher: What would you all think about the staff here at the centre doing a presentation on TCI for the SWM, social workers, trainers, and other senior management?

TCI Trainer: I think that would be excellent, could that be arranged? What kind of presentation?

Manager: Yes, that could be arranged....

Researcher: A PowerPoint presentation with a questions and answer session.

A multi-voiced discussion took place around this idea and it was decided that this could be attempted. The manager said she would contact the SWM and relevant parties to arrange suitable dates for same. The SWM and trainer had other appointments and left the CL session which continued as follows:

Researcher: How did you think that went?

Manager: Very good, great to get everyone together rather than emailing and waiting, wouldn't it be great if the SWM could follow through and us not to have to continue with the restraint training?

Practitioner4: Yes, having everyone together and us all having a chance to say our piece made all the difference. It's like first-hand information on the spot but it's not all great given that we now have to do a presentation!

Practitioner5: I can't believe it, that they came here to discuss that with us, wow!

Researcher: Yes, good knotworking progress.

This CL session proved that this was an ideal forum where practitioners were able to engage in dialogue with management and trainers. Anyone that wanted to ask a question or make a suggestion was respectfully listened to which provoked thought and provided learning for others who listened. As mentioned in chapter three, p. 110, CLs can be a source of unintended outcomes. This occurred in this CL session which produced the idea of a PowerPoint presentation. Resulting from this, it was decided to hold an additional meeting the following week to discuss plans for how to work out in detail how to present the PowerPoint presentation. After a brief consultation about who should attend the meeting, it was decided that the manager, the team leader, two practitioners and the researcher would think about and prepare ideas to bring to the additional meeting.

6.4.5 Additional Meeting

This meeting was not a CL. It took place at the centre and was attended by the five people chosen at the last CL, to attend it. Changes had taken place since the previous week's CL. A number of children of diverse ages with specific needs had been admitted to the centre on an emergency care order. The children had a whole range of issues; they were noticeably traumatised in relation to alleged physical/sexual abuse prior to being admitted to care and at times exhibited extreme aggressive sexual and physical behaviour directed at staff.

It was apparent that core staff were overwhelmed and could not cope so it was agreed that third cover staff had to be hired for the weekends. Now staff had new contradictions in their activity system, for example, the need to understand and learn more about these children, their background and the reasons why they were suddenly admitted to care. As well as these children, there was the other resident who was already at the centre and who was upset and needed more attention due to the sudden impact of the arrival of the others.

Staff expressed exhaustion with their workload and said they had never experienced such dramatic intensity of stress in their careers to date. The team leader while broaching the upcoming presentation, suggested to the manager to postpone it given the change in circumstances. The others agreed this was a good option. The manager agreed to consult the SWM regarding these views and immediately rang his office. The SWM rang back and said 'after thinking about it for a while, it was best that the PowerPoint presentation should go ahead as planned'. Staff then discussed ideas and tactics (who would do what and when, what aspects of TCI should be focused on) for the upcoming presentation which was to be held on the 23rd April at 9.30am in one of the HSE offices.

Staff who were present at this additional meeting were quite stressed, yet eventually focused on the purpose of the meeting: to discuss details about the upcoming presentation, which they decided on and agreed to prepare for discussion at the next CL. After agreeing to meet the following week for the fourth CL, the meeting concluded. As above, the researcher wrote out the minutes from this meeting after it was over. In between the CL sessions, the researcher was in contact with the practitioners/manager regarding the intervention.

6.4.6 Fourth CL

This CL took place at the centre on 16th April and was attended by the all the practitioners and the manager. A practitioner volunteered to scribe. At the start of the session, the researcher conveyed to the group the details agreed upon during the additional meeting, attended by some staff the previous week, with regard to the PowerPoint presentation. Some practitioners made additional suggestions to be included in the presentation and all agreed that information discussed was relevant. Thereafter, the following dialogue took place:

Excerpt 4 (Change Laboratory 4)

Manager: I was in contact with the SWM; firstly, he told me to tell ye that: the idea of doing a presentation got him thinking...about others also doing a presentation on the same day as us about their work, such as foster care social work teams and after care teams ... he wonders what we think about that ... also he said he had contacted the area manager and others telling them about the upcoming CLs and asking them if they would be interested in attending the PowerPoint presentation which is proposed to take place next week; also the SWM conveyed to his manager about his attendance at the CL together with his new found views on staff at the centre requesting to desist from having to do the TCI restraint techniques given that it is not practiced at the centre. The SWM has agreed to update me, should he receive a reply about same

Everyone agreed on the SWM's idea of experimenting and sharing information and, from the perspective of staff at the centre, the idea of voicing a new TCI model that did not include Level 3 physical restraint was also welcomed. A discussion ensued regarding how best to go about doing the PowerPoint presentation: what would be included, what would be presented and who would present it. Some practitioners volunteered to partake in the presentation, while others were asked by the manager to help gather the necessary information. Some comments were as follows as regards how the CL and operation was unfolding:

Researcher: Bringing in more groups as above equates to Engeström's Boundary Crossing Change Laboratories.

Practitioner 6: Well at least now they will all see how we use TCI.

Practitioner 2: About time, yes, this is a good idea.

Manager: It's likely that some people won't know anything about TCI and it's great to have an avenue to put our ideas forward. I've been in this job for some time now and it's the first time that there seems to be someone listening to our concerns with regard to this TCI issue but we will see how far it goes....

Team Leader: Yes, I agree, it's a good idea all round...

All staff agreed that it was a new beginning as regards connecting and communicating with management, together with the added bonus of presenting to other groups and now other groups presenting and the possibility of everyone learning from each other about what they do. This had never been done before. This CL session finished with an agreement to meet at the presentation the following week. Participants taking part in the presentation decided to meet on the 22nd April, the day before the presentation, to finalise their performances.

6.4.7 PowerPoint Presentation

Staff began to assemble from 9am onwards. Once everyone was gathered in the large room, the SWM welcomed and addressed the group by outlining the plan for the morning. Sharing knowledge and ideas was the reason for initiating and presenting the PowerPoint presentation. It was evident from the group that the AT framework provided the foundation where ideas could be coalesced and where everyone gained and learned from listening to each other and from having the opportunity to share knowledge and ask questions therefore boosting horizontal/sideways learning discussed earlier in chapter three and later on (in the discussion of findings), chapter seven. This was a contrast to lack of communication discussed in chapters two and five. Also, it set the scene for continued interagency/collaborative work among the groups/teams.

In total there were approximately 30 people there spanning all work-teams; the area manager was not in attendance and sent an apology. Three people from the centre made the TCI presentation explaining about it and how it is used by staff. The overall view from comments made by various professionals about the presentations indicated they were excellent in terms of being very informative and educational, as they had highlighted pivotal points for consideration, for example, the need for feedback on work and on suggestions made by various professionals. They also gave everyone an opportunity to hear about and understand about the varied and diverse work practices carried out by individuals and teams; this first-hand knowledge aided communication, learning and reflection between teams.

While it could be argued that this process may operate in other workplaces and is not revolutionary yet it was the first time ever that centre staff (in this study) had the privilege of presenting the ethos of their work together with the theoretical principles of TCI that they adhere to, to other professionals that they have worked and liaised with, in some cases for years. The presentation introduced a new model in a new setting which was unique to social care because historically this was not the process. Previously, as we saw in the discussion on de-institutionalisation, it had been more of a top-down didactic, management-led approach which was the norm. This involved staff being told what to do as opposed to staff being listened to by management and colleagues while they explained to others with the aid of a PowerPoint presentation what they do and the aspects of the TCI policy that they find most helpful as well as giving good reasons for not continuing with the prescribed TCI restraint.

At the end of the presentations there was a questions and answers session. This included a commentary that examined the proposed new model. It was debated, with the trainer present and agreed, that at future TCI training sessions there should be more focus on more relevant aspects of TCI. There were questions and comments also about the work of the other teams. There was a consensus that it was a very good idea to get everyone together and all appeared to have benefited from the presentation. The SWM commented on the effort made by the presenters and thanked everyone again for attending. Most people were rushing back to work. The staff from the centre were stressed and under a lot of pressure due to the changes at work, leaving little time to reflect on the presentations. Still there was a sense of great camaraderie, purpose, and consciousness in the room.

In discussing the success of this PowerPoint presentation, and in capturing the positive feelings that emanated from it, professionals suggested continuation of this new model of learning which could be expanded to include trans-disciplinary teams such as gardaí, psychologists/judges, etc. The coming together for the presentation acknowledged the need for a new model of learning and support because, up until then, staff mostly worked in a solo capacity in their teams and as well as not having met some members of the other teams, they were not sure of the exact nature of the work they were doing. Having everyone together, sharing their competencies: knowledge, skills and values (discussed in chapter two, pp. 69-71) showed how advantageous it could be for the future and for inter-agency/collaborative working discussed in theme five, chapters one and two.

The researcher contacted the practitioners/manager for their views/comments on the presentation. As above, after returning from the PowerPoint presentation, the researcher immediately documented the proceedings that took place, while making comments that could be possibly used for future reference at the next CL.

6.4.8 Fifth CL

The fifth CL took place on the 28th May 2013, after the TM had finished. Two core staff were off on stress leave, a staff member had been physically injured by one of the residents, and another staff member was off on annual leave. Agency staff had been employed and the remaining core staff were finding work very difficult; team morale was extremely low and staff found the children were unimaginably difficult to work with. Only 6 attended the CL including five core staff and the manager. Dialogue was as follows:

Excerpt 5 (Change Laboratory 5)

Researcher: I know you have many new objects to contend with now in your activity system but has anyone got any thoughts on the PowerPoint presentation?

Manager: I thought it all went very well and I was actually surprised that I learned so much about what the other teams were doing....

Practitioner 2: Yes, while we have talked to some of them often on the phone and more not so often, it was good to put names to faces...

Practitioner 5: Has there been any response from the SWM regarding not having to do TCI restraint, given that they now know our thoughts on it?

Manager: Yes, the SWM confirmed to me that he is looking into this and he also said that he wants to implement this new way of working from now on. He was well impressed with how the presentations went and said he could see how this type of format could be tried when staff wanted to debate other issues; he is to look into it further but obviously not for awhile given the current situation here. Also he told me that he had contacted the area manager again and will get back to me once he has news...

Practitioner13: Has anybody mentioned about getting us some kind of external support?

Practitioners acknowledged the fact that this new way of working through the implementation of Engeström's CLs, was seen as a way forward for creating debate and advancing change. It was evident that practitioners could see how effective the CLs were and already they were making connections about how to expand the object further by enquiring about implementing practical applications.

6.4.9 Sixth CL

The sixth CL, a boundary crossing CL took place on the 18th of June 2013 after the TM, which discussed many pressing issues, had finished. The intention of the CL was to reflect and evaluate the process, albeit, given the stressful work situation experienced by staff. Three practitioners were still out on stress leave due to the ongoing physical violence and inappropriate sexual behaviour inflicted on the team by one of the residents.

The SWM, centre manager and six other staff including two agency staff were in attendance, at the CL. Because of recent traumatic events at the centre, the staff team has been fragmented. In an attempt to deal with these behaviours several agency staff have been recruited. The dialogue began as follows:

Excerpt 6 (Follow-up Laboratory 1)

SWM: I can confirm that I have emailed and spoken to the area manager and he confirmed that he is in agreement to allow the TCI policy for this centre to be amended to incorporate your requests to have it changed...

Addressing the centre manager, the SWM asked if she could make the necessary amendments and forward it to him.

Manager: No, problem, I will gladly do that...

Multiple voices were heard as they conveyed their delight that this change had been made. The SWM said that only since he heard exactly how TCI works did he fully appreciate why staff at this centre were not practicing the restraint part of TCI. Also he referred to the PowerPoint presentations, saying it was good to have shared the knowledge in this way about training and challenges with the other teams who also attended the presentations. In addition, he reiterated that everyone benefited from hearing about each others' practice and experiences, which culminated in the questions and answers session afterwards.

In commenting on the present stressful work situation, both for practitioners and the social work team he promised that when he had more time he would like to set up and attend meetings (CLs) with the local managers: the manager in the residential centre, the manager of the aftercare team and team-leaders for foster care, whereby they could outline to each other the work they do, perhaps also by doing a PowerPoint presentation. This idea from doing the TCI presentation could be replicated with other groups within the HSE. The researcher suggested the need to incorporate an interagency approach, by having other professionals involved, for example, local gardaí, probation officers, teachers, youth workers and Home Youth Liaison Officers (HYLOs).

This idea was welcomed by all. Practitioners said that finally they felt they were being listened to on this issue, given that for years they had been asking to have the TCI policy changed. It was felt that this was an example of good progress being made, when staff from the bottom-up are given a voice and listened to by management, where both activity systems are holistically and collaboratively changing policy and re-designing their work practice (Engeström, 2001, p. 139). In evaluating the process, everyone present was pleased with the progress to date.

The SWM said he was waiting to hear if support in the form of a psychologist/counsellor could be provided to the team. The manager asked for assistance from computer proficient practitioners to assist her in amending the TCI policy at a convenient time during that week. While the researcher had thought about the reflective learning journal that was mentioned at the second CL, she decided against mentioning it here because of the unprecedented changes that had occurred in the meantime as regards the work situation. Moreover, the researcher was aware that it could be worthwhile to re-start this process at a later date, in all three centres, because the reflective journal/portfolio, as well as recording and documenting outcomes (Halton, et al, 2014b, pp. 145-151) including present and ongoing CPD sessions, could encourage reflection and can promote CPD while also evaluating progress.

While it was not done at the time, it would have been a good idea to have circulated an evaluation sheet giving all professionals present a chance to document their individual views and comments while suggesting future changes that could be made to increase development, interagency/inter-collaborative work and learning across teams.

Over the ensuing months and especially in the last weeks before the date of seventh (final) CL the researcher was in regular contact and discussion with staff about the intervention.

6.4.10 Seventh Consolidation CL

The seventh consolidation CL took place on 26th November 2013 at the centre; the manager and all practitioners were present. Since the evaluation CL, the coordination between the two activity systems - practitioners/centre manager and management/trainers - ran very well in practice. There had been exchanges back and forth between the manager and the SWM regarding changes to the wording of the TCI policy. Eventually, the area manager received his copy of it. After reading the amended policy, he suggested one change regarding the wording before he signed off on it. Then it came back to the centre manager who had sheets printed with each practitioner's name and the date. She asked all staff to read the new policy and when they had done that, to sign and date the sheet, indicating they had read and understood it. At the CL the following unfolded:

Excerpt 7 (Follow-up Laboratory 2)

Manager: This centre has been complimented on changing its behavioural management policy regarding TCI physical restraint and already there has been correspondence from three other centres who want to change their policy the way the policy in this centre was changed.

Practitioner3: Yes, it is unbelievable to think about restraining children nowadays because of the many problems they have already when they come into care as a result of various changes in society...

There was unanimous agreement on this point and staff were very clear on why they have desisted from restraining children/young people at this centre. In the Helsinki study Engeström (2001, p. 145), discusses that the *care relationship* and *critical pathways* (described in chapter three) were tools created to address historical contradictions in their health services. Similarly, in this study, it was evident that TCI was created in response to particular historical contradiction, that of addressing aggressive behaviour in children/teenagers. Now there is evidence from research indicating that children/young people should not be restrained if they are obese or have different medical conditions, or if they have been sexually abused or are abusing alcohol and drugs (Holden et al, 2009a, p. S123).

The TCI refresher took place on 3rd December 2013. Staff from the centre involved in the intervention did the protective technique exercises only; because practitioners from the other centres were also present, restraint techniques were practiced and tested for the exam; everyone had to answer questions on the exam paper about restraint techniques. It is envisaged that this will change when the other centres, who are in discussions with management, amend their behavioural management policies and obtain permission to desist from using TCI restraint.

Approval was subsequently granted for a psychologist to work with staff in two centres, to give them support and provide a space where they can discuss their practice and get advice about how to address difficult challenges that arise. Staff have commented on how beneficial it was to their self-esteem, to the team as a whole and to their work which has vastly changed over the period of months.

In summary, the CL aided the reconfiguration of one element of this centre's behavioural management policy. It was effective and efficient in changing the ongoing pressing issue for staff. The application of AT as a model of advancing progress, has not been used before (as far as the researcher is aware) in a residential child care or social care setting in Ireland by an individual in a small scale research setting. Based on the intervention, the researcher argues that CHAT involving CLs/DWR and expansive learning is an opportune forum to discuss and elaborate on the five core epistemological issues envisaged by Fook (2011, p. 32,

cited in Halton et al, 2014b, p. 178): contextuality (the ability to work with the whole context); transferability (the ability to create knowledge and theory relevant to contextuality); processuality (an ability to think and act methodically); critical reflexivity (the ability to critically reflect); and a transcendent vision. In the questionnaire study (3 years later) participants were asked about their recollections and experiences of the CLs. The following section includes excerpts from individual participants outlining their perspectives and recollections.

6.4.11 Update on CLs – Questionnaire participants

Question 1: what did you think of the Change Laboratories (CLs)?

P1 said: ‘It was good to have a meeting where the talk was about issues affecting us as staff and not talking about the young people like at supervision and team meetings’. It was noted by P2 that ‘It was the first time a meeting like that was ever held’ and she said ‘it was great to have everyone around the table and it led to vibrant discussions’. P5 shared that she ‘was used to going to a lot of meetings and nothing coming out of them’, so when she heard about the CL she said she ‘was somewhat cautious in the beginning but this time she was surprised at the attendance and participation and actions which she said seemed to be conducted in a timed framework’ She claimed this was ‘attributed to two factors (1) The known problem of restraint in TCI and (2) something had to be done’.

In addition, P4 said that ‘while management turned up she was sceptical that anything would change or that they’d take anything on board’. While P6 said she ‘hadn’t heard about CLs until then’, and ‘was amazed at the concept involved: of bringing everyone together to make changes; it’s so simple yet so beneficial and effective’. P3 explained that ‘the CLs helped in the move away from the ethos of discipline in their residential centre’ and also said ‘now it’s more about talking through de-escalation which is a more amicable means of dealing with behaviours like ordinary folk do at home with their children’. P3 went on to say that ‘the CLs showed them a better way to portray themselves as role models for the children as opposed to restraining them like they did before’ She concluded by saying ‘I think this is way better for these children as they can pass on this form of parenting to their children after they leave care’

The excerpts point to participants being part of history, remembering a forum that occurred for the first time where everyone assembled together and where there was time allocated in a structured space to discuss and debate issues (contradictions) affecting them as well as making changes to their work practice. Practitioners were aware that the CLs contributed to change in that as opposed to the structured team meeting, this was a new forum where they could deal solely with their queries (contradictions). As pointed out by P3: they were able to attribute changes in TCI to their involvement in the CLs and they learned new and

better ways to work through issues with children/young people, modelled on how any family unit works through difficulties.

Question 2 Did the CLs change anything?

In their responses four out of six participants mentioned the 'restraint' theme and the face-to-face discussions that took place around it. For P1 and P5 the big change was the thinking around restraints which changed the TCI policy, so now they do not have to do restraints anymore. In addition, P3 said 'key people/ideas were identified and roles were established regarding a presentation they did and it was all aimed at getting management to see the impacts of TCI restraint and for to get them to agree for us to formally stop doing these restraints'. On this same theme, P4 said 'it was clear to see that we had our own agenda and this led to a good discussion about TCI and us continuing to be doing exams on techniques for restraining the kids but us not implementing it at the centre'. In addition, P1 and P6 commented that they felt listened to and their views were acknowledged which P1 felt 'was a positive move for the future'. P2 said the thought that 'as a result of the CLs the ethos seems to have shifted to a more cohesive team effort than top management lead with a dictatorial approach'. On this point, P6 commented:

On a personal level they helped dissolve barriers between people on the ground and management in offices. It was the first time I was able to sit face-to-face with people when management were not telling me what to do. Instead they were interested in hearing what I had to say.

Picking up on this theme of a more cohesive team, P5 said 'apart from the change in TCI – no more restraints, the CLs led to staff being more in tune with conflicting situations with the focus more now on all forms of communication as opposed to restraint'.

Practitioners' comments centre on being listened to by management which led to the change in TCI policy that they were asking about for years. As with earlier responses, practitioners' also remarked that the move away from restraint was good as it led them to think critically. The CLs made them more aware of how to address conflict and aggressive behaviour, where they learned to focus more on communication as a form of de-escalation as opposed to previously using restraint. Practitioners thought that the CLs contributed to the team being more cohesive and focused in their communication with each other and with management. The CLs helped to dissolve barriers between them and management as they provided an avenue for face-to-face communication on the TCI issue (P6).

Question 3: Did it lead to more?

In answering this question, practitioners acknowledged the main changes which included having good communication and vibrant discussions (P6). This

culminated in them not doing restraints anymore. Four out of six participants also highlighted the theme of being 'listened' to. This inspired them, and P1 said:

Because I felt I could express my views and that I was listened to then it gave me the courage to push for the CPD that I want, for what I need like IT training; I've asked for this.

Practitioners said because they were listened to it empowered them. P3 said:

The restraints stopped and this empowered me because I now feel like a professional who doesn't have to agree with something for the sake of it and I know I will be listened to and that I don't have to agree with everything the management proposes. At least I can and will question it, if I need to. Before this I would have let it be.

Picking up on the theme of empowerment, P4 also felt empowered and said:

It led to me up-skilling myself, the meetings that we had got me thinking about my work and I had an idea about how to improve my work. I did an addiction counselling course which I enjoyed and I learned a lot from it that I can use at work.

Being empowered gave P2 a new sense of confidence, she said:

I now feel like as if I'm more part of a team and that my voice is finally listened to. This has given me increased confidence in senior management and in expressing my views which I realise can be as worthwhile as anybody else is because at that meeting no matter what anyone said it was listened to and respected.

P1 summarised that she too 'felt more confident about saying what she thought from then on'. She observed that, 'I notice it's much freer now when we go to trainings away from the centre and when we meet other staff'. P5 also commented on the confident theme, she said:

Staff appeared to be more confident and I think this was because they were listened to and felt valued and felt part of the bigger organisation than individuals or numbers doing a job.

Practitioners acknowledge that the CLs benefited children/young people and staff alike; they saw that it was an avenue for debating as well as resolving issues as the CLs culminated in the discontinuation of TCI restraint. Respondents are suggesting that taking part in the CLs empowered them and this enhanced their thinking and in turn their practice. Because they were listened to and could outline

their views it gave them the impetus and the confidence to ask for training that they knew would benefit them. Also they are saying that because communication was opened up they felt more at ease than previously with management and more able to put their ideas and thoughts forward because they knew this was the space where everyone was valued and everyone had a voice and were respected.

While we have seen in the intervention above how Engeström's CLs/DWR and expansive learning aspects of CHAT can be utilised, we now turn to the future by showing in the next section how Engeström's conceptual models, namely the *care calendar*, *care map* and *care agreement*, could be adapted and possibly implemented to address some of the findings of this study. In the next section the analysis moves beyond the TCI/CPD issue to look at broader issues of workforce/communication/change.

6.5 ACTIONS, SCRIPTS AND ACTIVITY SYSTEMS

Actions, scripts and activity systems are described in the following scenarios by drawing on Engeström's (2000, p. 961) Helsinki study while also using examples from this study. It is important to understand that these are key elements in the process which consisted first of questioning and debating the issues. With the aid of conceptual frameworks as depicted in diagrams, and as described by Engeström (2000, p. 961), these can be displayed in a set of easily-read documentary tools.

6.5.1 Scenario

The centre manager is taken as the starting point. She is on duty at the centre on a given day and at 3pm gets a phone call from the social work department confirming an emergency admission of a boy aged 12, who will be accompanied by his father, the duty social worker (DSW) and two gardaí (one male and one female) who deliver the boy to the centre. As well as reading the garda notes and notes given to her by the DSW the manager also checks RAISE (HSE electronic database, where social workers input data about children/young people in care and which can be viewed by social care practitioners and other HSE professionals), for more information. This action of reading displays the classical set-up of human - machine interaction studies: a human operator working on a machine (Engeström 2000a, p. 961). As explained by Engeström, even a slight temporal and spatial extension of this observation reveals that the manager is not only working on the computer. She is simultaneously reading the child's background notes on paper files. So the human-machine interaction is actually interaction between the human and multiple mediating artefacts in complementary representational modalities (ibid, p. 961).

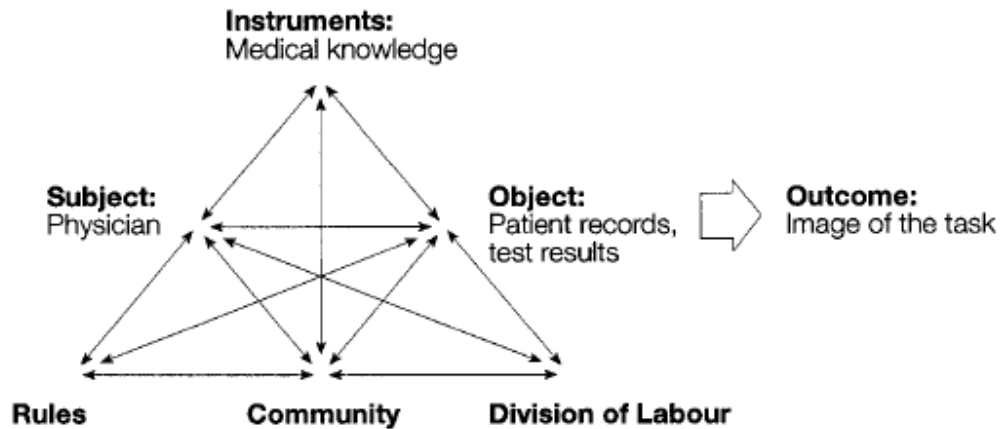
As the observation is extended, the manager, assisted by two practitioners on duty, acutely observes the boy in the activity room of the centre. They have prior

knowledge and experience of children acting out in this way. The boy had been truanting from school, abusing alcohol/drugs and had been on the run for the previous week. Gardaí noted he was engaged in anti-social behaviour in town, immediately before being arrested and taken to the centre. One of the gardaí had recognised him from a previous incident; he and his family were known to the social work department. The manager/practitioners' attention was now focused on the child and his father. From observing the child and from the visual and written information at hand they deduced that this boy had a problem with alcohol and possibly substance/drug mis-use.

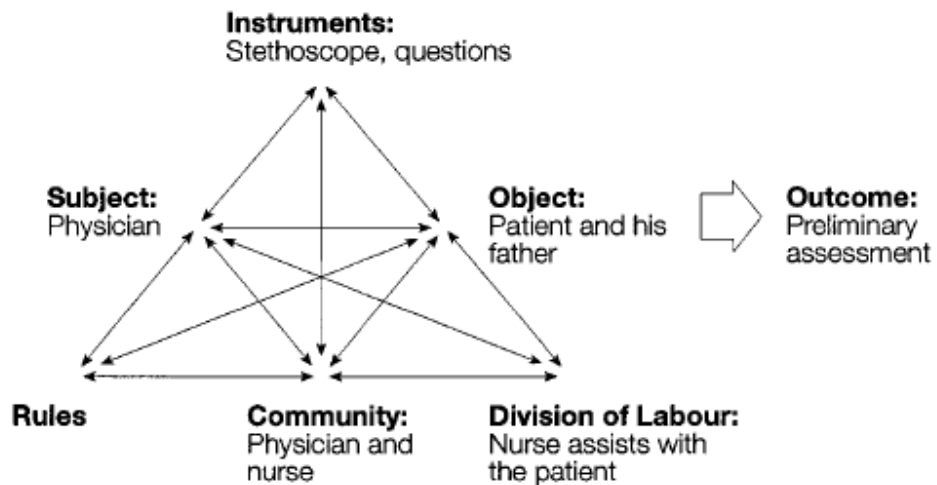
In his study, Engeström (2000a, p. 963) describes the actions taken by the physician in action 3 shown in figure 6.6 below. The physician in that case immediately made a telephone call to the lung specialist, located in the hospital, who happened to be free at that time asking her to come and take over the care of the child presenting with asthma. In this case, the manager at the centre discussed her observations with the social worker who in turn said she would discuss it with her team leader or SWM, and would then phone the addiction counsellor from her office the next day and enquire when he/she would be available to assess the child who would be taken (possibly months later) to see the counsellor by one of the practitioners on duty at the centre.

Engeström (2000a, p. 963) explains that within 10 minutes a string of four rather distinctive actions was observed: (1) reading medical records and test results (2) examining and diagnosing a patient (3) making a phone call to invite a specialist into the scene (4) deliberating and making a decision concerning the next steps of care of the patient. To graphically explain the actions, Engeström uses the model of the human activity system that he developed (Engeström 1987, p. 78) (Figures: 6.5, 6.5a, 6.6, 6.7 and 6.8 below and cited in Engeström 2000a, pp. 962-3).

In the researcher's study depicted in figure 6.5a, 6.7 and 6.8 below and adapted from Engeström, (2000a, p. 962-3) all actions unfolded in a similar manner except for action 3. The actions were as follows: (1) reading the child's background files and checking RAISE on the computer (2) observing the child closely (3) the social worker (instead of immediately telephoning the addiction counsellor) intending to make a phone call to an addiction counsellor the next day, and (4) deliberating and making a decision concerning the next steps of care of the child. Engeström, (2000a, p. 963) asks how can one make sense of these actions in terms of their impact on the participants and their developmental potential. He answers: the first step is to uncover the anatomy of these actions as successive, momentary instantiations of a wider and more stable system of collective activity.



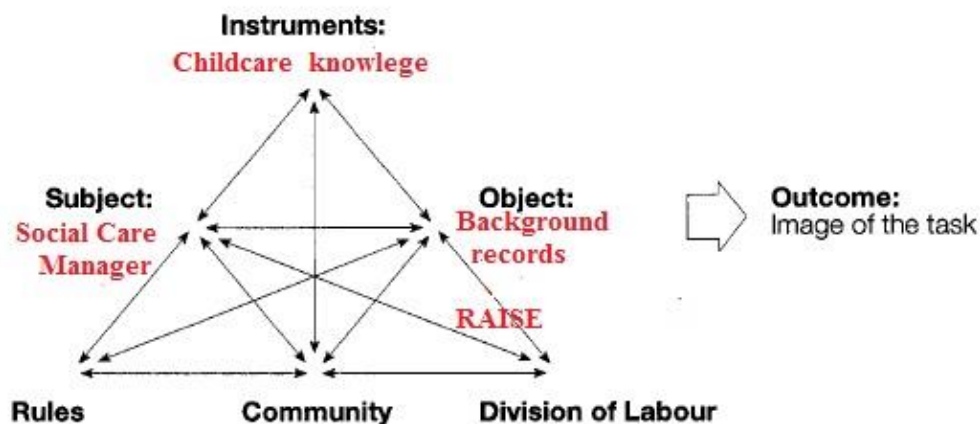
ACTION 1: READING PATIENT RECORDS AND TEST RESULTS



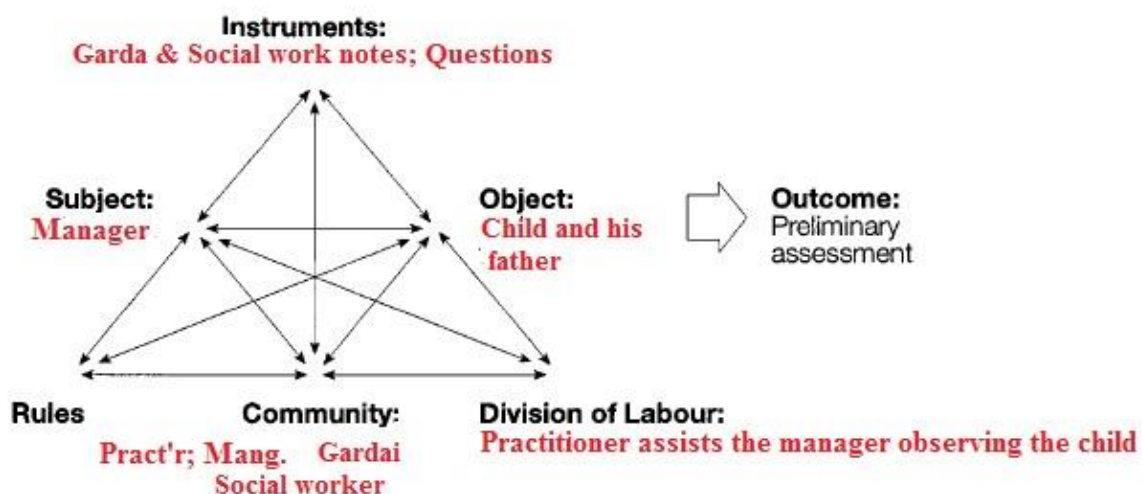
ACTION 2: EXAMINING AND DIAGNOSING THE PATIENT

Figure: 6.5: First two work actions (Engeström, 2000a, p. 962).

The manager's first action of reading the garda and social worker's notes and checking RAISE is represented without underlining the importance of the computer. It is not the computer the practitioner is focused on, it is the information given by RAISE on the screen. According to Engeström (2000a, p. 961) the computer would only become the focus of her attention if she had problems operating it. In activity theoretical terms, the computer as a technical instrument remains at the level of automatic operations; it is not a central element of the goal-directed conscious action in this case.



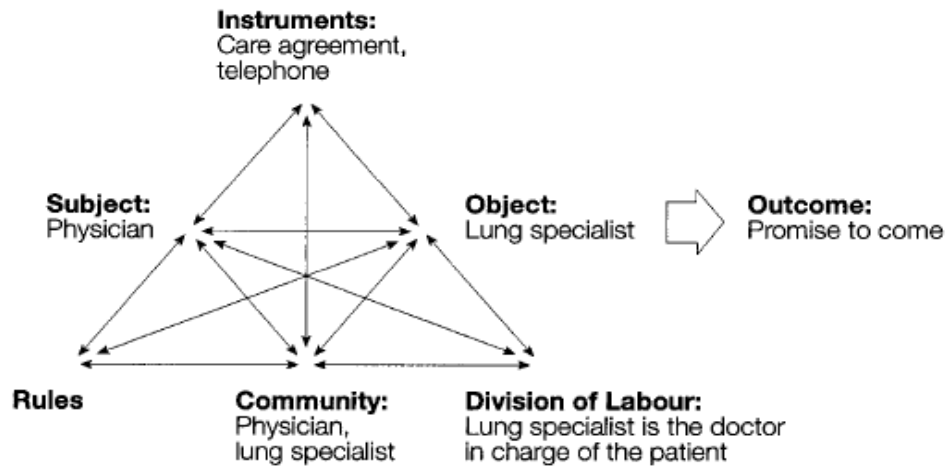
ACTION 1: Reading Child's Records and RAISE results



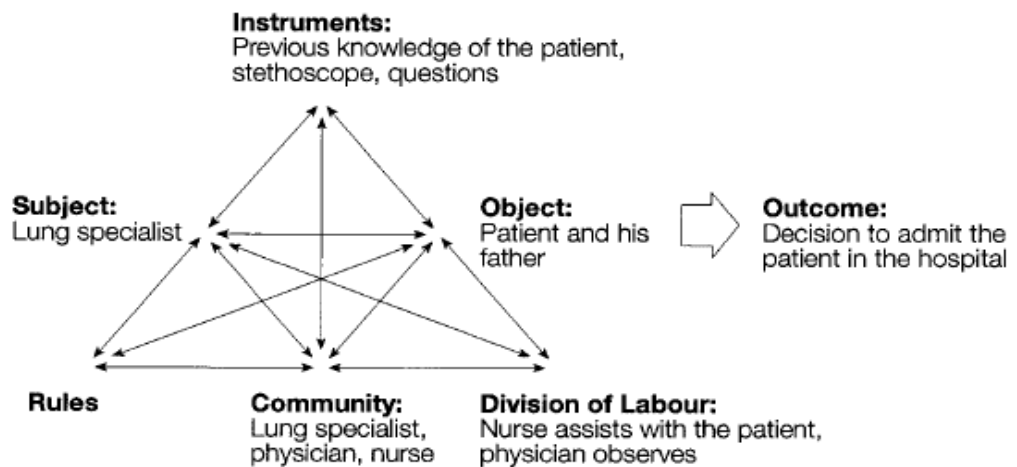
ACTION 2: Observing and Assessing the Child

Figure 6.5a: First two work actions in researcher's study, adapted from Engeström (2000a, p. 962).

In figure 6.5a, the bottom part of the first action (rules, community, division of labour) is left empty because these elements, while they undoubtedly frame the action, are not made visible and articulated by the participants in this particular action (this issue will be discussed below). The outcome of the first action is a preliminary image of the task, accomplished by drawing on the manager's explicit and experiential childcare knowledge. This would be articulated by the manager if she was interviewed on the spot or immediately after the string of actions and it could be used when typically viewing the action on videotape as a stimulated-recall prompt (adapted from Engeström, 2000a, p. 961).



ACTION 3: CALLING THE LUNG SPECIALIST



ACTION 4: DELIBERATING AND MAKING A DECISION

Figure: 6.6. Third and fourth work actions in Engeström's study (Engeström, 2000a, p. 963)

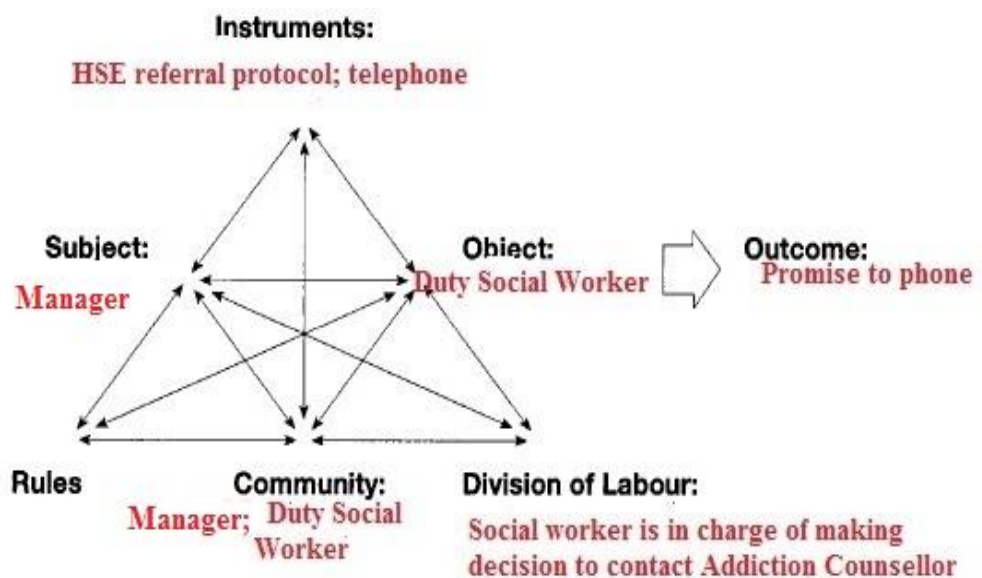
In the second action, of observing the child and making an initial assessment, the object of attention shifts from documents to the child and his father. The outcome is a preliminary assessment of the child's condition: the manager explicates the possibility that the child may be hung-over as a result of consuming X amount of alcohol and possibly drugs. This outcome is reached by means of observation and consultation with all persons present including questioning the father about the child's previous behaviour which plays a prominent role in the outcome of this assessment. Another important mediating factor in the action is the division of labour between the manager and the practitioner; the latter assisted the manager in her initial assessments. Together, the two are the visibly present representatives of the community of the centre.

In the third action from Engeström study (2000a, p. 963) (Figure 6.6), the focus shifts again to the lung specialist of the clinic. From observing and recording a large number of patient visits to the outpatient clinic, this action is known to deviate from the standard script. Instead of calling the senior physician on duty, the junior physician called a specific lung specialist. From interviewing the junior physician immediately after this string of actions, it is known that he did this because he had seen a box in the patient's medical chart, titled 'care agreement'. In his interview, the junior physician explained:

I've seen in practice how this care agreement works. I noticed in the patient's papers that there was a designated physician responsible for his care in the hospital, so I called to consult with her. And it happened so well that she could come to the spot herself. Now it's important that the personal physician gets informed about the patient's phases here, now that she is also involved in the care (p. 966).

The box indicated that the lung specialist was named as the physician in charge of the continuous care of this patient in the Children's Hospital. This information, together with the telephone, mediated the junior physician's action (p. 963).

In the third action of the researcher's study (figure 6.7, below), the focus shifted from the child and his father to the duty social worker (DSW):



ACTION 3: Promising to call the Addiction Counsellor

Figure 6.7: Researcher's study: The DSW promising to call the Addiction Counsellor, adapted from Engeström (2000a, p. 963).

Unlike the deviated action described by Engeström (2000, p. 963) the DSW was true to the standard script. Had she seen a box in the child's RAISE file titled 'care agreement', with the addiction counsellor named as the counsellor in charge of the continuous care of this child in the local service area, this, together with the telephone call, would have mediated the social worker's or, if she had not been present, the manager's, action.

Finally, in the fourth action figure 6.6 above, in Engeström's example (2000a, p. 963) and based on the knowledge of the care agreement, the subject position was taken over by the lung specialist and the junior physician moved to the background. The action itself resembles action 2, only it was mediated by deeper and longer-term knowledge of the patient and his medical condition.

In the researcher's study (figure 6.8 below), the fourth action, which like Engeström's did resemble action 2, the subject position was taken over by the DSW who deliberately made the decision, promising to ring the addiction counsellor the next day:

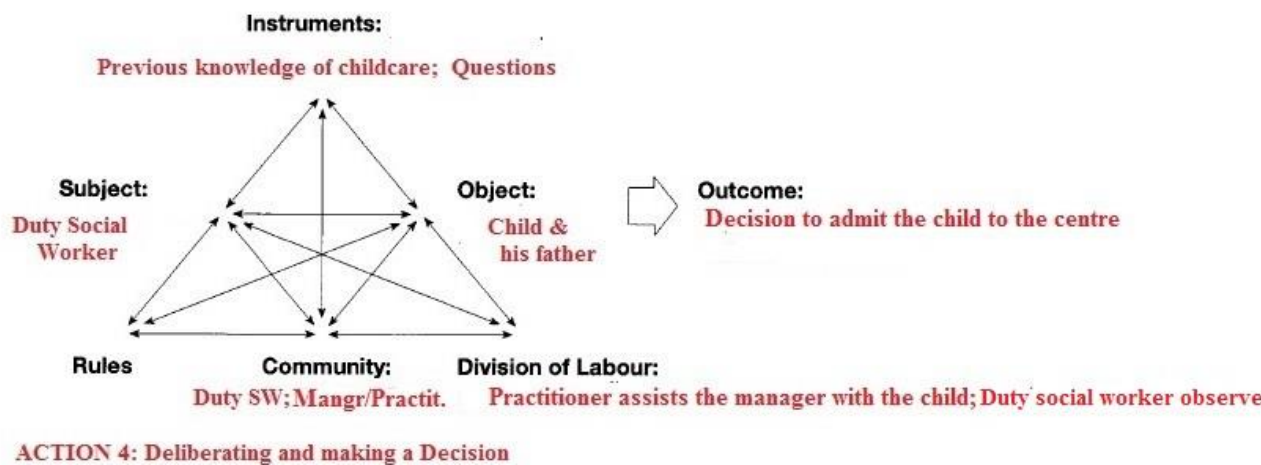


Figure 6.8: Researcher's study: DSW deliberating and making a decision to ring the addiction counsellor

Engeström (2000a, p. 963) argues that the shift in the subject position in action 4 demonstrates that the actor's identity is not a sufficiently robust basis for understanding the continuity and coherence of actions. Identity equals the role and the person; different participants could be doing the role and can take the lead in different steps within a string of actions. However, this was not observed in the researcher's study because due to no previous 'care agreement' in place for this child because of a lack of particular structures/processes. This led to the DSW having to take on extra roles and responsibilities by taking the lead in promising to source a suitable addiction counsellor.

In summary, at an intermediate level, as was shown in the above example, the continuity of actions is accounted for by the existence of standardised or habitual scripts that dictate the expected normal order of actions. But Engeström suggests that the notion of script itself requires an explanation: how do the scripts emerge and gain coherence? Scripts alone leave unanswered the crucial question of motivation. Engeström (2000a, p. 964) asks: if the essence of work boils down to collections of scripted action strings, what drives the practitioners in their actions? Is it rational willpower and force of habit only?

Engeström (2000a, p. 964) explains that in activity theory (AT), the distinction between short-lived goal-directed action and durable, object-oriented activity is of central importance. A historically evolving collective activity system, seen in its network relations to other activity systems, is taken as the prime unit of analysis. Goal-directed actions, as well as automatic operations, are relatively independent but subordinate units of analysis, eventually understandable only when interpreted against the background of entire activity systems. Activity systems realise and reproduce themselves by generating actions and operations.

Thus, if medical practitioners (or social care practitioners) are asked why they do what they do, the eventual answer almost invariably is because of the patients (children/young people). This is not only an idealist statement that naively reproduces or advocates selfless devotion to a higher calling among healthcare (social care) employees. What more than anything arouses involvement, effort, emotion, excitement, frustration, and stress among frontline primary care/hospital staff/managers/practitioners is daily encounters with real, live patients (children/young people), no matter how cynical or instrumentally oriented the individual employee. The object of medical work is the patient, with his or her health problem or illness. The object of social care work is the child/young person with his/her individual problems/issues needing attention. This is what in the end gives rise to continuity and coherence to both the actions and the scripts. Without patients (children/young people) the activity would cease (ibid, 2000a, p. 964).

As described by Engeström (2000a, p. 964) a collective activity system is driven by a deeply communal motive. This is embedded in the object of the activity. The child as object of social care work is a generalised child that carries the cultural motive of a vulnerable child in care, displaying challenging /aggressive behaviour and being cared for in a centre promoting protection, safety and security. At the same time, each specific child brings the object to life and embodies the motive in a unique way. The four actions discussed above were all driven by the same object and motive: the child and the challenge of vulnerability/safety and protection. The object and motive give actions their ultimate continuity, coherence and meaning, even when the ostensible object of many actions (such as actions 1 and 3) does not coincide with the object of the overall activity.

Continuing with the emphasis on the object and motive, which in this study is children/young people in centres (activity systems), the next section looks at disturbances and contradictions, previously discussed in chapter 3. Engeström (1996a) refers to deviations from standard scripts as disturbances that typically indicate developmentally significant systemic contradictions and change potentials within the activity. While the object and motive give actions coherence and continuity, by virtue of being internally contradictory, they also keep the activity system in constant instability.

6.6 DISTURBANCES AND CONTRADICTIONS

In Engeström's Helsinki study (outlined at the end of chapter 3), disturbances were uncovered as patients were followed through the system. In this study, from practitioners' interviews and from the experiences and observances of the researcher, disturbances were also noted in the centres. They included an increase in a range of issues, more intense and severe than normally expected in residential child care, such as children/young people self-harming and mixing drugs and alcohol which they simultaneously abuse. The normal route of problems was disturbed; practitioners had not previously encountered the intensity and severity of such abuse. Also, they were experiencing for the first time, children/young people who had been sexually abused and were alluding to suicide ideation.

As discussed in the previous chapters, practitioners were not adequately equipped to address these disturbances because of a lack of resources, training, expertise or support. Aiming to counteract this while working through the everyday challenges, practitioners relied on their own and their colleagues' learned knowledge as well liaising with social workers and referring children where appropriate, to the medical profession. A number of children had to wait for several months to be seen by addiction counsellors/psychologists and psychiatrists. Disturbances were compounded further by children having to wait for up to two years for suitable foster family placements. In the meantime, practitioners noted that the behaviour of some of the children/young people escalated and deteriorated. The only recourse for dealing with aggressive behaviour was the TCI policy that included physical restraint. Some of these children had numerous visits to different care professionals during one year. It can be argued that sometimes a contradiction between the need for services/lack of services, can lead to an escalation of aggressive behaviour.

Figure 6.9 graphically describes the contradictions in Engeström's Helsinki study, (described in detail in the final section of chapter three); it shows systemic contradictions giving rise to disturbances depicted with the help of two-headed lightning-shaped arrows. For example, it shows a contradiction between the object and the instruments. Engeström (2000a) gives the example: when a child had, for instance, both asthma and severe food allergies, he/she fell into two separate

critical pathways. In these cases, critical pathways are clearly insufficient instruments, possibly even sources of additional disturbances.

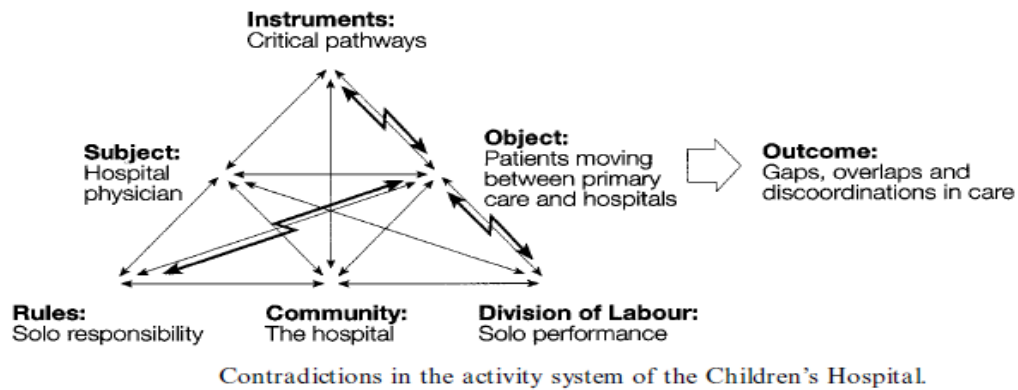


Figure 6.9: Contradictions in Engeström's study: the activity system of the children's hospital

Figure 6.9a, below represents practitioner's contradictions. In the centre the HSE normative care plan is the officially accepted instrument for use by the manager and practitioners to work with children placed in State care. The care plan is constructed by the social workers and is sent to the centre within the first week after the child is placed in care, to be used by practitioners when addressing individual needs of each child. Practitioners in one centre experienced a child being placed in care as a result of an emergency care order; the gardaí brought the child to the centre after 5pm one evening. Social workers constructed a care plan which was sent to the centre within the week. The main issues involved the mum's addiction problem. However, she agreed to stop drinking and get help for her addiction. The child's grandmother agreed to move into the child's home to help to take care of the child. After constructing the care plan, it was then decided that there was no reason now why the child could not go home and instead of a care plan, a support plan needed to be constructed for the child to enable her to be discharged from the centre. In a case like this, as in Engeström's study regarding critical pathways, normative care plans are clearly insufficient instruments for addressing children's needs.

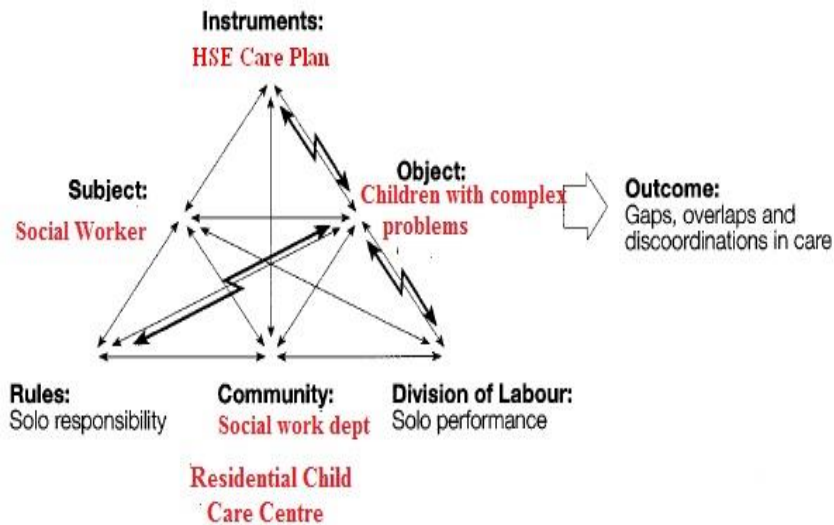


Figure 6.9a: Contradictions in the residential child care centre

As in figure 6.9, there are contradictions in figure 6.9a: children with multi-problems who move between different health and social care professionals requiring collaboration across institutional boundaries. Additionally, the division of labour in social work emphasises solo performance where a social worker may refer a child to another professional/specialist but may not constructively and regularly engage in collaborative negotiations about the course of care because that same social worker may have many other cases and, due to lack of sufficient resources, may have an excess of many children's cases on their files.

By contrast, the manager and practitioners work in a small unit and get to know more intensely about the needs of the children in their care and may be better positioned to know how their needs should be addressed and would consistently work towards those goals in prompt fashion but do not have the power to make decisions like those made by the professionals referred to above by Engeström (2000a, pp. 960-974). Therefore, there is a potential contradiction between where the authority is and where the knowledge of the case is located.

Engeström (2000a, pp. 960) describes figure 6.9 as a working hypothesis whereby the first version of the contradictions represented was derived with the help of analysing the history of the activity system of the Children's Hospital. Subsequently, in this study, the researcher continuously observed and analysed the conversations, interactions and interventions put in place by professionals when confronted by complex or contradictory issues presented by the children in the centre. Engeström's case demonstrated in various ways disturbances caused by lack of coordination and communication between the different health-care providers in the area. Disturbances took the form of excessive numbers of visits, unclear loci of responsibility, and failure to inform other care providers involved (including the patient's family) of the professionals diagnoses, actions and plans.

In this study, disturbances also centred on communication. Practitioners stated that at times it was lacking between for example, social workers, psychologists, psychiatrists, GPs and teachers in various schools with the team in the centre. This resulted in the team having to sometimes follow up on queries; for instance a social worker may not have informed centre staff about the conversations they had with a child, although centre staff would notice a dramatic change in the child's/young person's behaviour after being out with the social worker or vital information could be missing or not filled in on some forms, such as information missing from a GP about a child or vital information withheld which the school should have forwarded but did not to the staff at the centre.

In aiming to pre-empt and address disturbances and contradictions in activity systems, Engeström (2001) states that in collaboration with research teams they devised three useful intervention tools in their implementation laboratories. These include: the care calendar (an example shown in figure 6.10 below), a care map (figure 6.11) and a care agreement (figure 6.12) used to plan and coordinate the care of chronically ill children/patients who had multiple illnesses (for example, patient with asthma ailments discussed above) and who moved between different care givers in the health centres/hospitals in Helsinki. These three models were first created in the project (chronically ill children) at the children's hospital in Helsinki at the end of 1999 see (Engeström et al, 1999; Engeström, 2001). The second project in which the care agreement was further developed was in the care of adult patients with multiple and chronic illnesses in Helsinki during 2000-2002, see (Engeström et al, 2003; Kerosuo and Engeström, 2003; Kerosuo, 2006).

CARE CALENDAR	
Diagnosis or problem	Care contact
Rheumatoid arthritis, 1997	Helsinki University Central Hospital
several rheumatic orthopaedic operations, including wrist arthrodeses fusion and left hip arthroplasty, 1997	Surgical Hospital
Hypertension, 1997	Care and follow-up at patient's own primary care health centre
Spell of unconsciousness, June 2000	

Figure 6.10: Care Calendar of a patient, presented by the Chief Rheumatologist cited in Engeström et al, (2003, p. 18).

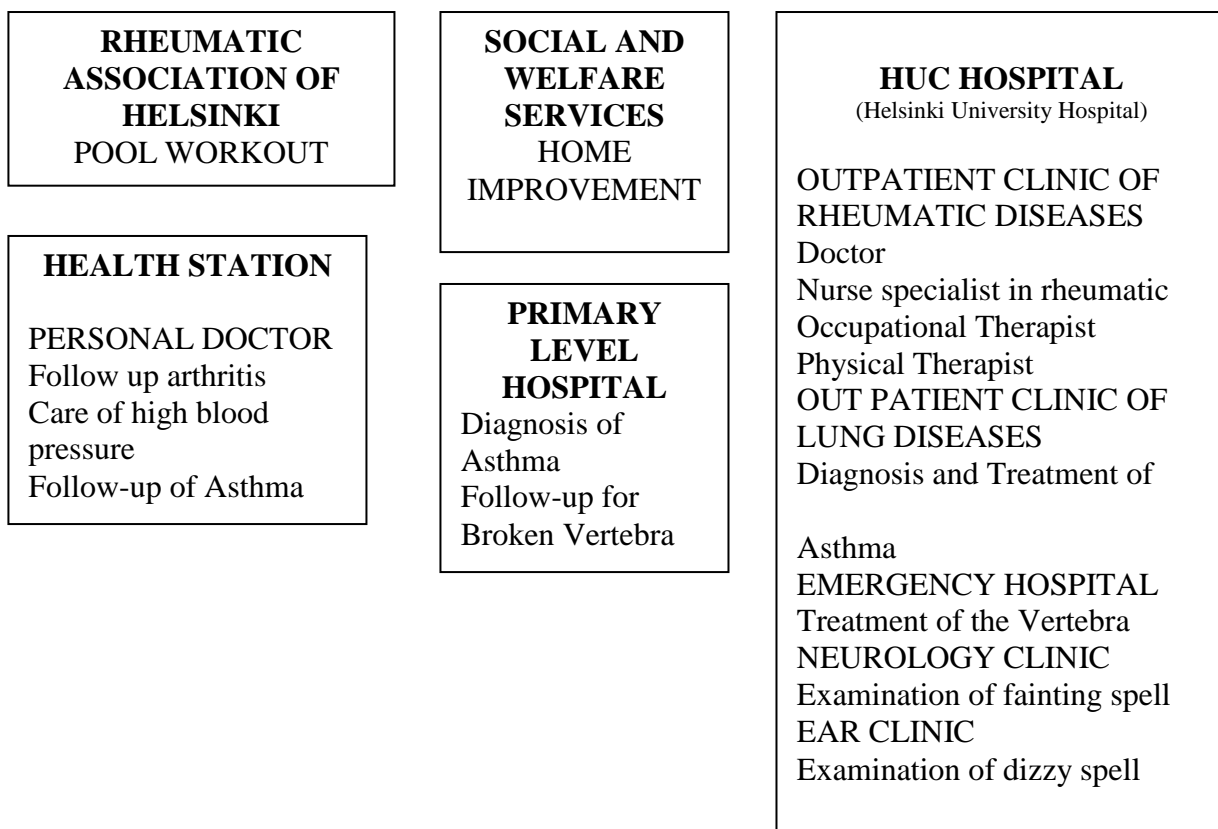


Figure 6.11: Care map of a patient, presented by the Chief Rheumatologist, cited in Engeström et al, 2003, p. 179.

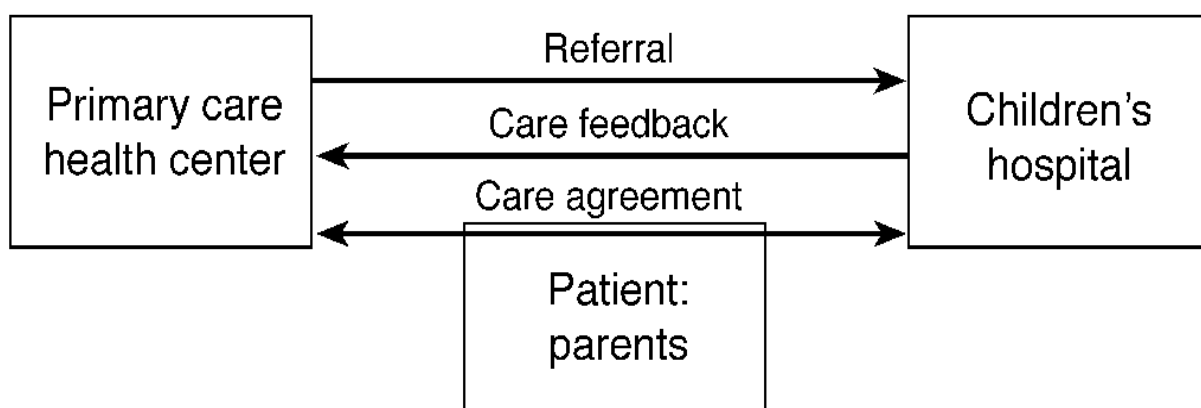


Figure 6.12: A model of the Care Agreement cited in Engeström (2006, p. 10)

In relation to the researcher's study, Engeström's three intervention tools described above (Figs 6.10-6.12) could be adapted and implemented to address disturbances and contradictions resulting from CPD training deficiencies.

As in Engestrom's example above, a designated person/CPD training officer could be appointed to oversee this operation. Appointing a designated training officer in each centre could be seen as a good measure, especially in the light of impending changes for practitioners in line with CORU. Such an officer would make sure that all practitioners, especially older/longer serving practitioners who may not be as familiar with portfolios/journal/CPD logs or the use of computers as their younger colleagues, are aware of how to access the new information about requirements concerning CPD.

In relation to the three intervention tools discussed above, firstly, the events calendar, based on Engeström's care calendar and formulated from practitioners' contradictions could be discussed in the CLs; it will give senior management/trainers a first intimation of problems experienced by practitioners, and will mark the individual important events/experiences that each professional has encountered over the past few years, and how they dealt with it. As above the idea is to condense the often prohibitively voluminous historical information stored in log books/reports/journals and in the professionals own recollections and interpretations, into one or two pages that may be easily reviewed in any encounter or planning situation. The construction of the events calendar would be co-narrated between the manager/practitioner and the delegated person/training officer in each centre. While it could be argued that practitioners may be disempowered or may not be able to engage in their own research to address the issues in their work, currently, they simply do not have the time or resources and are often exhausted from the intensity of the work, as was described during the construction of TCI intervention above.

First, figure 6.13 shows an example of an *Events Calendar* depicting possible challenges experienced by practitioners, without adequate relevant training.

Second, figure 6.14 presents an example of a *Training Map* adapted from Engeström (2006 p. 12). On the right hand side it displays the professional affiliations involved with practitioners/managers whereas the left side shows the gaps/missing connections in the form of relevant CPD training required by practitioners. The one page training map template will represent the different trans-disciplinary teams involved with the professional. As above the designated person/CPD training officer will construct the first version of the map.

Finally, adapted from Engeström's care agreement, a potential *Training Agreement* for practitioners/managers is outlined at figure 6.15.

EVENTS CALENDAR FOR CENTRES	
Diagnosis or issue/problem	Mode of address
Challenging/risktaking behaviour (2005-2011)	Ongoing at the three research sites involving many children. When TCI talking theory did not work, nothing else was available apart from TCI restraint; sometimes due to underlying conditions in the child's ICMP, restraint could not be administered. Recorded in Significant Event Reports (SER) and emailed to relevant senior management.
Sexually abused traumatised/children	No training provided.
Suicide ideation/self harming (ongoing)	No training provided, staff playing down issues brought up by children/young people. Lack of resources: no night cover/extra staff. As above re SERs
Bullying/alcohol/drugs related incidents	No training given apart from staff using their own experience, knowledge and initiative As above re SERs
Children in wrong placements	Staff utilised to work with these children
Obsessive Compulsive Disorder (OCD)	Staff did not have relevant training. As above re SERs
Voice of staff not heard/ listened to by senior management	On-going problem: staff asked what training they wanted, but did not get relevant training apart from TCI; sent to training with SWs
Communication skills training	Interviewees said all needed this training
Reflective practice/Supervision	Not fully or properly implemented
Key working training needed	Staff continuing on as before on precedents
Stress management not provided	Interviewees said the only recourse for staff was an appointment (if required) with the HSE occupational therapist

Figure 6.13: Events Calendar for Centres, adapted from Engeström et al, 2003, p. 181.

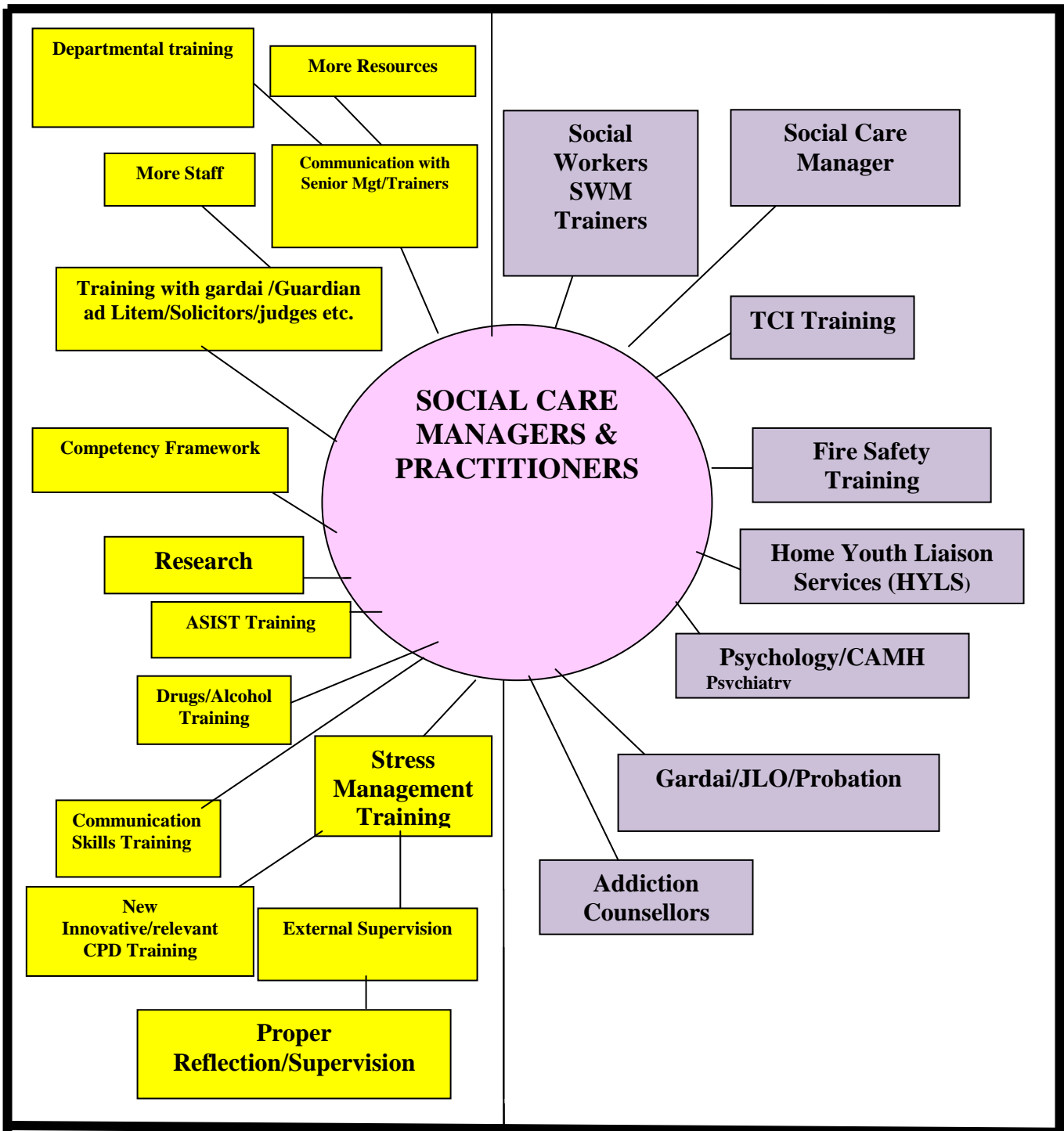


Figure 6.14: Training map for practitioners adapted from Engeström’s (2006, p. 12) Care Map.

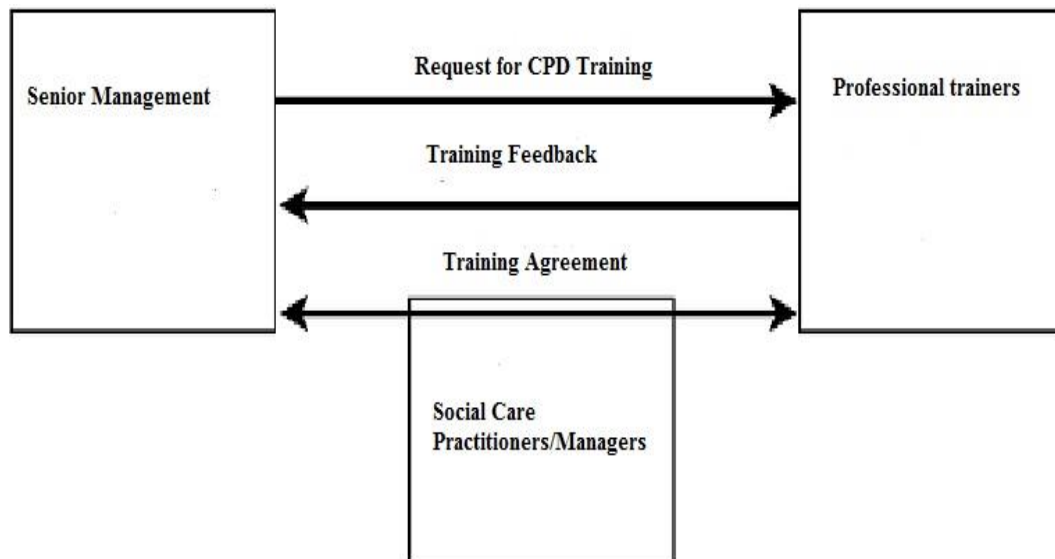


Figure 6.15: CPD needs agreement, adapted from Engeström, 2006, p. 10.

The easy to read, one page graphical training map (fig 6.14) will also allow the CPD training officer and the manager/practitioners to add on boxes to each professionals' map once different training is completed. For example, if a practitioner has completed the ASIST course, this will be added to the right hand side of the map; or if a manager has not completed a managers' training course or if a practitioner has not completed the TCI course those boxes will be displayed on the left side of the graph, until they have completed all the relevant training. The same will apply to all CPD training for practitioners/managers. This map will also allow for personal CPD, undertaken by individual practitioners/manager, other than that offered by the HSE, to be added to the map.

The crucial point of the training agreement model (fig 6.15) is that minimally the three key players of CPD training, namely the practitioners/social care manager, social work management and trainers together, are engaged in negotiating an overall framework for relevant specific CPD training for the next year. They sign a mutual agreement that obliges them to inform each other of any significant needs for training and about upcoming training events and changes in the plan. From the discussion so far it can be seen that for the future practitioners could construct and implement the three tools: events calendar, training map and training agreement to debate, discuss and change their practice by addressing the following key findings emanating from practitioners interviews:

- The need to address the lack of staff, resources and relevant training
- The need to address challenging behaviour of children/young people
- Communication skills training to work with vulnerable children/young people
- The voice of frontline staff is not heard; they are not asked for their views or listened to by senior management

- They are trying to deal with the challenge of the paper trail/accountability
- The need to have a competency based framework, like social workers
- Due to time/staff/resource constraints, few staff engage in reflective practice
- Staff are dissatisfied with current supervision; external supervision mentioned
- Current CPD training only partly beneficial/effective
- Participants are calling for changes to CPD training to include: consistent, relevant CPD training, in collaboration with management to address issues pertinent to working with children/young people.

In the next section, with reference to practitioners' workplace, innovations and visions are discussed by returning to Engeström's (2000a, p. 966) third action (figure 6.6 above). Action three shows how the junior physician performed an innovative action based on the information he read in the patient's medical chart with reference to the hospital which had recently begun to implement their new instrument: the care agreement.

6.7 INNOVATIONS AND VISIONS

The projected training agreement model for practitioners aims at resolving the contradictions depicted in figure 6.9a above by creating a new instrumentality. This instrumentality, when shared by practitioners across institutional boundaries, can expand the object of their work by opening up horizontal, socio-spatial interactions in the practitioners'/managers' evolving network of care, making the parties conceptually aware of and practically responsible for the coordination of multiple parallel needs and services in children/young people's lives.

The training agreement model (fig. 6.15) implies an extensive expansion of the object of activity for all parties: from being able to deal with a singular problem such as a child self-harming on one occasion to engaging in a long term trajectory of care such as a specialised course on how to care for children/young people who are self-harming (temporal expansion), and from relationships between the child/young person and a singular practitioner (psychologist/psychiatrist) to the joint monitoring of the entire network of care involved with the child/young person (socio-spatial expansion).

The model encourages practitioners to see the bigger picture. It is a spearhead (Engeström, 2000a, p. 967) of the zone of proximal development of the activity systems involved, a vehicle for traversing 'the distance between the present everyday actions of the individuals and the historically new form of the societal activity that can be collectively generated as a solution to the double bind potentially embedded in the everyday actions' (Engeström 1987, p. 174).

To achieve such an expansion both conceptually and in practice, a new kind of learning process was needed, namely the expansive cycle of learning actions,

(discussed in detail in chapter three and again above: TCI restraint intervention). In the CLs and boundary crossing CLs practitioners engaged in knotworking until a new model of working was constructed and implemented. In continuing with this model, the researcher has observed that in centres and amongst management since the introduction of the initiative of using a PowerPoint presentation where all practitioners came together to hear about and discuss their work, this new process of initially bringing teams of practitioners/staff together, continues to expand to other groups of professionals. For example, the manager of the after care team, of the residential child care centre and the foster care social work team leaders have attended sessions in which each manager has presented a PowerPoint presentation of their past, present and future work practice in their respective workplaces. As described in Engeström's Helsinki study, it can be seen that there has been horizontal learning for management as well as for staff in centres.

6.7.1 The horizontal dimension: directionality in learning and development

Engeström (2001, p. 154) claims that people habitually tend to depict learning and development as vertical processes, aimed at elevating humans upward, to higher levels of competence and rather than simply denounce this view as an outdated relic of enlightenment, he suggests that we construct a complementary perspective, namely that of horizontal or sideways learning and development. The Helsinki study (Engeström 2001) provides rich indications of such a complementary dimension, in particular with the construction of the concept of *care agreement*. As discussed above this could be adapted to the *training agreement* (with the related concepts of knotworking, care responsibility negotiation and feedback) by the participants of this study and used in CLs and in boundary crossing CLs that can include trans-disciplinary teams for example, (gardaí, probation, teachers, GPs, solicitors, judges, etc).

In his classic work on concept formation, Vygotsky (1987) presented the process as a creative meeting between everyday concepts growing upward and scientific concepts growing downward (figure 6.16, below).

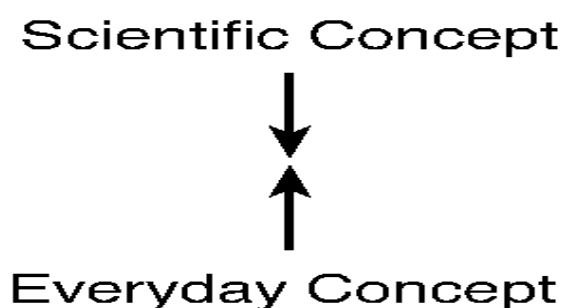


Figure 6.16: The basic Vygotskian view of concept formation.

While this view opened up a tremendously fertile field of inquiry into the interplay between different types of concepts in learning, it did retain and reproduce the basic singular directionality of vertical movement and hierarchy of knowledge. Later works by western scholars such as Nelson (1985, 1995) and Davydov (1990) enriched and expanded Vygotsky’s ideas, but the issue of directionality remained intact.

Engeström (2001, p. 155) asks: how does this image correspond to the data on expansive learning in the boundary crossing change laboratory? In answering this question in this thesis, (while similar patterns were found in the Helsinki study, see figure 6.17 below) concept formation in the CLs started out with the ‘scientific concept’ proposed by management: *HSE/TCI restraint policy*.

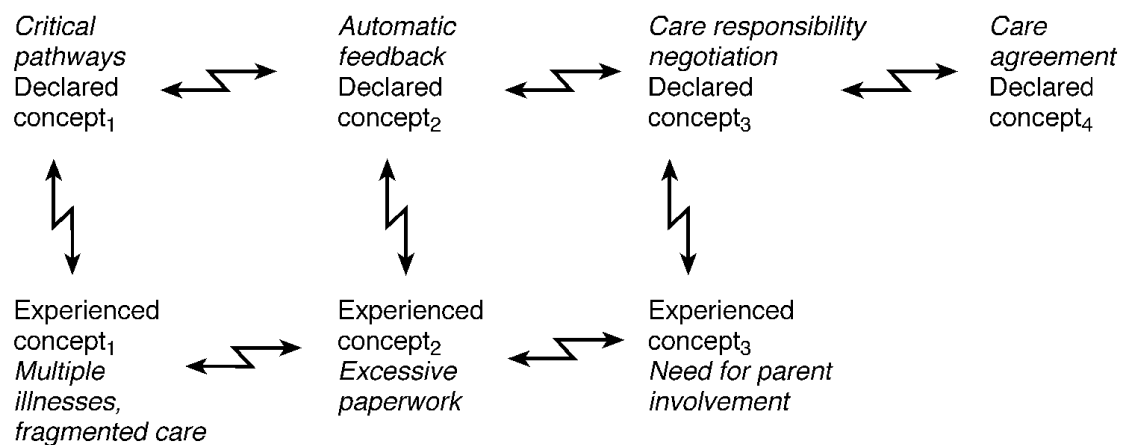


Figure 6.17: Engeström’s study: vertical and horizontal movement in concept formation and learning: care agreement.

As well as the every-day concept of work realised by practitioners, it was further confronted by practitioners discussing the non-use of TCI restraint. Also, they discussed why children in care at present cannot be restrained as they had been in the past due to experiencing traumatic affects of sexual, emotional and physical abuse as well as other medical reasons. The meetings were beneficial in that management/trainers were able to learn at first hand why practitioners/managers were reluctant to use TCI restraint which backed up their request to desist from doing the unnecessary training for it. What followed was a sideways move:

Rather than trying to merge the possibly incompatible worlds of the ‘scientific concept’ of TCI restraint and the everyday experience of addressing children with challenging behaviour, at the CLs the practitioners/manager gave their views together with a series of alternative conceptualisations. This sideways move started with the questioning of the rationale for continuing to do TCI restraint. This attempt at formulating a new deliberate concept was rejected by the poorly

received feedback from senior management when asked on numerous occasions about the possibility of refraining from doing TCI restraint on children.

The proponents of the new idea did not give up. They initiated another sideways move and proposed a new concept: training *responsibility negotiation*, involving all parties. This was met more favourably. The practitioners used their experiences of the need for management/trainer *involvement* (see excerpt 3: Boundary Crossing Change Laboratory 3 above) to elaborate, refine and concretise the concept. This matter was pursued further through the SWM contacting senior management again with a fresh appeal to desist from doing TCI restraint. This led to the initiation of another sideways move proposing a new concept: a PowerPoint presentation show-casing TCI for other professionals including senior management/trainers by explaining the complexity of level three, TCI restraint as a means for addressing aggressive behaviour of children. This led to yet another sideways move: the formulation of the concept of desisting from using TCI restraint and changing the behavioural management policy for this centre. Through their actions of implementing this concept in practice, practitioners have been accumulating experiences to challenge and transform this concept again in new sideways moves, for example by asking for the services of a psychologist for the team on an ongoing basis.

In creating these sideways moves that encouraged learning and development, the CLs were instrumental in providing the forum to allow for these changes to be made. In them, practitioners used their experiences to show how TCI restraint cannot be practised on vulnerable children, for example, those who have been sexually abused. Similarly, if this process was used to highlight any of the other findings from the study in this thesis, it could point to where staff, as discussed in chapter five from their interviews, have been receiving irrelevant CPD training. If this could be debated and discussed in the CLs as indicated in figure 6.18 below, it could eventually result in another sideways move: the formulation of the concept of a new model of training discussed above: *training agreement* that includes the involvement of all practitioners/managers and senior management/trainers. Furthermore, through their actions of implementing this concept in practice, practitioners/managers, management/trainers and parents could accumulate other experiences to challenge and transform this concept again in new sideways moves.

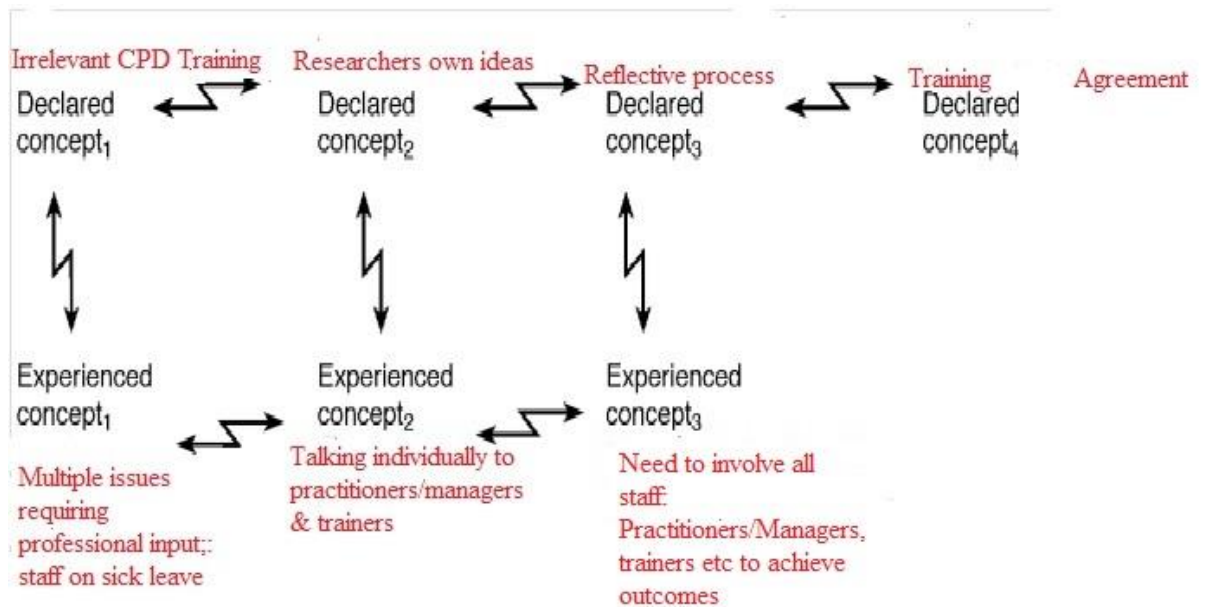


Figure 6.18: Researcher’s study: vertical and horizontal movement in concept formation and learning: Training Agreement.

The care agreement model constructed by healthcare professionals in Helsinki is a good example of steps toward an emerging type of work organisation, referred to as knotworking by Engeström and also by Victor and Boynton’s (1998) which culminates in co-configuration of work practice (both explained in chapter three). It can be argued that the proposed training agreement model for practitioners/managers will provide a new type of work organisation in their work practices which will also result in co-configuration of practitioners work practices. This is discussed further in chapter seven, the concluding chapter of this thesis.

CHAT is both deeply rooted and evolving. As practical theory, it enables rich analysis of complex, changing forms of collaborative human activity (Foot, 2001, p. 56). In discussing CPD, CORU suggest that once a health and social care professional registers, they must ensure their knowledge, skills and performance are of a high quality, up to date and relevant to their practice (CORU, 2014). CORU (2013b) indicates that once the two year transitional period is over and eligible practitioners have registered, the Registration Board will introduce them to a CPD scheme for their profession, specifying how much CPD a professional must do and the evidence they must provide to support this (ibid, p. 12). In their framework document, CORU provides examples of types of CPD activities but acknowledges this is not a list of all activities from which we learn.

While CORU (2014) has established the standard which a registered professional must meet, they claim to have no role in reviewing and/or approving CPD courses or events. The framework document clearly places that responsibility on the

individual professional (i.e. they must identify what their learning needs are and source the most appropriate activity to meet that learning need).

As there is an extensive range of learning opportunities available to Health and Social Care professionals (eg learning achieved through reading research, supervision, team meetings, and reviews) and CPD is not just learning from formal CPD courses, it would be impossible to develop an approved list for each of the twelve professions who will be required to register, of every single CPD activity available. In that case, it can be argued that every individual professionals' understanding of CPD, what it is, how to engage in it and the value they place on identifying their learning needs and striving to meet these will be the most crucial part of CPD requirements for registration.

Therefore, it can be argued that for the future both CORU and practitioners must work together and be dynamic in keeping up with the changes that impact on the CPD training that practitioners are receiving. For practitioners, the ideal way to prepare for this is to engage in knotworking sessions by having regular CLs where they can discuss and debate the current disturbances in their work practice. This will highlight where they can see a need and/or foresee that they will need specific relevant CPD training. In improving and supporting their learning and development, this evidence can be submitted to CORU.

In summary, this is what we did: in linking chapter five and six, we saw that in chapter five the data was collected and presented; this chapter has explored the issues of TCI by getting an overall look at the workplace and then doing the TCI intervention/AT exercise. Moreover, in this thesis there are explicit links between chapters five and seven focusing on the research questions and on how they are answered, whereas chapters three and six centres on activity theory. These connections will be expanded and discussed in much more detail in chapter seven.

CHAPTER SEVEN: DISCUSSION OF FINDINGS

The changes that I'd like to see is that the training should not be given to us by people who have never worked in this job. They haven't a clue how it is or how it works. When we leave that training and come here, we still have to deal with the frustrating situations that we still need help with but are not getting from them. It's useless. I suggest that if one of them trainers or some trainer were to come in here and be here when the trouble arises with the young person and let them observe it". Also, "we are on call in this job all the time. Many nights are spent in the barracks or in casualty but we don't get the on call pay like the doctors or others who do it. We are in here for 50 hours on our two shifts but we only get paid for 36, isn't that some disgrace? We have absolutely no support. Social care workers don't fight, they are all bet down. It's a job you can only do for a short time. I think I'm at the end of mine.

(Practitioner15, a female aged 58, 10 years work experience)

7.1 INTRODUCTION

As expressed in the above quote, the issues of working conditions, CPD and respect are closely linked and cannot be separated. This chapter discusses the research findings from the study. It specifically investigated the issue of CPD training for practitioners working in residential child care centres, in the context of the changing nature of the social care practice sector. I will demonstrate that the findings, together with the issues identified above, can be discussed and transformed by adapting and applying Engeström's Cultural Historical Activity Theory (CHAT), commonly shortened to activity theory (AT). This can be a key step which can help to reconfigure CPD for social care practitioners. Engeström and his teams of researchers have been engaged in the reconstruction and reconfiguration of complex work situations such as in the Helsinki study (Engeström, 1987, 1999a, 2000a, 2000b, 2001, 2006, 2007a, 2007b) which presented similar issues as those highlighted by practitioners in this study in the residential child care centres.

In activating this process, Engeström et al use the concepts of AT, including Change Laboratories (CLs) in which practitioners/managers/trainers and senior management discuss contradictions arising in their centres. In the CLs they use tools such whiteboards to depict the present, past, and future models of their reconfiguration. Also, as shown in chapter six, Engeström uses a care calendar, a care map and a care agreement to help to address the disturbances and contradictions that occur when children have multiple illnesses and move between different care givers in the health centres/hospitals in Helsinki. In this study of residential care centres, these tools could be adapted by practitioners to the events

calendar, training map and training agreement. This thesis argues that, by utilising the aforementioned tools in the CLs, CPD training can be enriched and can offer practitioners more appropriate skills for working by aiding communication, collaboration, competence, professionalism and accountability.

Chapter one, the introductory chapter, highlighted five themes that are explored throughout the study: the changing field of social care practice; changes in the nature of the client group; professionalisation of the workforce; accountability and risk culture; and the greater focus on interagency/inter-professional work. It also explored CPD training. In chapter two, the themes were further explored and developed through a comprehensive review of the relevant literature, including that related to CPD training. This formed a knowledge base from which were devised specific questions for the purpose of conducting 18 semi-structured interviews, so as to explore the themes to a deeper level.

An exploration of the literature discovered the following challenges related to the central themes: de-institutionalisation; aggressive behaviour; professionalisation; accountability; and communication. Results from the interview process and updated data from questionnaires are presented in chapter five; some of the issues raised in these interviews/questionnaires are explored in chapter six, which demonstrates how, following the AT approach, the TCI intervention was constructed in CLs, through engaging in the expansive learning cycle, to address a contradiction in the centre. Chapter six also demonstrated how Engeström's other tools could be adapted (the events calendar, training map and training agreement) and implemented by practitioners to address their contradictions.

As with constructionism, the researcher is aware that constructions in these research findings may not be more or less true, in any absolute sense. The interpretive research paradigm views reality and meaning-making as socially constructed and it holds that people make their own sense of social realities (De Villiers, 2005). Therefore, as researchers we must take great care to record and present verbatim the views and perceptions of individual practitioners as they have been expressed in interviews or in their responses to questionnaires.

I realised that if I utilised Engeström's AT that CPD could be enhanced and could better meet the needs of practitioners. An example of this is shown in the TCI intervention (chapter six) where practitioners moved from a position of resisting to do TCI restraint, to one of amending their behavioural management policy. This structured discussion process identified weaknesses in the CPD training and allowed for further education and development among staff. A key thing I learned from constructing this intervention was that communication and collaboration between practitioners/managers and senior management is best achieved in a face-to-face setting. The questionnaires highlighted this aspect of communication also when practitioners discussed their experiences of having taken part in the CLs.

In the CL everyone is listened to and their voice is heard, which empowers professionals, resulting in a more desirable outcome favoured by all concerned. I also found, as a result of the intervention, a realisation of the inadequacy of the TCI policy; this focused practitioners to think creatively in terms of how to deal with aggressive behaviour. As a result of constructing the intervention, the most important thing that I did was to enable the collaboration of practitioners and managers, trainers and senior management, by bringing them together in the CLs to discuss and debate the TCI contradiction in a structured and theoretically informed way. This had not been done before but, after having experienced this type of participation in the CLs, it helped to change the culture of the organisation in that other groups, for example managers, were coming together as a group for meetings: managers in centres, in after-care, social worker team leaders and the social work managers. These meetings resulted in further positive outcomes.

A review of the literature on the changing field of social care practice outlined how – dating from the nineteenth century - children were cared for in large institutions that were originally managed by religious orders and, later on, by lay people. The ethos of care was based on the medical model. Everything was provided under the one roof, with institutions having their own GPs or professionals there or on call if they were required. Children had little freedom and everything was done for them. Workers in these institutions employed strict regimes that involved structure, routine, boundaries and control. Children were not consulted nor did they have choices. There was little accountability and few audits or inspections. Reports in later years, among others the *Ryan report* (2009), revealed that there was an abuse of power in these institutions which resulted in children being neglected and abused: physically, emotionally and sexually.

In the 1970s, as a result of evidential reports, de-institutionalisation, based on the social model, occurred where children were moved from large residential institutions and cared for in small units or bungalows in communities. This was part of a broader global trend that included foster care for children who were less problematic than those placed in residential child care. When this happened, the nature of the client group changed because, in comparison to the above, strict structures, routines and controls were not part of the new method of caring. New boundaries had to be created: this introduced the concept of choice which was not available in the older institutions. Some children found it difficult to cope with this and they began to act out, which may have contributed to behavioural issues that required safety, welfare and protection precautions to be put in place to help practitioners cope. This was also part of a broad international trend driven by a new focus on the rights of service users.

The government and the health services recognised that, in order to address these changes, professionals needed to have enhanced educational qualifications and training, to equip them to understand the changes including aggressive behaviour

and the reasons behind it. This was indicated in the landmark *Kennedy report* (1970), for example. This was a major contribution and was one of the drivers of professionalisation of the workforce. It introduced standards to be adhered to by professionals in their work practice which initiated the need for more accountability and the emergence of a risk culture. Because professionals were working in small groups in bungalows or units in communities and caring for up to four children, as opposed to larger institutions, they felt isolated. Reports and research showing the need to establish interagency/collaborative working amongst professionals, formed part of a broader push towards ‘joined up’ approaches to provide a more holistic approach to care (Rafferty and Colgan, 2009).

In conjunction with this professionalising of the workforce, the HSE responded by providing mandatory CPD training. This was mainly limited to fire safety training as well as TCI training to help to deal with aggressive behaviour of children/young people. From time to time ad-hoc CPD was also provided, regardless of its relevance for practitioners. Due to changes in the social care sector, in the nature of the client group, in professionalisation and accountability, a new approach for the provision of CPD is now needed to address the complex issues that practitioners are experiencing. This thesis argues that the shift towards this new approach should incorporate and utilise Engeström’s AT.

Engeström’s AT has been in existence and used widely over the past 25 years or more in projects by Engeström and a team of dedicated researchers at the Centre for Research on Activity, Development, and Learning (CRADLE) at the University of Helsinki. Engeström’s healthcare study in Helsinki (1987, 1999a, 2000a, 2000b; 2001, 2006, 2007a, 2007b) has particular relevance for this study and transfers well to the social care sector as it involved, like this study, teams of professionals who identified contradictions in practice. This is an AT term to describe inadequacies in practice, referred to in AT terms as *objects* in their work in practice (described in detail in chapter three). In challenging and aiming to change their work practice, in Engeström’s study, practitioners reconstructed and reconfigured their work situation by using tools and creating interventions to enable them to provide a better service to children with chronic illnesses. Similarly, in this study, practitioners worked together to address one contradiction (the TCI intervention) through reconstructing and reconfiguring their work situation, by using tools that helped them to provide a better service to children/young people in their centre.

As described in chapter three, AT uses the methodology of Developmental Work Research (DWR) which comprises CLs: structured spaces for practitioners, their managers, trainers and senior management to meet at a designated time and date over a period of time. If other professionals are involved, these are referred to in AT terms as Boundary Crossing CLs. In the CLs practitioners (subjects) engage in knotworking sessions: an AT term to describe how they can debate and discuss

their contradictions while incorporating the rules and views of the community, in their activity system. This process provides a forum for practitioners to advance CPD with management (employers) and with the wider community of practice; an avenue to discuss and address challenges that may be presented by all subjects.

Knotworking continues until co-configuration is reached, whereby a transformation is made and the learning is expanded through the cycle of expansive learning. This is similar to action research, which can be described as action science or participatory action research, commonly used for improving conditions in work practices (Koshy et al, 2011 p. 1; Shirley and Gelling 2013, pp. 6-7). All are similar in that groups of practitioners examine their own practices in order to make improvements and transformations. Action/participatory research is about trying to understand professional action from the inside: research carried out by practitioners on their own practice (Carr and Kemmis, 1986).

As stated by Zeichner (1993, p. 200-201), 'there are many different cultures of action research and it seems to me that much of time and energy is wasted in arguing over who are the 'real' action researchers and who are the imposters'. With DWR, professional researchers are first invited into the practice. They always use the same AT model which can include input from practitioners who are present and can include interview data and usually videos of participants at work. These are utilised to generate data for discussion in the CLs where they employ activity theory to examine disturbances and contradictions (Helle, 2000) that can be transformed and a new object generated.

CLs use dual stimulation (described in chapter three, section 3.7, p. 114), where practitioners are given tools that can include boards and flipcharts to record the present, past and future model for reconstructing a contradiction. Interview/video material can be used as a starting point for discussion. This process is aided by Engeström's five principles: two or more activity systems are collectively taken as the prime unit of analysis; activity systems emphasise the multiple voices of participants to accommodate different views, traditions and interests; historicity is used to reflect evolution over lengthy periods of time; the central role of contradictions used as sources of change and development and the possibility of expansive transformation in activity systems.

The four questions are: who are the subjects of learning; why do they learn; what do they learn; how do they learn? CLs can comprise up to 12 professionals/representatives of groups and can last from three to 12 months. In the CLs, practitioners progress through the seven stages of the cycle of expansive learning. In stage one, based on current contradictions in their practice, they ask questions about how to reconfigure the object. Then they work through the remaining stages, remodelling and reflecting on the object, until they reach consolidation of the new model by agreeing on outcomes that they have discussed and debated

(knotworked) until agreement (co-configuration) is reached, which can culminate in a transformation of the object.

I found, through exploring the challenges emanating from the five themes: de-institutionalisation, aggressive behaviour, professionalisation, accountability and communication, that practitioners' CPD training lacks an holistic approach. I adapted Engeström's CHAT as he and his teams of researchers have reconstructed and reconfigured complex work practices where there were tensions in practice. Engeström does not ignore tensions; he brings them into the open in the CLs and encourages practitioners to tease them out by knotworking until coconfiguration is reached. This is what is needed. If this does not occur it can be argued that practitioners will not feel as if they are being valued. In the questionnaire study, participants were asked if they thought the CLs had changed anything (chapter six). They replied that as they had been listened to they felt valued.

Furthermore, if there is a lack of consultation and poor leadership, there may be an absence of 'clear vision' resulting in views not being listened or responded to. Engeström's work has resonance with this study because of the many changes and pressures for practitioners that have occurred in the complex and dynamic context of social care practice. In employing Engeström's approach, I convened CLs in which I constructed the TCI intervention, which proved that open communication between practitioners/managers, trainers and senior management, can enrich CPD training. Also, in chapter six, I demonstrated how Engeström's other tools could be utilised by practitioners in the CLs: the *care calendar* was adapted to the events calendar for this study, the *care map* adapted to the training map and the *care agreement* adapted to the training agreement. Chapter six explored how these tools worked well and were useful and could be adapted by practitioners/managers to create change in their centres.

In summary, the five themes introduced in chapter one and studied in more detail in chapter two, have been running throughout the study. Activity theory (AT) was introduced and described in full in chapter three. The methodology of the thesis was explored in chapter four while the results of the semi-structured interviews/follow-up questionnaires were discussed in chapter five. Chapter six saw the application of AT to the findings. So far, I have brought a body of knowledge concerning social care practitioners to the fore, which has not been brought before. This provides a new lens for looking at CPD in particular which, in conjunction with the above, has been brought together in a new way. The chapter moves now to re-introduce the research questions and revisit the themes while showing how the AT approach is useful and can be adapted and utilised to reconfigure CPD.

7.2 RESEARCH QUESTIONS

The *central question* for this study is as follows:

How should the CPD training that social care practitioners receive, be reconfigured?

The five *associated* questions are:

1. How is the work in the social care sector in Ireland changing?
2. What type of CPD training is delivered to social care practitioners in Ireland?
3. What aspects of CPD training are most useful to meet the needs of social care practitioners?
4. How can CPD training be reconfigured to respond appropriately to changing contexts and cultures of professional practice?
5. What has been the impact of relevant developments in CPD?

Before discussing the findings in detail in relation to themes I will briefly recap on the research questions and what the thesis shows in the responses to them.

7.2.1 Findings from the research questions

Q1. How is the work in the social care sector in Ireland changing?

Work in social care was highlighted in chapter one and comprehensively explored in chapter two. The trends identified were reinforced with material from participants' semi-structured interviews and response to the questionnaires where they highlighted changes in their work practice and in the social care sector. Findings to this research question from the social work (allied profession of social care practitioners) literature are similar in that the work practice of social workers, like social care workers has changed considerably over the past decade. Professionals in both professions now have more documents, policies and procedures to contend with. As noted by O'Connell (2014, p.51) in her study of the social work profession: 'Overall, all of the participants noted the complexities involved in negotiating the changes in practice necessitated by the implementation of new guidance documents, policies/procedures'. As highlighted in chapters one and two, these changes in work practice are in line with international trends and in keeping with legislation, changes in the nature of their work practice, changes in relation to the client groups they are working with, professionalisation, accountability, and interagency working for the social care profession. The social work profession is longer in existence than the social care profession (1970s).

Q2. What type of CPD training is delivered to social care practitioners in Ireland?

The thesis explored the type of CPD delivered to the participants. This was reflected in what was found in the two other studies, in Byrne's (2014) study with social care practitioners and Halton's (2011) study with social workers. All three studies reported (see p. 293) that supervision was the main form of CPD practiced, with Halton reporting that 86% of participants received some form of professional supervision; Byrne's study showed that 69% of participants engaged in supervision and in this study 99% engaged in supervision. What was different about this was that in Halton's study 'a surprisingly high proportion of respondents (41 per cent) had completed, or was currently undertaking, post-qualification higher education courses' (Halton et al, 2014b, p. 67).

Q.3 What aspects of CPD training are the most useful to meet the needs of social care practitioners?

The findings to this research question were similar to the two other studies i.e. Byrne's (2014) study with social care practitioners and Halton's (2011) study with social workers. In Halton et al (2014, p. 68) she noted that participants 'highlighted the need for changes to include better education, qualifications and relevant CPD training'. Byrne (2014) found that further training/education is most desired by practitioners in mental health, challenging behaviour, stress management and alcohol/drugs (p. 5) CPD needs were further clarified when respondents were asked to identify critical issues at work. These included challenging behaviour, self-harm and suicide ideation. In this study practitioners' said further education/training to include proper communication training was needed so as to set the foundations for accountability and transparency on all levels in the centre both for/with young people, with staff and for compliance with inspections. Building relationships was cited as important when working with young people as was the importance of dealing with young people presenting with aggressive behaviours amongst other issues. Many interviewees mentioned the need to have another form of training to complement the therapeutic aspects of TCI training.

4 How can CPD training be reconfigured to respond appropriately to changing contexts and cultures of professional practice?

The findings to this research question were similar to the findings in the Helsinki study which was outlined at the end of chapter one. In utilising Cultural Historical Activity Theory (CHAT) which incorporates the change laboratories (CLs) and the various AT tools employed by Engeström and his team of researchers they successfully reconfigured and changed work practices in the health sector in Helsinki. The importance of AT is that it prioritises a bottom-up local approach, mentioned, for example, on pp.17, 19, 21, 58, 234, 250, 299, 328, 332, 356, 359

and 362, where the practitioners themselves are part of the decisions taken to reach an outcome for their contradictions. The difference between the Helsinki study and this study was that it was a large scale study, the TCI intervention in this study was small scale in comparison.

Q.5. What has been the impact of relevant developments in CPD?

In comparing findings to this research question from the studies examined in this thesis there are varying responses. Firstly, Social workers in Ireland were the first profession to be registered with CORU. As discussed in chapter two social workers now have their competency framework and are engaging in the CORU processes and have been since 2013. Social care practitioners are still awaiting CORU registration. On p. 50 above five studies exploring the effectiveness of CPD were reviewed involving the dental profession (Eaton, et al, 2011); hospital consultants (Schostak et al, 2010); nurses (Joyce and Cowman, 2007); occupational therapists (Penny, 2005) and with teachers (Cordingley, et al, 2003). There were various responses to the effectiveness of using CPD. The largest study by (Eaton et al, 2011) found there was no direct links with quality of care delivered, performance, professional standards, competence, public satisfaction or safety (p. 37) when engaging in CPD. The only study reporting positive results was Cordingley et al (2003) who found positive outcomes linked to sustained and collaborative CPD for teachers.

The remainder of this chapter discusses the findings in detail and expands on the five questions. In doing so I have revisited the five themes from the literature review: the changing field of social care practice, changes in the nature of the client group, professionalisation of the workforce, accountability/risk culture and interagency/inter-professional collaboration, in terms of knowledge constructed through the interviews/ questionnaires and application of the CLs.

7.3 THEMES

1. The changing field of social care practice

This theme highlighted that the field is continuously changing; practice has changed from caring for children/young people in larger institutions at the start of the 20th century to de-institutionalisation, where children are now cared for in bungalow-style houses modelled on family homes, in local communities. The driving force behind changes in social care practice since the 1970s in Ireland has been the State, in response to various reports. There have also been international influences, coupled with contributions from professional organisations, including, most recently Social Care Ireland (SCI), which itself has developed and evolved (Lyons, 2014, pp. 24-37). Education too has contributed greatly. Share and Lalor, (2009, p. 6) argue that a quality service encompasses an educated and fully-

trained workforce with specialities in aspects of care. Third level institutions, in collaboration with other stakeholders, have been at the forefront in providing education, research, training and development to students and practitioners, though there has been little involvement of the Higher Education sector in CPD.

As indicated through responses from the interviews on the changes in their social care practice, participants' perspectives added to the knowledge from the literature review. This was complemented by follow-up questionnaires. Practitioners affirmed that they were experiencing a severe lack of resources, a shortage of staff and were mostly only receiving mandatory and minimal CPD training. Follow-up questionnaires have shown that practitioners are subsequently receiving additional training (detailed in chapter five). Data from the interviews indicated that resources were inadequate; the HSE did not listen to their staff, but instead provided whatever training was available and did not ask for feedback.

Data from questionnaires has confirmed that resources remain inadequate; practitioners cited a continuous lack of external support, especially needed but not provided for the changeover from HSE to Tusla, the new Child and Family Agency. In interviews practitioners had argued that the opinions of staff members needed to be ascertained regarding training needed in each centre, prior to the HSE proposing it. In the questionnaires, practitioners were asked about their thoughts regarding the current state of their CPD, if it was top-down and how they saw their role in it. Five out of six participants said it is still top-down and, while they are sometimes asked about training they would like, they may not get it but are told about what is coming down the line for them. As discussed above, because of the mis-match between the CPD offered and the substantial challenges that have emerged across the contemporary social care sector, a reconfiguration of CPD for the future is necessary.

The research established that CPD needed to be addressed. In order to do this I had to firstly understand CPD by exploring the positives and negatives. This confirmed that a reputable theory needed to be identified and employed to address the complexities in centres and to reconfigure CPD for the future. I chose Engeström's AT because of its relevance and success in reconstructing and reconfiguring work practices. In particular the descriptions of CLs that included DWR appealed to me as they showed how to explore cultural historical changes in workplaces while incorporating material artefacts/tools to make transformations in the practice. They allow for the inclusion of participants from outside the activity system in boundary crossing CLs, so that, for example, gardaí, teachers or probation officers can be invited to participate in the CL. Children/young people (where appropriate) and their families can also be included.

As chapter six displays, using DWR/action research in this study worked well: practitioners engaged in the enquiry by collectively naming and highlighting their

issues around using TCI restraint, a key issue that surfaced many times in practitioners' interviews. Practitioners learned from each other and took ownership of their issue, persisting with it until they gained recognition and change which improved conditions in their work practice. Practitioners in Engeström's study also used video material as well as interview data. Use of video was not feasible in this study due to the nature of the work, coupled with time, resources and financial constraints. I was the only researcher conducting the study; Engeström and his teams of researchers are well funded when asked to reconfigure work practices in their many projects.

The CLs had a tangible impact on management and communication processes in the centre studied. They revealed the interplays between staff, including rivalries between staff and management, and that practitioners were not antagonistic but eager to meet and liaise with colleagues from the outside to procure better outcomes for the centre. Up until then written requests had been made but face-to-face meetings had not readily occurred. The CLs set the tone for what was to follow. From researching Engeström's work (2001) it was evident that before introducing CHAT similar trends existed in the Helsinki site. There was a clear lack of communication and interaction between staff in the hospital and in the community clinics that led to feelings of being unheard by staff and parents of the children. Similarly, in employing Engeström's AT for the reconfiguration of CPD training, I can concur that these feelings also exist among practitioners. The CLs created clear communication and increased participation and interest among staff.

As mentioned above, in the questionnaires participants were asked about their views and recollections of the CLs. They responded that the CLs had improved communication on different levels, including amongst themselves and with other professionals and between them and management. They claimed that because communication was opened up they felt more at ease with management and more able to put their ideas and thoughts forward, because they knew this was the space where everyone was valued and everyone had a voice.

2. Changes in the nature of the client group

Based on data from the interviews, challenges highlighted included caring for children/young people placed in care who have been abused, who are self-harming, discussing suicide ideation and who are abusing alcohol/drugs. It became evident that in trying to address these issues, practitioners' challenges were compounded by a lack of staff and resources as well as deficiencies in their CPD training, as explained by practitioner9 who said: 'kids come in at 2am in the morning, full of drink and possibly drugs, and staff don't know what they have consumed and don't know what to do with them as we have not had any specific training in this area'. Another challenge is the stress involved in the nature of the work, spending up to 25hrs at a time in the company of children/young people.

Depending on the young people in residence at any given time, the work can sometimes be dangerous if aggressive challenging behaviour is not controlled.

Participants' interviews backed up the knowledge garnered in the review; they emphasised the need to address challenging aggressive behaviour. All participants reported that this was an ongoing issue. Questionnaire participants said that their work is still challenging. Acknowledging that their current CPD is only partially beneficial and effective, practitioners stressed that the only recourse they had for addressing such behaviour was TCI. TCI is in many ways symbolic of residential care and embodies a lot of the tensions, but practitioners gave many valid reasons why they were/are not satisfied with employing TCI physical restraints. Their main concern was that when they previously did restraints on young people they found it was not successful and from then on had desisted using them. Practitioner4, said: 'TCI is no good; it does not equip you to deal with stuff that crops up on a daily basis in a children's centre' While practitioners had repeatedly voiced their views and contacted senior management asking to desist from using TCI restraint in their practice and from being tested in physical restraint techniques, they had been unsuccessful in this.

The focus of the CL intervention was to address these concerns. The CLs demonstrated that when practitioners are given a voice to express their views they can collectively work out solutions and make transformations to resolve issues. At first it seemed a daunting idea, inviting management to come into the space of practitioners, with practitioner 5 saying: 'I can't believe it, that they came here to discuss that with us, wow!' Also the CL showed that there has to be a bottom-up as well as a top-down approach to development and learning where management as well as practitioners can learn from listening to each other. Questionnaire participants said they benefited from the CL forum, which enabled them to voice their opinions and listen respectfully to each other. In the CLs, CPD for practitioners will address the challenging demands of the client group, by identifying issues and putting actions in place to address them at ground level.

3. Professionalisation of the workforce

The discussion on professionalisation identified a number of key issues for practitioners including CPD, educational qualifications, lifelong learning, competencies, reflective practice and professional supervision. All these issues are grounded in the issue of imminent registration. The key challenge presented in the literature was that professionalisation is putting pressure on practitioners. For example, the pressure to be a new type of professional, ready to respond to demands, including the pressures of accountability and performativity which can include addressing and partaking in audits and inspections from HIQA. On the other hand, students leaving colleges are now learning about professionalisation, including knowing about how to reflect on their practice. Processes of reflection

have become a key element of social care practitioners' education. For experienced practitioners, new demands will be manifest in a new professional identity/task that will become apparent with the introduction of registration.

Knowledge established on this theme in the literature review was strongly backed up in practitioners' interviews, when they engaged in dialogues about professional aspects of their work. Practitioners recognised that they do not have a competency framework; their lifelong learning is limited (while the questionnaires pointed to improvements in training, one long serving practitioner said she was still awaiting training in IT, to use the computer); they were not satisfied with their professional supervision (questionnaire participants did not comment about their supervision, which suggested they were satisfied with it) and, while most participants were aware of reflective practice (questionnaire participants did not comment either about reflection/reflective practice), only two engaged in personal reflection. They summarised their views on this by saying that while they did it personally, it was not common practice; reflection was mainly done as part of a team at handovers and at weekly team meetings.

During dialogues in the CLs at the time of the TCI intervention, the researcher tried to encourage personal reflection by recommending the idea of using a daily reflective journal. From the questionnaire study, it was evident that this idea was not part of their practice yet; some practitioners were aware of the requirement of CORU's CPD portfolio. There is now a new focus and a lot of talk about reflecting and reflection in social care practice and the understanding that in order to move forward in practice, one has to examine the present by identifying positives and negatives and learning from them. Reflection is done at two levels: personal and practice levels. The research established that time needs to be given to the process and it needs to be ongoing and continuous. CLs provide the ideal forum for practitioners to learn about and practice reflection.

4. Accountability and risk culture

The literature review explored ethics in work, the roles of key regulating bodies such as CORU and HIQA, professional benchmarking and bureaucracy. A key question was the issue of addressing the 'paper trail' that has resulted from the need to be more accountable in work practices. Adding to this was the number of reports published and, more specifically, the impact of these reports on professional practice. O'Brien (2013b) refers to 29 reports into child abuse in Ireland which have outlined failures in the system. Publication of such reports has put the spotlight on social workers and associated professionals such as social care practitioners, resulting in them being the subject of much public commentary and critique (Halton et al, 2014b, p. 97) and, presumably, also to changes in behaviour, specifically as regards increased accountability.

For HIQA (2013a, p. 18), the key regulatory body, ‘inevitably, preventing and managing risk-taking and other challenging behaviour remains an issue’ and, for practitioners, this means more bureaucracy and a lot of paperwork. A lack of staff and resources adds to the tension for practitioners and causes stress for them while trying to reconcile the two where they see areas where they need more training and development. In October 2013, Noel Howard, while being interviewed regarding a HIQA inspection at Rath na nÓg, a high support unit, alluded to this point by saying ‘the Irish Association of Social Care Workers has asked that HIQA, in addition to highlighting the problems uncovered in inspections, should elaborate on how those problems could be addressed’.

It could be argued that a way to reduce bureaucracy would be to computerise everything, but evidence from mishaps involving PULSE (Garda computer system) discussed by Sheehan (2014) would question if this would be the right approach; the issues related to accountability and risk remain salient. The interviews showed that the paper trail/accountability issue was taxing for staff; all participants recognised the challenge of dealing with it; the three managers agreed that it was challenging trying to balance the needs of young people and staff as well as managing the centres and coping with the vast amounts of paperwork, within the constraints of a lack of staff and resources. Questionnaire participants commented that now, more than ever before, they are being asked to comply with documentation coming downstream from the national Tusla office as part of the national reconfiguration of residential child care centres. They said they were not being given any extra supports for complying with these new demands.

5. Interagency/Inter-professional/Collaborative work

This final theme examined communication, relational agency and technology culture. The key tensions concerned how to address various aspects relating to communication. For example, issues around who staff work with and on what basis; time and pressure; and staff going off on maternity or annual leave or retiring and not being replaced due to the HSE staffing embargo and cutbacks. In the questionnaires this was a big issue for staff as they commented on dissatisfaction with the rota; more computer work and form filling and the possible introduction of 12 hour and live night shifts. While the review pointed to the benefits of technology, many pressures remain for practitioners due to new demands placed on them, requiring changes based on actions from HIQA inspections and audits and, as revealed in the questionnaires: more paperwork. These are compounded by a lack of staff that prohibits collaborative work practice. All these changes in the residential child care field have opened up gaps requiring practitioners to have relevant CPD training.

The interviews saw practitioners highlight the lack of communication throughout their practice. Questionnaires suggested that while communication can still be an

issue, they also commented on the improved communication that resulted from the CLs which, they said, also benefited children/young people and staff alike. Practitioners asserted that communication is an important element of their work. Three participants (practitioner 1, 7, 14 and manager 2) summarised that while they are satisfied with TCI, other communication training is needed to be added to it to make it more effective in building relationships and addressing behavioural difficulties of young people. Another aspect of communication was alluded to by Manager1 who said: 'I feel alone and isolated here, being the only manager in this area; communication is an important element for all social care professionals'.

As outlined in chapter six, the CLs provided an ideal forum for communication to be opened up in new and different ways, such as providing time and a space that allowed practitioners, management and trainers to have a voice and be listened to. This comment was reiterated by the questionnaire participants. Respect was given to their multi-voiced, diverse views on the object in question: TCI restraint. Through applying dual stimulation, participants were guided through the seven stages of the cycle of expansive learning, adapted from Engeström's AT, whereby they questioned, debated, assimilated, analysed and reflected as they worked through the cycle that culminated in transforming the object.

Consolidation of the change that transformed their practice was achieved when management finally listened to staff and allowed them to change their behavioural management policy. Again questionnaire participants were vocal in their praise of the CLs which helped them to change how they did TCI and gave them a voice and courage to make changes that led to them feeling empowered in their practice. This permitted them to desist from continuing to engage in TCI restraint with young people in order to curtail and reduce aggressive behaviour. When commenting on the usefulness of CLs, the team leader said: 'we actually need time like this; we are always discussing the children; it is good to reflect and analyse our own situation as workers for a change'. These comments were updated in the questionnaires with P1 saying: 'It was good to have a meeting where the talk was about issues affecting us as staff and not talking about the young people like at supervision and team meetings'. Because of the small group, everyone was involved in the CLs and practitioners welcomed the idea that they all had a chance to express their views about their work while being listened to by colleagues, management and trainers. While the purpose of the CLs in this study was to focus on the TCI intervention, they also highlighted other issues such as efficacy and power. Questionnaire participants acknowledged their feelings of openness in communication with management and others which led to empowerment in addressing issues in their practice.

In summary, the experience of the TCI intervention has shown practitioners that CLs are an ideal forum to address challenges that impact on practitioners as a result of de-institutionalisation, aggressive behaviour, professionalisation, the

paper trail and issues surrounding communication: all of which will require relevant CPD. Questionnaire data showed that practitioners had positive recollections of their participation and outcomes from the CLs. The next section discusses how the reconfiguration of CPD can be achieved.

7.4 WHERE TO NOW – RECONFIGURING CPD

In discussing CPD, Halton (2014a) suggests that it involves process and outcomes and balancing tensions; there is no ‘one’ or ‘right’ way of ‘doing’ CPD. Rather, there is an opportunity for individuals and centres to tailor training to their own particular diverse needs, to enable them to address various contradictions in their activity systems. Also, as we saw in chapter two, CORU is the body responsible for regulating health and social care professions. It comprises the Health and Social Care Professional Council (the Council), established in 2007, and the 12 registration boards established under the Health and Social Care Professionals Act, 2005 (as amended) (the Act). CORU’s role is to protect the public by promoting high standards of professional conduct, professional education, training and competence amongst the twelve professions (CORU, 2013b, p. 9).

From the questionnaires, it was evident that as of yet practitioners have not began to engage with CORU with five of the six participants saying they know very little about the body; only one participant had attended a CORU information session. Halton (2014a) states that ‘the learning outcomes of CPD are influenced by: professional and organisational context; individual learning needs and objectives; learning styles and preferences and programme content and style of delivery’. Also, external, political and accountability issues come into play such as audit requirements. So far this thesis has shown how CPD was organised (or not organised) in the three centres and it reflects a lot about the nature of the work and organisation of those centres.

Halton et al, (2014b, pp. 39-71) report on findings of a 2010/11 study on CPD conducted by Halton with social workers in Ireland. Chapter two of this thesis cites Byrne’s (2014) report on CPD of social care practitioners in Ireland. Among other issues, these studies highlight the barriers to participation in CPD training. Table 7.1 shows results from Halton’s and Byrne’s studies that echo the findings from this study.

Although the social work profession is much longer in existence than the social care profession, similar issues affecting the two were discussed in the three studies. For example: work practice, education, supervision and reflective practice. Halton revealed that 86% of participants received some form of professional supervision; Byrne’s study showed that 69% of participants engaged in supervision. All participants except one in this study availed of professional supervision, making supervision the most popular form of CPD undertaken both by social workers and social care practitioners/managers. It is interesting that

supervision has now been re-defined as CPD, as opposed to part of the everyday practice of practitioners/managers.

Byrne's Study	Halton's Study	Thesis Study
63% identified cost/resources as a barrier	Lack of funding; cost of programmes	Lack of staff/funding/resources
Workload, time to engage in CPD activities, lack of information about activities	Workload and time constraints	Stress/pressure at work to maintain timely schedules
80% engaged in CPD activities relevant to their role, which was not necessarily supported through their organisation	Insufficient management recognition/support for CPD	Management not promoting relevant new innovative CPD
Staff made their own arrangements to get CPD	Not available at convenient locations	Staff sometimes need to travel long distances to attend relevant CPD
CPD was done in their own personal time away from work	Not available at convenient time	Some CPD put on during holiday times, e.g. during summer months when staff are on annual leave
Organisational support recognised as a barrier to CPD	Lack of incentive to undertake CPD	Motivation to undertake CPD is not encouraged by management
Post-qualifying qualifications not recognised by management	Lack of recognition for career development	Masters degrees and/or other courses not recognised/supported

Table 7.1: Main barriers to CPD participation

It is significant that the results of Byrne's study, also involving social care practitioners, are similar to the findings from this study. Also, significant is that Halton's study results are similar to the findings from this study given that it involved responses from 282 social workers from all over Ireland who took part in the online survey, as well as the 16 who took part in face-to-face interviews and the four who took part in the focus group (Halton et al, 2014b pp. 42-44). The work of child protection/foster care social workers can be similar in some ways to practitioners. Most especially, the focus of their work is on children/young people who are in care, on their care plan and managing and reviewing their placements. While there are differences, social workers and practitioners alike can have concerns about suitable placements for children/young people and around issues concerning collaborative working of multi-disciplinary teams.

Similar to the other two studies, interviewees/questionnaire participants in this study commented on a lack of funding and resources including workloads and time constraints; they alluded to not being supported and that they were not listened to by senior management and their voice was not heard. In their interviews, issues surrounding convenient times and locations for CPD also surfaced, with participants saying they did not want to go to training that was scheduled during the summer months. Manager1 said she ‘would have to travel long distances if she were to avail of management training offered to her and she was not prepared to do this’.

Participants discussed the lack of incentives to ask for CPD training, mentioning that the only training offered to them, and then not to everyone, was mandatory TCI training and they were bored with this. They called for more innovative relevant training to address their challenging needs of working with children/young people. The questionnaire data has shown that this has since been addressed. It can be argued that there was a significant disconnect between the work and CPD. Questionnaire participants now have new concerns (new objects in their activity systems) as they express dissatisfaction with the new changes involved in moving from the HSE to Tusla, as well as the many issues of impending concerns regarding the national reconfiguration of residential child care centres. A different finding in Halton’s study was that: ‘a surprisingly high proportion of respondents (41 per cent) had completed, or was currently undertaking, post-qualification higher education courses’ (Halton et al, 2014b, p. 67). This is a positive finding as there was little mention in this study of post-qualification education, but this is an issue to be highlighted when practitioners register with CORU and have a competency-based framework for their work practice. In response to this potential demand, HEIs operating in the social care field will need to make relevant PQ and other CPD opportunities available.

In this study, in citing the lack of recognition for career development, participants complained about the lack of relevant CPD offered to them. Interviewed practitioners mentioned that a small number of colleagues had completed masters degrees or other courses pertaining to work, having paid for them themselves, but were not recognised, nor did such additional qualifications (as is the case for teachers) lead to monetary or other recognition in their current posts. In the questionnaires, practitioners commented on their being no motivation for further CORU CPD training as there was still no promotion or advancement in their careers and expressed dissatisfaction with engaging with CORU when their educational achievements have not been recognised financially or otherwise. Furthermore CORU wants them to pay for initial registration and thereafter. Although social workers in Halton’s study were availing of post-qualification courses, Halton et al (2014b) comments and the researcher agrees that ‘there appeared to be little sense of shared vision for CPD, among management, leading to inconsistencies across different services’ (p. 81).

With the imminent registration of social care practitioners, it will be incumbent on the profession to incorporate CPD into its professional domain. Comments from questionnaire participants showed they are not enthused by the prospects of CORU's introduction of formal CPD. Halton et al (2014b, p. vi) state that 'social work like many other professions (law, medicine, teaching, nursing, etc) is in the process of incorporating CPD into its professional domain'. Questions they ask:

HALTON'S CPD QUESTIONS FOR SOCIAL WORKERS

- What exactly is CPD?
- How is it impacting on social workers' practice?
- Can it be made more relevant to social workers' professional lives?
- Who benefits?
- In an era when deprofessionalisation threatens social workers' role and task, does CPD help to put professionalisation back into social work?
- Or, is CPD simply a management tool to promote proceduralism and uniformity in social work practice – globally, in the age of austerity?
- Can social workers utilise the reflective space offered by CPD to redefine themselves in challenging times?
- In a knowledge society, is CPD the key to social work's future? Will CPD help social work practitioners remain relevant to the needs of service users?

Figure 7.1: CPD questions for social workers

Halton et al (2014b, p. vi) further note that while a substantial international literature has emerged on CPD over several decades, precious little research attention has been paid to what social workers want from CPD and what they think about it. Furthermore, they note that while the literature often leads those interested or involved in CPD to assert that 'we know what it is', much of the knowledge is speculative, at best. Questionnaire participants commented that they were not consulted about CORU CPD prior to proposed CPD changes that will impact them in their practice. Halton et al ask a set of questions about who engages in CPD and what they get out of it. In addition they refer, among other topics, to international debates about social work education, before seeking to provide conclusions that relate to the challenging times that people live in; that provide the context in which social workers practice; while also attempting to map the futurescapes of social work practice.

The futurescapes of social care practitioners' practice are also being mapped at present: the Irish Association of Social Care Workers (IASCW) in conjunction with Colleges and Institutes of Technology has facilitated a seminar: *Enhancing Skills to Engage in Continuing Professional Development* (SCI, 2014). CORU, at

time of writing, is hosting briefing talks across the country for social care practitioners informing them about statutory registration. Only one practitioner who took part in the questionnaire study had attended a CORU information session. The Irish Association of Social Workers (IASW) is much more advanced as regards CPD for their profession, the first to be registered with CORU. In light of this CORU has proposed a CPD policy/framework.

7.4.1 CORU CPD Policy/Framework

There are four stages in the CORU CPD process, with reflection integral to each:

1. Review
2. Plan
3. Implement
4. Demonstrate (planned and unplanned activities) (CORU, 2013b, p. 13).

Each stage is briefly explained as follows:

7.4.1.1 Review

The CORU Code of Professional Conduct and Ethics states that: ‘each registrant must ensure that their knowledge, skills and performance are of a high quality, up to date and relevant to the registrant’s practice’ (CORU, 2013b, p. 15).

In light of this, the first stage of the CPD process requires the registrant to carry out a self-directed review of their knowledge, skills, performance and professional qualities in the context of their professional role, mindful of current and future practice. The outcome is the identification, by the registrant, of their personal and professional learning needs and the identification of learning outcomes (what do I want to know or be able to do when I have completed the learning activity?) for each learning need. Registrants can prioritise their learning needs so that particular needs can be addressed within the current CPD cycle and others may be put on a longer timescale. The needs, outcomes and prioritisation will be recorded in the registrant’s Personal Learning Plan (PLP).

7.4.1.2 Plan

The planning stage requires the registrant to identify learning activities that will address the learning needs and learning outcomes identified at Stage 1. The planning stage can be carried out on one’s own or in consultation with an employer, manager, supervisor or colleagues and should result in the development of a PLP (CORU, 2013b, p. 36). The PLP template includes the following headings: learning need; learning outcome; priority; appropriate learning activity and timeframe. A wide range of learning activities is recognised for the purpose of CPD; CORU provides a list of these (CORU, 2013b, pp. 29-32).

7.4.1.3 Implement

This is the stage where the registrant puts the PLP into action. Registrants must complete 60 CPD credits during each 24-month cycle. It is the responsibility of the individual registrant to allocate CPD credits to each learning activity: generally, one hour of CPD learning activity is equal to one CPD credit. This is a very individualistic approach to CPD in contrast to the collective approach through the CLs/AT. The key point when allocating credits is to allocate credits on the basis of 'new' learning as CPD is about enhancing knowledge, skills and professional qualities. The allocation of CPD credits should be supported by evidence that is included in the CPD portfolio.

Examples of supporting documentation include: journal reference with relevant personal note/reflection; confirmation of meeting attendance and role from a senior officer along with a reflection of the learning gained from participation on the committee; a certificate of attendance at the training course along with course programme and a short reflection on 'new' learning gained. The evidence should enable the assessors to validate the allocation of credits to each activity. Examples of appropriate supporting documentation for a range of CPD activities are provided (CORU, 2013b, pp. 29-32) together with an example of a form and a list of supporting documentation used for each activity (ibid, p. 41).

7.4.1.4 Demonstrate

The fourth stage in the CPD process is where the registrant provides evidence to demonstrate how they have met the CPD requirements. The evidence is presented in the form of a CPD portfolio. The CPD portfolio is a structured presentation of evidence of engagement with the CPD process and must contain:

1. Professional role and practice setting (maximum 500 words) (p. 35)
2. Personal learning plan (p. 36)
3. Record of CPD activities (planned and unplanned) (p. 37)
4. Reflections on eight different learning activities (pp. 39-40)
5. Evidence of CPD learning activities (pp. 29-32).

7.4.1.5 Reflective Practice

As mentioned, reflection is integral to each of the above stages and is one of the defining characteristics of professional practice. CORU suggests that a registrant can be guided in the reflective process by questions such as:

- What new knowledge, skills or insights did I gain from this activity?
- Did the learning activity address the need it was designed to?
- What are the benefits for my service users following this CPD activity?

- How has my practice changed as a result of the learning activity?
- Has this activity highlighted any areas for further development?

Reflection on CPD activities is designed to increase the learning gained from the activity or experience. The questions encourage the registrant to identify the positives, the impact on one's practice and to identify further learning needs. If a registrant is selected for audit they will be required to include in their CPD portfolio reflections on eight different learning activities that they have undertaken. This number is deemed to be sufficient to demonstrate to the assessors that the registrant is engaging in the process of reflection. It is notable that this is a very individualised approach to CPD that misses completely the collective aspect nurtured by the AT approach.

Social care practitioners can learn from the IASW's and the CPD policy/framework proposed above by CORU. Both processes are useful and applicable for use by social care practitioners/managers to ensure that their knowledge, skills and performance are of a high quality, up to date and relevant to the registrants practice. Practitioners' work can be difficult because of the dynamic and complex nature of the work in social care practice. This thesis argues that, in conjunction with the above and to consolidate this process further, a CPD framework, that emphasises the workplace decision-making process for practitioners, could be designed and created by employing Engeström's AT. This framework would include practitioners, their managers, trainers and senior management working together, through the cycle of expansive learning in the CLs. It could also include the use of the events calendar, training map and training agreement adapted in chapter six from Engeström's care calendar, care map and care agreement. The CLs are an ideal forum in which participants and senior managers can meet face-to-face to discuss their contradictions and CPD issues of concern, and where everyone is given a chance to voice their opinions as to how to effectively bring about necessary change and, ultimately, relevant CPD training.

At present, while social workers can plan their CPD by using their PLP either in supervision or at appraisal, practitioners can do this also but can have the added advantage of utilising the CL forum to discuss their individual PLP. This will allow them to incorporate the benefits of teamwork to augment their plan, through learning from the ideas of others when discussing and planning their CPD. This forum also provides, as suggested by Halton (2014a), a space to renew, review and revise practice. If a training issue cannot be resolved in the CL, the algorithm below (figure 7.2) aligned with Engeström's *care agreement*, shows how it can be forwarded through the designated CPD officer in each centre (discussed in chapter six) to CORU, to third level colleges who work in conjunction with centres and to senior management at Tusla for consideration. This process can be enhanced by the inclusion of SCI, (discussed in chapter two), the representative body for social care practitioners/managers.

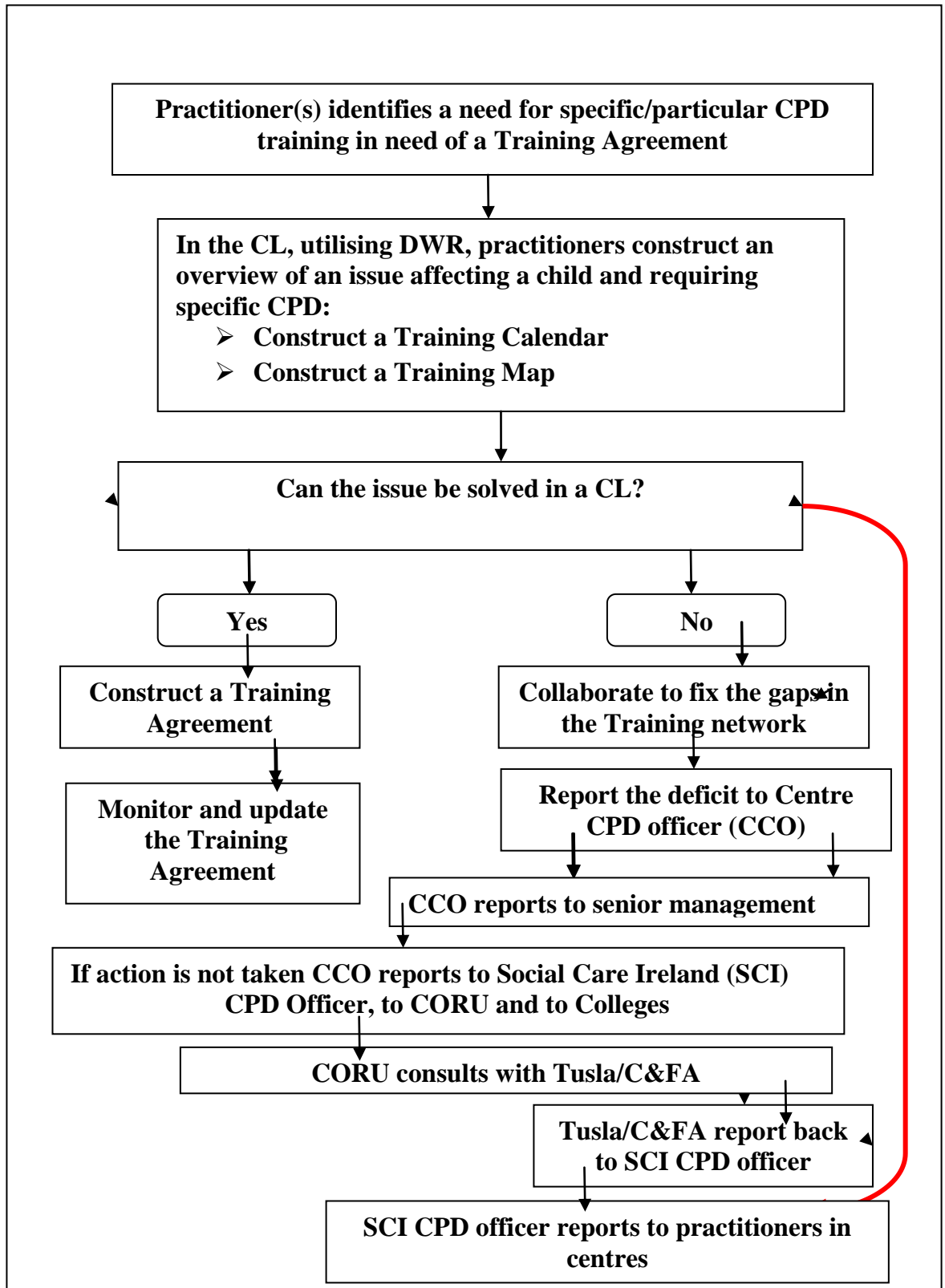


Figure 7.2: Algorithm for negotiated training agreement practice, adapted from Engeström, (2006, p. 10).

The algorithm addresses the issues of working conditions and respect, mentioned in the opening quote of this chapter, as the multi-voiced nature of the CLs allows

for everyone to be listened to: they can express their views on contradictions regarding their practice as opposed to a top-down didactic approach to learning and sharing knowledge. The SCI CPD officer can update practitioners in the centres about the outcome of their requests. In line with current consultations provided by CORU, this approach, while bringing all the stakeholders together, will continue to maintain their bottom-up/top-down approach to CPD training. Practitioners and all the other stakeholders will thus be contributing to double-loop learning (Argyris and Schon, 1974, 1978), and will also be partaking in a community of practice/knowledge (Lave and Wenger, 1991). This collaborative chain/channel of communication (figure 7.2), which includes allocating space and time, allows for feedback and reviews of all issues discussed in relation to CPD.

In summary, the preceding section reintroduced the research questions and revisited the five themes. In revisiting the themes I have incorporated the views of practitioners from their interviews and also from responses to updated data from questionnaire participants. This data confirmed that the changing field of social care practice; changes in the nature of the client group; professionalisation of the workforce; a culture of increased accountability and risk; and interagency/inter-professional collaborative working have affected social care practice. This has been compounded by participants' reported experiences of a lack of staff and resources, while they have only been receiving mandatory CPD training. The questionnaire study showed that while they are now receiving other CPD training, still there is a shortage of staff and resources, as well as other emergent issues.

The preceding section has shown how the work in the social care sector in Ireland is changing and in moving this situation forward I have shown above that CPD for practitioners needs to be reconfigured. I explored the IASW's CPD framework, followed by the CORU CPD policy/framework. Both processes are useful and can be utilised by practitioners in conjunction with Engeström's AT to reconfigure their CPD training for the future. In the past, as discussed above in chapters one and two, it was a top-down as opposed to a bottom-up/top-down approach that was used in the delivery of services, including CPD training for residential child care. To counteract this, figure 7.2 above, while moving from the individual to the collective, incorporates a top-down as well as bottom-up approach that will allow for the collaboration of practitioners views as well as those of management, third level colleges, CORU and Tusla when delivering relevant CPD training.

This approach is useful too, for addressing and discussing contradictions (discussed in detail in chapter three) in practitioners' work practice. These are important and in this study are culminations of the types of issues presented in previous chapters. They can pinpoint where tensions are happening in centres. Contradictions in this study have been highlighted by practitioners/managers and have emanated from the semi-structured interviews. Engeström's (2001) study showed that when there are a large amount of contradictions, they can be broken

down into key contradictions that can be individually knotworked by all participants until co-configuration is reached in the CLs.

7.5 CONTRADICTIONS IN THE CENTRE

Contradictions can highlight inadequacies, cracks, divisions and gaps in information and in practice. They are the ‘the driving force of change in activity systems’ (Engeström, 2001, p. 133). As discussed in chapter three, Engeström’s theoretical framework includes four questions and five principles, as follows:

Questions

1. Who are the subjects of learning: How are they defined and located?
2. Why do they learn, what makes them make the effort?
3. What do they learn – what are the contents and outcomes of learning?
4. How do they learn – what are the key actions of processes of learning?

Principles

Contradictions are covered under *principle four*, discussed below; briefly the other principles are as follows: *the first principle* refers to a collective, artefact-mediated and object-oriented activity system, seen in its network relations to other activity systems, and is taken as the prime unit of analysis; *the second principle* is the multi-voicedness of activity systems; *the third principle* is historicity and *the fifth principle* proclaims the possibility of expansive transformations in activity systems.

The *fourth principle* addresses the central role of contradictions as sources of change and development, with Engeström (2001, p. 137) emphasising the importance of the primary contradiction in activity systems. In capitalist economic societies, the primary contradiction constitutes a double bind, eg the opposition between the exchange value and use value of commodities. This causes tensions that arise from the dual construction of everything and everybody as both having inherent worth and being a commodity with market based socio-economic relations. Engeström (1996a, pp. 72–73) describes this while referring to the idea of care and control amongst GPs in the US; it can also be applicable here in Ireland when discussing care in residential child care centres and control of money for services, such as CPD training by the HSE.

The primary contradiction occurs within each node of the activity system; it is like an undercurrent pervading in general society and in all elements of our activity systems (Engeström, 2001, p. 137). Activities are open systems and, when an activity system adopts a new element from the outside (for example, a new technology or a new object); this often leads to an aggravated secondary contradiction where some old element (for example, the rules or the division of

labour) collides with the new one. Such contradictions generate disturbances and conflicts, but also innovative attempts or progress to change the activity (ibid, 2001, p. 137). As discussed above and in detail in chapter three, *the fifth principle* proclaims the possibility of expansive transformations in activity systems (similar to Kuhn’s notion of ‘paradigm shift’), leading to a full cycle of expansive transformation that may be understood as a collective journey through the zone of proximal development (ZPD) of the activity, explained in chapter three.

In Engeström’s (2001) study, in both the hospital and the health centre, a contradiction emerged between the increasingly important *object* of patients (children) moving between primary care and hospital care and the *rule* of cost-efficiency implemented in both activity systems. Engeström (2001) draws attention to the constellation of contradictions in the fields of activity systems which are schematically depicted in (figure 7.3).

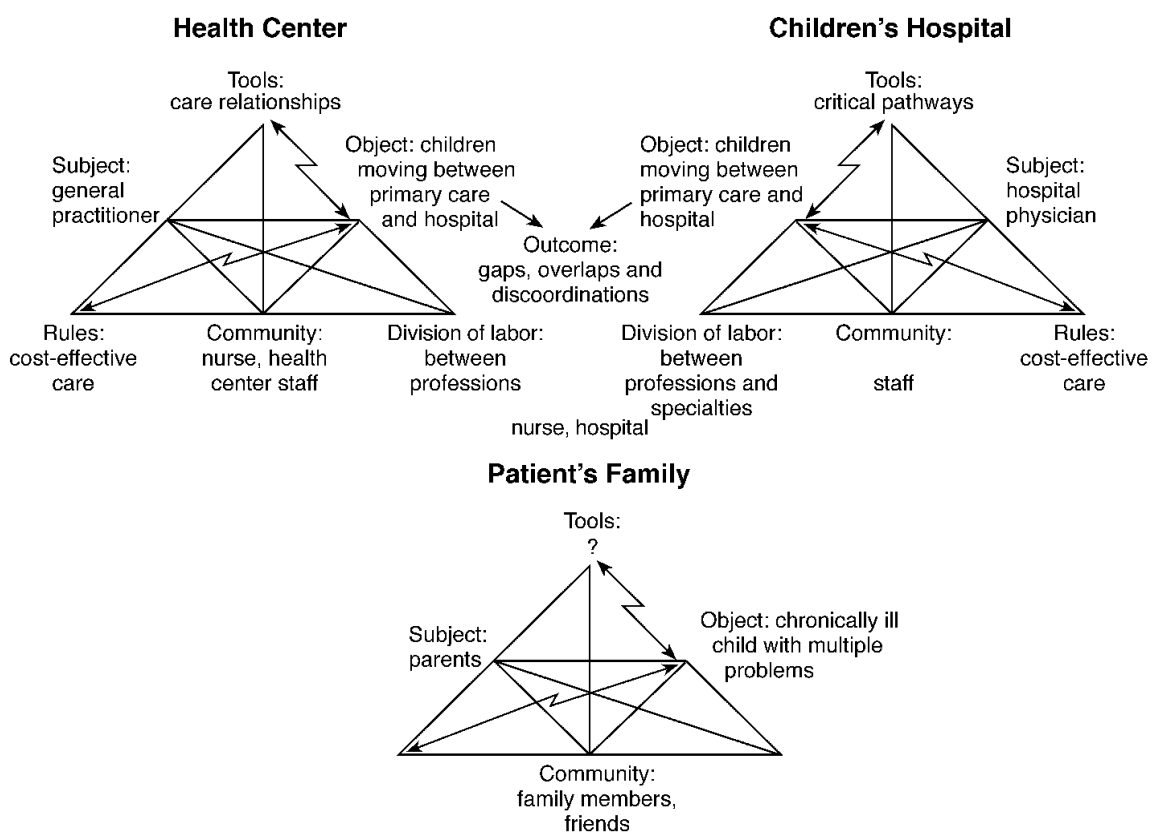


Figure 7.3: Contradictions in children’s health care in the Helsinki area.

In this study, practitioners reported that the rule of cost-efficiency was also evident in their activity systems (centres). Contradictions emerged between the important *object* of vulnerable children/young people placed in the care of centres, and the lack of adequate services and supports provided to practitioners by HSE

management to care for them. Contradictions in residential centre are schematically depicted in figure 7.4 below.

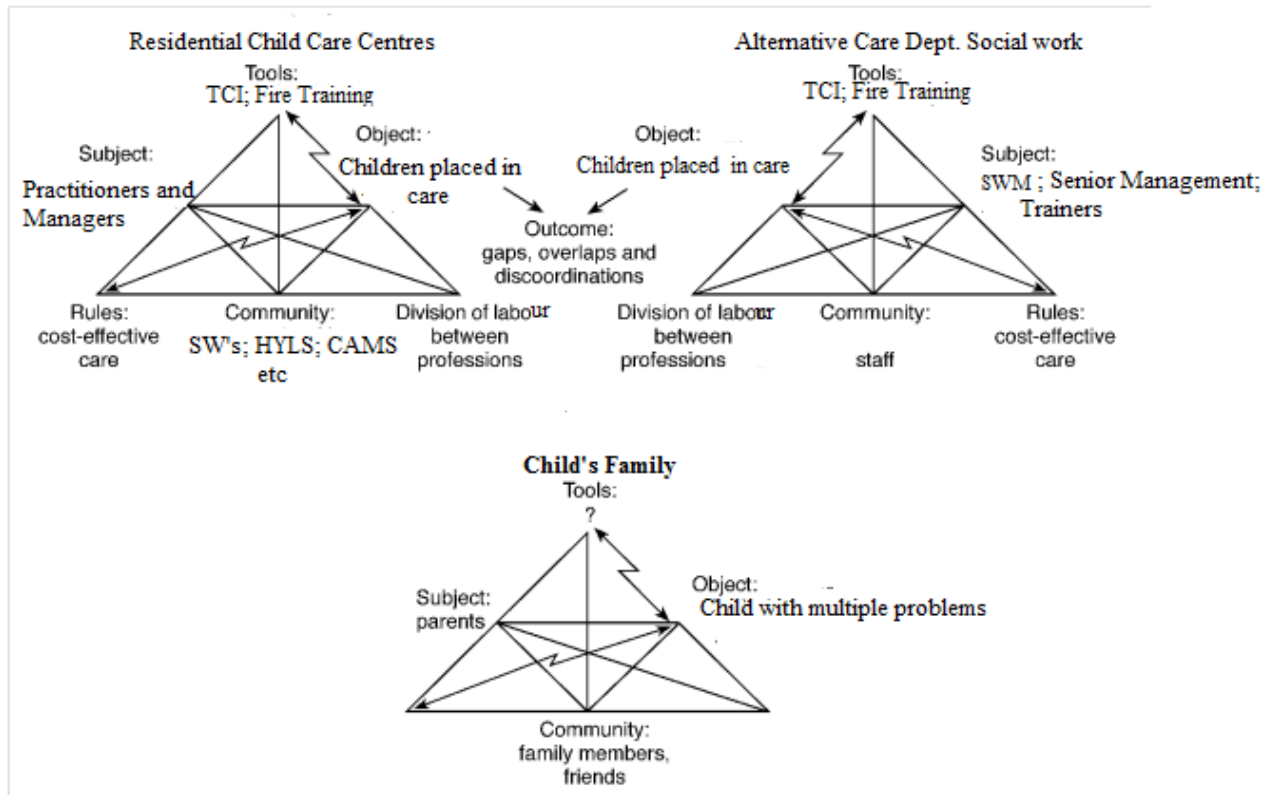


Figure 7.4: Contradictions in residential child care centres

Contradictions are not the same as problems or conflicts. As stated by (Engeström, 2001, p. 137), contradictions are historically accumulating structural tensions within and between activity systems. This definition can be broken down and explained as follows in relation to each contradiction below:

Historically: the need to be clear on time period.

Accumulating: the issues have built-up either due to change or institution or both.

Structural tension: how are the issues being generated by the structure of the occupation, workforce (de-institutionalisation).

Activity Systems: { Within: inside the practitioners/managers centre
Between: between practitioners/managers and others }

The next section summarises the contradictions that emanated from practitioners interviews regarding their work practice.

7.5.1 Contradiction between Object (children/young people) and Tools (Assessed needs) and Rules (cost-effective care)

While the research data for this study proposed that every child should receive good quality care, the interview participants found that some children were misplaced in the HSE service as a direct impact of cost-cutting efficiency, in the same way that Engeström (2001, p. 137) describes the effects of the primary contradiction above. This is graphically shown in figure 7.5 as follows:

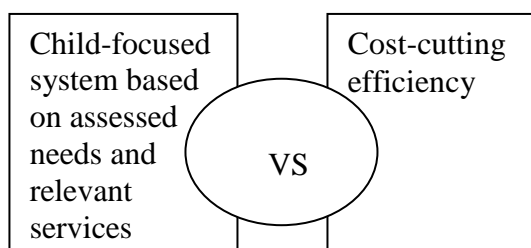


Figure 7.5: Assessed needs v cost cutting efficiency

It can be argued that the affects of the primary contradiction may be a universal issue in public services provision. In Ireland in particular, public services were told by the government to cut costs and the recession made the situation worse, culminating in difficulties experienced in providing services. Also there are power issues between the public and the private with links to pay and a lack of training and resources, coupled with lack of respect for workers and work being done in difficult circumstances. All of these aspects are highlighted in the opening quote to this chapter.

This contradiction can be examined further under the following headings:

Historically: This tension has long been an issue, going back to industrial schools, especially the issue of resources. While there may have been a lot of resources invested in the provision of care and services, at that time much of it was consumed by the religious orders themselves.

Accumulating: Practitioners' interviews showed that tensions and challenges were increasing and were evident from the affects of the five themes of the study that culminated in a lack of proper services and relevant CPD training. Also, repeated ignoring of communication had impacts.

Structural tension: Tensions arose because the government/HSE cut back on spending and the moratorium on public service recruitment and therefore were not able to provide adequate services.

Activity Systems: *Within:* Tensions are experienced inside in the centres among practitioners/managers as a result of the cutbacks as they were unable to support or provide the care that they knew the children needed.

Between: Tensions, were evident in different levels in the HSE and could have been exacerbated in the current economic/organisational setting through the imposition of a rule by the HSE whereby they place children/young people in centres who should be in another service, more suited to their needs. This might include children//young people with medical conditions or who are presenting with severe behavioural issues resulting from being sexually abused. This measure can be implemented to ensure that bed capacity is filled and these children are cared for in a service, albeit in the wrong placement.

The following comment relates to a child in such a placement.

Really, children are placed in the wrong centre. The people who are placing these children do not know what the children need. They should be finding out the information and listening to us the people who work on the ground with these children... the boy who has autism, is angry because he is caught between his mum and dad who are going through a very nasty breakup, he is lashing out at us, he trusts nobody because his trust in his parents has broken down and mum is playing him off against dad and vice-versa, we are not trained to deal with this, we don't have the tools, he is in the wrong centre, the wrong placement. (Practitioner 9: Field notes)

As well as the rule of cost-efficiency dominating this contradiction, also, there is tension between the systems, graphically described in figure 7.6 as follows:

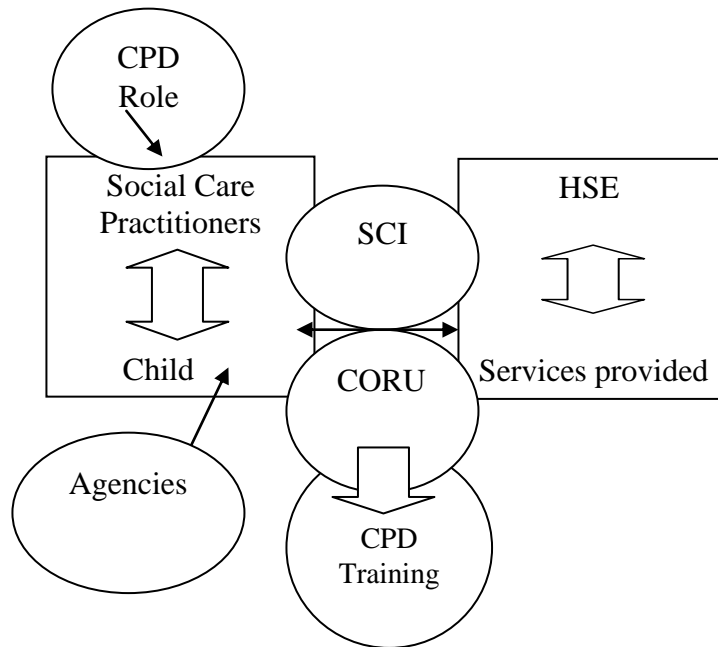


Figure 7.6: Tension between the systems.

As can be seen from figure 7.6, there is tension between the two activity systems in that while practitioners are involved with the agencies and working with children/young people in their system, we know from their interviews that they are in need of relevant CPD training. In their system, the HSE is providing services but not relevant CPD training which is needed but is outside their activity system. In the centre and bridging both activity systems is SCI and CORU; both are in the process of preparing practitioners/managers for registration/CPD training. As practitioner interviews showed: while the HSE (now Tusla) has been providing CPD training, the issues that practitioners see, requiring relevant CPD training, are not ideally the ones that the HSE/Tusla see. Questionnaire participants did say that while they are asked about training that they needed, they may not get it unless it is already earmarked by Tusla.

Because of the changing nature of the client group, the centres found that they were not able to deal with the issues and as we can see in figure 7.7, the system is not responding as there is no evidence of joined up thinking/working. As discussed above and shown in figure 7.2, CORU and SCI could provide a communication system to Tusla. Part of the job is to work with agencies and there is a need for many people to be relaying back to Tusla about these contradictions as shown in the algorithm in figure 7.2. The algorithm shows how it could be done through the chain/channels of communication involving all parties. Once Tusla are aware of the issues, their job, which can be in conjunction with third level colleges, will be to provide funding and relevant CPD training. For example, would Tusla consider funding practitioners to do post-qualification courses, such as addiction studies, higher certificate in advocacy studies, or a master's degree in a relevant area, such as in therapeutic interventions for working in residential

child care? Also, could Tusla pay for an expert such as Engeström, to attend a conference to provide learning for practitioners/managers?

As described above, the ideal forum to kick-start this process is in a CL. For example, taking the quote above by practitioner9 regarding the contradiction of the child placed in the wrong placement due to cost-efficiency, when discussing this contradiction in a CL with members of management and interagency staff, the practitioner will be relaying first-hand what was going on in the centre, the difficulties involved in coping, and what has been expected of her. By engaging in Engeström's approach, professionals in CLs will all be able to work out viable solutions to this problem, albeit that they may not be able to provide them at that time. Moreover, through the interagency/boundary crossing nature of the CLs, other practitioners present will collaborate by sharing ideas with other professionals there, who may be able to provide, or know of a better suited service for the child. By practitioners highlighting this contradiction together, there will be a better outcome as the child's needs will be acutely identified and discussed and progress could be made.

A similar contradiction was discussed by practitioners at a TCI refresher training day, where they shared information regarding their current situation in their centres; this also involved a child placed in a wrong placement:

A child with Asperger's syndrome, who also had ADHD, was placed at the centre by management. The child, a girl aged 15, has, according to staff, a mind of a child aged three; she had to be constantly supervised by staff as she was placed with a boy who had sexually abused his siblings. This girl was sexually explicit in her behaviours and in the choice of clothing that she insisted on wearing. This child was in the wrong placement, she was not getting the help/support that she required; practitioners were finding it extremely difficult to work with her as well as the other three children, yet when staff asked management for extra cover, management replied that practitioners were paid to supervise this child. Staff disagreed, saying they did not go to college and get a degree in social care to do this kind of work. Experiencing children placed in the wrong placement was demeaning for staff, not to mention for the child and their family [Field notes].

As we can see, this child is not in an appropriate placement to meet her needs. When practitioners, managers and the interagency team in a CL discuss this contradiction, they will clearly identify that the placement is wrong. If practitioners did not do this they would be doing an injustice to the child. It is vitally important that they flag the incident with the aim of getting appropriate help to address the child's needs. While the child is presenting with behavioural issues that practitioners could address, there are also medical issues that need

attention and these practitioners were not trained in how to deal with them. As mentioned above, better interagency work will provide a better outcome by identifying a more appropriate placement for this child.

In addition to figure 7.6 showing tensions in the activity systems, there is also tension in relation to the changing nature of the client group versus the changing role of the practitioner described in figure 7.7.

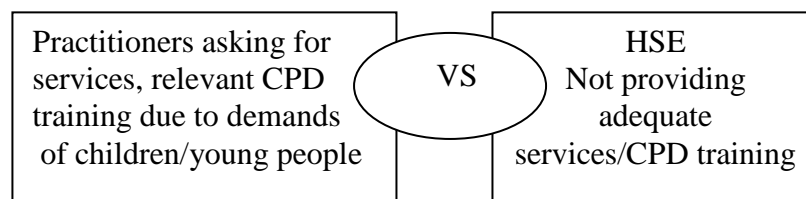


Figure 7.7: Changing nature of the client group v changing role of practitioners

Historically: This tension has gradually built up over the past five to ten years. Experienced long-serving practitioners explained that they notice big changes because until then practitioners cared for children who had not been showing signs of severe alcohol/drug misuse and who were not presenting with self-harm, suicide ideation or had not been showing signs of trauma from being sexually abused.

Accumulating: As the interviews showed, these tensions and challenges were accumulating and getting worse. Practitioners had no recourse for dealing with them apart from TCI, which only addressed challenging behaviour.

Structural tension: Tensions arose because practitioners saw that they needed support and relevant training and are not getting it due to cut backs reflected in lack of staff and resources.

Activity Systems: *Within:* Tensions arose in the centres between practitioners who were angry and frustrated while exchanging conflicting views on how to address the issues that occurred while they were on shift, that they have had no CPD training in how to deal with them.

Between: Tensions arose between practitioners who felt that management were not listening to them. Tensions were also evident in different level in the HSE, for example, as mentioned above in chapter two, there was a shortage of social workers and children without care plans which impacted on the work of practitioners in centres. Also there

were the reports in the media regarding the deaths of children in care and the way this was dealt with by the HSE.

While the client group has changed, relevant CPD training for the practitioner has not moved according to these changes; the system has not changed and this causes frustration and anger for practitioners. In larger institutions caring for children, practitioners' roles were clearer, now they are more complex. Moreover, the role of the practitioner has expanded. For example, practitioners discussed about not having had key-working training and in addition to this practitioners' were newly engaged in outreach/respite work in the community and were not given any relevant preparation/CPD training in how to do this important work.

Their interviews confirmed that the only training offered was mandatory CPD training. Questionnaire results show that in the past 2/3 years practitioners have been receiving other CPD training. As a result of this, practitioners found it difficult to cope with children's/young people's escalating issues. Practitioners, in their interviews, have shown that professionals working in this area need to be trained properly and up-skilled; they need more support. While questionnaire participants said they had received CPD training, they indicated that they have not received extra supports or resources in the past 2/3 years. Practitioners did work at trying to change their situation. For example, we saw how some of them sourced their own CPD training and paid for it themselves while off work and also they sought out local free training from professionals in their area by asking them to come and give free talks to them during their team meeting sessions.

The CLs will be the ideal place that practitioners can meet and discuss about work with others including management. On the phone and through email and occasionally meeting them, practitioners have liaised through their work with many other professionals, among them the Home Youth Liaison Service (HYLS) team, yet, they were not exactly sure about the work these professionals were doing. In future CLs practitioners will be able to invite a member of the HYLS team to give a presentation and explain to them about their work and how it complements the work of practitioners.

Management will benefit from discussing contradictions that concern them, such as suggestions as to how the running costs of centres could be reduced. For example, practitioners attending CPD especially designed for them will cut costs for management by not going to other training more applicable to social workers, for example, legal/legislation training. Moreover professionals can also discuss and inform the CLs about the benefits of early interventions for young children (Gershoff, 2003; Heckman 2004 and 2005). These could result in subsequent cost savings if money was invested early to prevent children becoming involved in the justice system later on, like some of the children/young people who are in care in centres. By practitioners and others working together in the CLs, there would be a

better outcome for the future because they will know how to address recurring contradictions which will prevent this or a similar occurrences happening.

7.5.2 Contradiction between Object (children/young people) subjects (practitioners/managers) and Tools (Knowledge)

Practitioners are working on the ground with children/young people. They know the knowledge they require as they see first-hand the changes reflected in the problems that children present with when placed in care. The problems coincide with the information discussed in the five themes. Yet, while practitioners/managers are faced with the issues on a daily basis the HSE is not responding with the knowledge of how to address these issues (figure 7.8 below) such as children/young people presenting with more challenging behaviour. As practitioner10 said: ‘more training other than TCI is needed to deal with children coming into care now who have changed due to abuse of alcohol/drugs’.

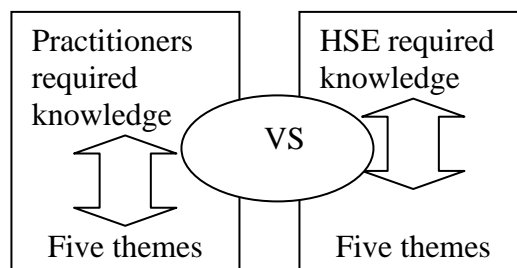


Figure 7.8: Practitioners knowledge v HSE knowledge

Historically: Previously some children in care occasionally dabbled with alcohol, but in recent years children are mis-using both alcohol and drugs at a younger age and experienced practitioners are finding this difficult to cope with

Accumulating: Over the years, these issues have escalated; practitioners said they have received no training in how to address them.

Structural tension: Tensions arose because practitioners saw that they needed support and relevant training and are not getting it due to cut backs in lack of staff and resources.

Activity Systems: *Within:* Tension and stress were evident amongst team members who were relying on their own and colleagues’ knowledge while trying to deal with the agitation caused by some children in the centre who presented with these issues that staff did not know how to deal with.

Between: There were tensions between staff in the centres and management because staff saw that management were stuck in a time-warp and were not keeping up with what was happening on the ground

What is needed is for practitioners to take part in CL sessions where they will be able to let management and trainers know about how these issues are affecting them and how they are trying to deal and coping with them. Hearing about how this work is impacting on practitioners may prompt management to source relevant training or provide other types of CPD opportunities to address their concerns and improve their work practice or not. As explained above, by utilising the CLs in conjunction with the chain/channels of communication (figure 7.2); this will provide a better alignment of what is happening in centres.

7.5.3 Contradiction between Subject (practitioners/managers) and Rules (HSE/HIQA policies/protocols)

As stated by interview participants: when HIQA does an inspection, planned or unplanned, or when the HSE issues circulars/memos, they do not advise or suggest relevant CPD training to address an action that requires change; they expect practitioners to address the actions after they have been issued and later check back to see if the actions/recommendations made have been adhered to.

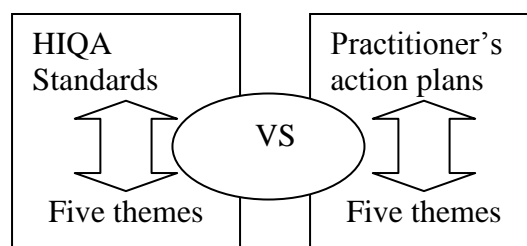


Figure 7.9: HIQA standards v Practitioners' Action plans

Historically: In the past, there were few audits. Then based on research and reports, policies were designed and implemented by senior management.

Accumulating: Over the years, it was discovered that these policies were not working and there were significant reports about incidents where children's needs were not being met. This established the need to have audits with themes developed and standards outlined.

Structural tension: These themes had to be implemented but there were no clear guidelines as to how they were to be put into practice.

Activity Systems: *Within:* Tensions about the audits arose between practitioners and their manager as to who would be doing what and how it was to be done in preparation for inspections.

Between: There were tensions between staff and HIQA as the inspections meant that more work was needed to address actions by staff who were already under pressure from everyday work.

Engaging in the CLs will open a space for possible actions to be discussed. Practitioners will benefit from advice from other professionals about how best to make changes and to address actions suggested by HIQA; also ideas could be discussed about how to be proactive in pre-empting actions needing to be addressed by HIQA. The CLs will provide for debates on circulars/memos that managers receive; also in the CL they can get time away from their routine work where they can read/study same.

7.5.4 Contradiction between Subject (practitioners) and Division of Labour (working nights):

In their interviews, practitioners while referring to the need for workforce on site at all times, said that many nights, depending on the clients in residence, they had to work through the night and were effectively on-call. This is also a pay issue: interviewees said they were only paid a flat rate allowance of approximately €40 from 12 midnight until 7am, in contrast to other professionals who are fully paid while on-call:

Practitioner1: Practitioners like other professionals (medical personnel) doing over-nights should be paid while on call.

Practitioner15: Practitioners are effectively on call, they work 50 hours over two shifts but are only paid for 36; they are not paid for working during the night despite spending many nights up, some either in the Garda station or in the hospital Emergency Department.

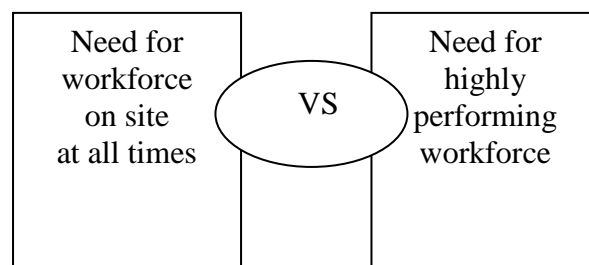


Figure 7.10: The need for workforce on site at all times v the need for highly performing workforce

Historically: According to experienced practitioners, years ago children in care understood the need for reasonable structures and boundaries and influential issues back then were different to those described under the five themes of this study.

Accumulating: In recent years there has been an accumulation of incidents regarding absconding which has increased due to issues around alcohol/drug mis-use where children/young people can be out all night, maybe involved in anti-social behaviour and in some cases may not return to the centre until the next or following days, with staff up and out checking for them around town or in other areas where they suspect that children/young people could be.

Structural tension: Tension arises because there is a need for highly performing staff and those who are there are unable to be up all night and up again in the morning, for example to get other children out to school and to continue with their other duties.

Activity Systems: *Within:* Tensions are high among practitioners on shift who get stressed and agitated; burnout can easily occur for fulltime staff.

Between: There is tension between staff and HSE management because practitioners are annoyed and feel they are unsupported especially because they are not paid at their increment pay scale through the night, yet they are expected to be highly performing at all times.

It can be argued that the solution to some contradictions requires training but others need consultation in the CLs where a solution could be attempted locally. For example, this contradiction could be discussed and debated in the CLs between management and centre staff with the possibility of finding a solution to address the pay issues highlighted.

This contradiction was also alluded to by questionnaire participants who complained about a series of proposed new changes by Tusla in conjunction with the national reconfiguration of residential child care centres entailing extra work, including paperwork, with no extra supports provided to do this work.

7.5.5 Contradiction between Subject (practitioners) and Tools (technology)

As discussed in the literature review, the data suggests that lifelong learning should encompass the professional practice of all practitioners. This issue still

needs to be addressed in the centres, as was described in the interview excerpt below by this older staff member:

At present all the talk here is about computers and I don't know a thing about them. There was none of them in my time but I'm hearing at team meetings about how this and that has to be done on the computer. I haven't a clue how to turn one on so I'd need training in that but no word of it... (Practitioner13, 13 years work service).

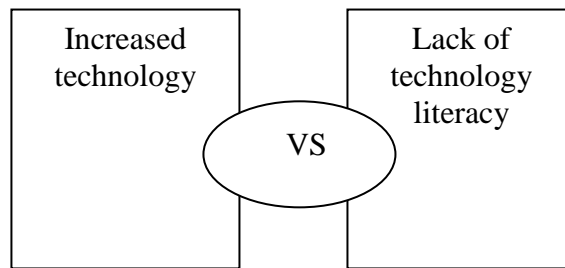


Figure 7.11: Increased technology v lack of technology literacy

Historically: Experienced older practitioners working in centres were not trained and did not know how to use computers or technology. New, young members of staff were being hired, who had just left college and were somewhat familiar with them as they would have learned about them in school/college.

Accumulating: The change-over to computers/technology has built up over the years due to changes in the centres, including direction from outside such as HIQA requiring staff to be competent at recording information electronically and in the use of technology: fax, email, printers etc. Social workers can upload information to RAISE; practitioners can log-in and view same.

Structural tension: Tensions were evident amongst some experienced older staff who felt they were not being supported due to a lack of training in the use of technology. Others did not want to change and/or were not interested in learning new skills.

Activity Systems: *Within:* In the centre there was tensions as younger staff felt that they were taking on more work than their colleagues due to having to do administration work on the computer as well as having to do the other chores that were part of the job.

Between: Tensions were evident amongst some older experienced staff and directed towards senior management as they were not being given the technology training that they had been promised on numerous occasions.

While management did provide half-day training sessions sporadically in computer technology, this was not adequate for long serving experienced practitioners. In the questionnaires one participant said she has still not had adequate IT training. It can be argued that practitioner13 could take the initiative and learn how to use the computer herself, but the question to be asked in the CL is: how can we look holistically at the full range of skills that will be required in the work and how can we develop CPD accordingly? Engeström's AT approach that includes the exploration of historicity of the situation in the CLs looks at the totality of the work and professionals get to discuss the impacts of this on their practice and how/if situations are affecting their lives.

The issue in looking at computer training is that: all practitioners may have come to the CL thinking they needed to use computers but why should they be used, maybe everyone needs to know how to use a computer? CHAT gives us the opportunity to open this up to everyone and to get an holistic view, that can change the whole culture of the organisation, which can only be got through face-to-face interactions in the CLs. Face-to-face interaction that includes time given to talk about computers to staff who are not familiar with them will provide a better outcome as it involves the personal touch which is missing in the half-day sessions where large groups are brought together for training, for example in how to log onto the RAISE system.

7.5.6 Contradiction between Subject (practitioners/manager) and Tools (reflective practice)

The literature review expresses the advantages of structured supervised reflective practice for frontline professionals; it enhances their work and their professional development. Owing to time constraints amongst other issues, practitioner 2 said: 'reflective practice is not normally individually practiced by staff'. The following statement reiterated by other staff has reinforced this comment: reflection is always informal and done as part of handovers, team meetings and at supervision (Practitioners 2, 5, 6, 11, 12, 13, 14, 15 and manager 3).

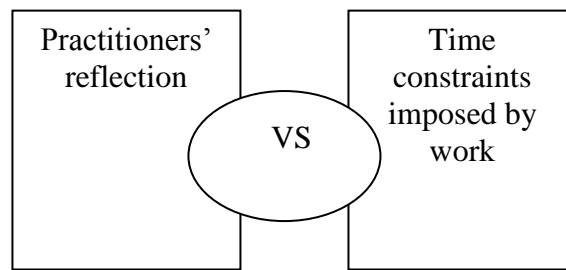


Figure 7.12: Reflection v time constraints

Historically: When practitioners first started working in centres there was little understanding of the impact of this work on staff or about reflection or its benefits for work practice.

Accumulating: Over the years and through college, practitioners began to hear about reflective practice and read among others, Schön's (1983) book: *The reflective practitioner*, where they learned about the benefits of reflecting on their practice and in recent years Lyons (2010a) book: *Handbook of reflection and reflective inquiry: Mapping a way of knowing for professional reflective inquiry*.

Structural tension: Practitioners know now they should be given time for reflection but this is not happening due to time and other constraints such as a lack of staff and resources.

Activity Systems: *Within:* Practitioners are not satisfied that in supervision they are not given adequate time for reflection.

Between: Tensions arise between centre staff and management because staff feel they are not supported while doing this complex work by being given a proper avenue to reflect on what they are doing, how it is impacting on them and how they can improve it.

At the CLs practitioners can discuss their thoughts about this contradiction with management and it could be decided that the CL will be an ideal place for practitioners to reflect with their supervisor/manager in a safe environment used specifically for this, as opposed to the supervision time that practitioners said did not allow for adequate time for reflection because of discussion on crises at the centre. Performance at the CLs can be boosted by participants bringing their CL portfolio/journal with them to the sessions. This can be used to record notes and participants can refer to them later to reflect or to discuss with colleagues or

supervisor. In order to provide a better outcome for practitioners and for the centre, they can discuss with management about why there is not sufficient time allocated for reflection or on how to incorporate reflection into the work process.

7.5.7 Contradiction between Subject (practitioner/manager) and Tools (supervision and TCI)

The importance of good supervision was highlighted in the literature review. Among others, Halton et al, (2014b) noted that the importance of good professional supervision has been highlighted in many policies and reports both in the UK by: Laming 2003 and 2009; Social Work Task Force, 2009 and Munro 2011 and in Ireland by McGuinness 1993; the OMCYA 2009, p. 42; Gibbons 2010; HSE 2010; and by the Department of Children and Youth Affairs (2011a).

In addition, the position of the supervisor and the benefits of two way supervision was highlighted in the literature review by Mezirow (1981) and Gould and Baldwin, (2004) who suggested that feedback should be given in an open and transparent way. However, practitioners were not satisfied with the supervision they were getting. Only two practitioners (practitioner 4 and manager 1) said 'it was good'. It can be argued that out of 18 practitioners this is a small number given the importance of supervision as part of the professionalisation of the workforce. Other staff gave a summary of their views by saying: There should be an external supervisor conducting the supervision; the supervision time is taken up by going over the crises that are happening in residential care with no time for reflection (practitioners 1, 3, 5, and 8 and manager 2). Questionnaire participants did not mention much about supervision but they did talk about having had external support which they found to be useful but is now discontinuing due to financial constraints.

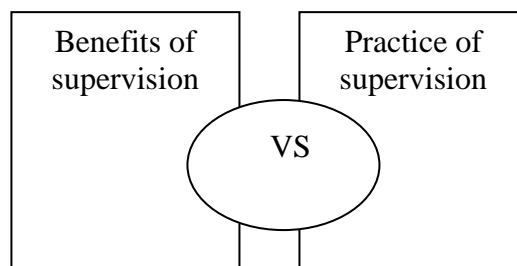


Figure 7.13: Benefits of supervision v practice of supervision

Historically: Practitioners have been accustomed to having supervision once every six weeks. The idea of supervision was that they could discuss their practice with their supervisor and how the work was impacting on them.

Accumulating: As the years passed supervision continued the way it had started, only that while the crises of the centre had exacerbated and were duly discussed there was not adequate time left for practitioners to discuss how this complex work was impacting on them.

Structural tension: Practitioners should be given ample time to discuss how their experiences of working with vulnerable complex children is impacting on them and their work and examine ways to improve situations.

Activity Systems: *Within:* In their interviews practitioners complained that they were supervised by their manager or team leader who was doing the same work as them because of working in a centre that is small and everyone knows what is happening as regards the work.

Between: Tensions arose between centre practitioners and management because as stated in their interviews, practitioners had been calling for external supervision as they wanted an objective view of their experiences which they felt will give them a better outcome for continuing with this complex work.

Like the previous contradiction, the CLs will give practitioners the opportunity to discuss in detail and get clarification regarding wider issues about supervision when knotworking with their colleagues, trainers and senior management. These sessions will be aided by their CL portfolio/journal in which they can record notes of importance/questions, which, if not clarified here can be brought to their personal professional supervision session with the team leader or supervisor.

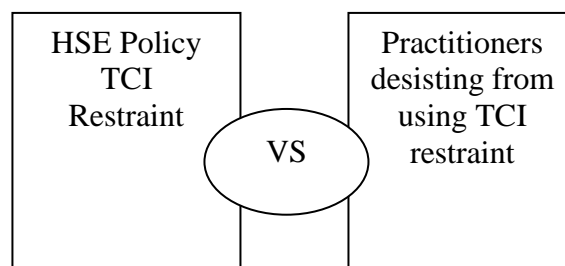


Figure 7.14: HSE Policy TCI restraint v Practitioners desisting from using TCI restraint

Historically: Practitioners were directed to use TCI theory, including TCI restraint. At their yearly TCI CPD training practitioners were tested on TCI techniques and were

required to answer questions on restraint in TCI exams. TCI trainers directed them to use physical restraint when trying to control and manage aggressive behaviours of children/young people.

Accumulating: While this policy continued tensions were rising because based on the information in the five themes above, especially the nature of the client group changing, there was evidence that using restraint was not an option for practitioner's based on their negative experiences of it.

Structural tension: While restraint was the preferred policy in use by management, practitioners saw that new challenges, as described in the changing nature of the client group were occurring. They knew that physical restraint would not help, if anything it would make situations worse and for these reasons practitioners wanted management to know first-hand how this was being manifest in their centre.

Activity Systems: *Within:* In centres only certain practitioners were able to do the physical restraints due to personal injuries. If a restraint needed to be done this caused tension with staff members who were certified fit but did not have support to do the restraint.

Between: Tensions arose between centre practitioners and management because while practitioners were telling senior management as to why they wished to desist from continuing to use restraint, they felt that management were not listening to them.

TCI, was one of only two tools available to most practitioners, with the other being Fire Safety Training. TCI was seen as being particularly important by the HSE and had been endorsed by the HSE (*Best Practice Guidelines in the Use of Physical Restraint* (Child care: residential units), (2006, p. 2). In their interviews, practitioners said they found level one and two useful. They were also expected to use level three/restraint but due to negative past experiences did not want to do it.

Kennedy (2008), cited in chapter five, denounces physical restraint as a beneficial intervention in favour of substantial evidence to support restraints negative effects and potentially devastating unintended consequences. This was based on negative experiences of staff that restraint caused trauma, suffering and humiliation to the child. The researcher agrees with this and argues that staff members doing the restraint may endure the same consequences. These experiences constituted the

reasons why practitioners desisted from continuing with it. This contradiction has been discussed and debated in detail in the TCI intervention discussed in chapter six. The following quotes are some practitioners' views about TCI:

Practitioner4: 'too much time and money is spent on TCI and the restraint part is not being used'.

Practitioner7: 'in the last four years, the only training I have had is in TCI and while the therapeutic part of TCI could be kept; another package is needed to compliment it

Manager 2: 'while TCI is ok, other communication training is needed to build relationships and better address behavioural difficulties of young people'.

Practitioner9: 'TCI is ok, but I think it was invented before young people started taking drugs/alcohol; staff need training but not rubbish training, people are bored with TCI training whereby staff have to attend this after working a long shift and it's is not helped by having to do exams, that other professionals working at the frontline don't have to do'.

In picking up on the first part of the comment by practitioner 9: 'TCI is ok, but I think it was invented before young people started taking drugs/alcohol', this thesis argues that while TCI restraint was an appropriate response to addressing children's/young people's aggressive behaviours at a particular time, it is outdated now because of being superseded by behaviours, witnessed by practitioners, that are as a result of or are associated with children/young people being abused before coming into care and as a result of continuing to severely misuse alcohol/drugs. For example, Holden et al (2009a, p. S123) lists that TCI restraint should not be used on a child/young person if:

- We cannot control the young person safely
- We are not in control or are too angry
- Sexual stimulation is the motivation
- We are in a public place
- Young person has a weapon
- Young person's medical condition prohibits it
- Young person has emotional problems risking re-traumatisation
- Young person is on medication(s) that affects his/her system

While the therapeutic element of TCI is good and is used by practitioners, an historical analysis of TCI restraint was required and was successfully conducted in the TCI intervention in chapter six by practitioners in conjunction with trainers/senior management in the CLs. Questionnaire participants expressed

delight at not having to do physical restraints any more and about the changes to their behavioural management policy.

7.5.8 Conclusion re contradictions

Contradictions are useful as they enlighten staff to question their practice and see if they are taking responsibility for their work and doing what is expected of them. When they reflect they realise that they are being pulled in many directions. This requires them to think rationally, so they prioritise and attend to what is important and they delegate things that they cannot do, while also seeking out solutions to the contradictions.

From now on practitioners will know that the CL is the forum for them to discuss contradictions that are occurring in their centres. As we have seen from above, the five themes of this study point to multiple changes that have occurred in the past decade in the social care sector, including professionalisation of the workforce, accountability and the need for interagency/inter-professional working. These themes co-exist with the changes in the nature of the client group and for these reasons, as was seen Engeström's (2001) Helsinki study, practitioners need to be supported in their work and the system needs to change. Practitioners who work with children/young people are best placed to know what is happening in their centres and what relevant CPD training they need.

Practitioners know that they need proper supervision, time for reflective practice, support and relevant training to assist in their work with vulnerable complex children/young people and they need to have their voice heard by management. By having the knowledge about the CL forum, practitioners together with different professionals taking part in the boundary crossing CLs will be able to have their contradictions debated and discussed and in some cases resolved, with transformations made or passed up along the chain/channel of communication as suggested in figure 7.2 above. This will lead to shifts in thinking about how to improve work practices and achieve better outcomes for practitioners, managers and interagency teams, albeit allowing for initial defensive objections to engaging in CLs by new professionals as was seen in the TCI intervention (chapter six) and in the Helsinki study (Engeström, 2001, p. 144).

For example, as in the Helsinki study, a shift in thinking for practitioners/managers, trainers and senior management taking part in this study should begin with addressing practitioners' concerns about deficits in communication. Communication and relationships play a big part in the work of practitioners and in their interviews practitioners recounted that there was evidence of a discontinuity of communication and planning on different levels and this was impacting on their work. Questionnaire participants commented on how the CLs created a shift in thinking and helped to open up and improve communication

which, they claimed, had enhanced their sense of well being and belonging in the organisation. By engaging in knotworking sessions while discussing their contradictions in CLs, in collaboration with other professionals, it will enlighten and awaken them to the need to share responsibility and plans by tying and untying knots which will uncover what they need. In the Helsinki study, practitioners designed and implemented a *care agreement* to make changes and to address their needs, (discussed in chapter three and six). Practitioners in this study can implement a *training agreement* to address both immediate and long term CPD needs while collaborating in CLs in conjunction with figure 7.2 above.

7.6 LOOKING TO THE FUTURE

From the interviews, the key points emanating from the five themes are challenging and somewhat negative. There has been a glimmer of positivity from the updated questionnaire study in that practitioners are now receiving other CPD other than mandatory training. Still, they have more new *contradictions* that need to be addressed. It could be argued that now is the time to get it right, by aiming for a quality service, in line with the change over from the HSE to Tusla and the development of CORU, registration and the development of new CPD structures and processes. The way to do this is to reconfigure CPD for practitioners for the future. In the Helsinki study, the hospital physician and others had thought that everything was working to plan until it was pointed out (Excerpt 6, Engeström 2001, p. 146) that their new contradictions were not being addressed by their current tools: care relationship/critical pathways.

In this study, practitioners'/managers' interviews said their contradictions were not being addressed by senior management even though they had voiced their opinions via their centre manager. As was seen in relation to the TCI intervention it is best to speak to people face-to-face where everyone can give their opinions and have their voice heard. Questionnaire participants also commented on the benefits of face-to-face interactions which they experienced from the CLs. The CLs allow for everything concerning practitioners' needs, to be discussed. This is done through practitioners engaging in DWR and working through the seven stages in the cycle of learning. As described above in chapters three and six, from this an *events calendar* will be constructed that will show incidents experienced by practitioners in which they needed but did not know/have relevant CPD training to address the situation and how they coped with it.

Then a *training map* will be constructed. It will outline CPD training currently available and services/providers associated with delivering it. A plan for CPD will be constructed, a *training agreement* that will list specific CPD training to be done in a certain time frame. The agreement will be signed by: the CPD officer/designated person in each centre, the practitioner and the trainer/person intending to conduct the CPD training and the manager in the centre. Some issues

discussed in the CL will be resolved by immediate dialogue, others will need specific training as described in the training agreement and other issues will need to be referred on for further clarification as described in figure 7.2 above.

As time progresses, practitioners will see the benefit of using CLs to suggest and share research/information (discussed in chapter six), with their colleagues and with other professionals. Questionnaire participants gave positive reviews and feedbacks from their recollections of the CLs. Some examples of what they could discuss could be: How can we value CPD, should people doing extra research/sourcing/paying for training themselves be paid more money than those who do not do this? Should practitioners who hold Masters or other extra educational qualifications be paid more? Who should pay for the CPD: the employer or the individual? As noted by Engeström, et al, (1996, p. 8) ‘the discourse moves *between the participants and their various voices*, typically including an entire work team or unit plus one or more researchers/interventionists’. Through the CHAT approach, once practitioners have experience of constructing the CLs they will be competent at showing practitioners in other centres how to use the CLs to knotwork through their present and future contradictions that require transformations.

The discussion on the contradictions above showed that relevant CPD is a potential way to address them. The CPD section in the literature review pointed to further changes that are coming. It revealed that CORU launched (March 2013), a public consultation on a framework scheme for CPD and are advancing CPD through registration, which includes a Code of Professional Conduct and Ethics to be adopted by each Registration Board. CORU’s role is to protect the public by promoting high standards of professional conduct, professional education, training and competence. The next section looks at how the delivery of CPD could address the key challenges expressed through each of the themes.

7.6.1 De-institutionalisation

Practitioners need relevant CPD training because of experiencing issues as a result of working in small groups in communities where they work with children/young people presenting with complex issues and where there is a lack of staff and extra resources in comparison to the larger industrial schools caring for children years ago. For example, in the Commission to Inquire into Child Abuse: *Investigation Committee Report Vol. I* (2009, p. 239), while referring to St Joseph’s Industrial School Artane in Dublin they describe a 1904 Annual that lists 102 staff working in the school of which 26 were Christian Brothers including a Manager, a sub-Manager and two secretaries. The other 76 staff comprised:

- A nurse and assistant nurse
- Nine assistant teachers

- Four professors of music
- A gymnastic/gym instructor
- A clerk of works
- A town agent and storekeeper.

Apart from the internet and HSE-land information website, practitioners are not co-located with the knowledge/resources and on-site support as listed above, thus there is a need for CLs so they can develop the techniques of accessing more distributed knowledge, such as having research presentations and learning from colleagues/interagency teams working in their local areas. In the changing field of social care practice, change is coming and formal CPD will be a major part of it. Questionnaire participants discussed many impending changes that will impact on their work practice. This thesis proposes that in order to do CPD better, the way forward will involve dialogues and consultations between all parties: practitioners/managers, social work teams, trainers/senior management and everyone involved in the care of children placed in centres. As described by Engeström (2000a, p. 964) ‘a collective activity system is driven by a deeply communal motive’. The reconstruction of a learning community or of a community of practice/situated learning (Lave and Wenger, 1990) is required.

A community of practice is defined as a group of people who share knowledge, learn together, and create common practices (Wenger, 1998; Wenger et al, 2002). Communities of practice are shaped by three fundamental elements: a *domain of knowledge*, which creates common ground, a *sense of common identity*, that inspires members to contribute and participate; a *community* of people who care about the domain, thus creating the social fabric for learning, sharing, inquiry, and trust; and the *shared practice* made up of frameworks, tools, references, language, stories, documents, that community members share. Members of a community of practice are bound together by common interests and a desire to continually interact (Wenger et al, 2002). Collaborative working in the CLs would create dynamic communities of practice.

According to Wenger (2011) communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly. The concept has found a number of practical applications in business, organisational design, government, education, professional associations, development projects and civic life. The concept has been adopted most readily by people in business because of the recognition that knowledge is a critical asset that needs to be managed strategically. Initial efforts at managing knowledge had focused on information systems with disappointing results. Communities of practice provided a new approach, which focused on people and on the social structures that enable them to learn with and from each other. Today, there is hardly any organisation of a reasonable size that does not have some form of communities-of-practice initiative. A number of characteristics explain this

rush of interest in communities of practice as a vehicle for developing strategic capabilities in organisations:

- Communities of practice enable practitioners to take collective responsibility for managing the knowledge they need, recognising that, given the proper structure, they are in the best position to do this.
- Communities among practitioners create a direct link between learning and performance, because the same people participate in communities of practice and in teams and business units.
- Practitioners can address the tacit and dynamic aspects of knowledge creation and sharing, as well as the more explicit aspects.
- Communities are not limited by formal structures: they create connections among people across organisational and geographic boundaries (Wenger, 2011).

From this perspective, the knowledge of an organisation lives in a constellation of communities of practice each taking care of a specific aspect of the competence that the organisation needs. The very characteristics that make communities of practice a good fit for stewarding knowledge—autonomy, practitioner-orientation, informality, crossing boundaries—are also characteristics that make them a challenge for traditional hierarchical organisations. How this challenge is going to affect these organisations remains to be seen.

Like businesses, government organisations face knowledge challenges of increasing complexity and scale. They have adopted communities of practice for much the same reasons. The concept of community of practice is influencing theory and practice in many domains. From humble beginnings in apprenticeship studies, the concept was grabbed by businesses interested in knowledge management and has progressively found its way into other sectors. It has now become the foundation of a perspective on knowing and learning that informs efforts to create learning systems in various sectors and at various levels of scale, from local communities, to single organisations, partnerships, cities, regions, and the entire world (ibid, 2011).

Kimble et al (2000) discuss virtual teams and their place in the networked economy. They present a framework for categorising virtual teams and argue that fundamental changes have taken place in the business environment that force people and organisations to operate in ‘two spaces’ simultaneously: the physical space and the electronic space. The authors use evidence from two case studies to highlight some of the barriers to effective virtual team-working and demonstrate the critical importance of trust and social bonding to the functioning of such

teams. They report on the use of a community of practice in a virtual team and argue that this may provide one mechanism for overcoming some of the barriers.

They found that there are important implications for the face-to-face element of distributed team working. Members felt that meeting in the physical world allowed them to get to know each other far better than electronic meetings. Questionnaire participants expressed similar views when commenting on their experiences of the CLs. The importance of having a good relationship with the other members was regarded as essential by all of the members, as this carried the community through the periods of the electronic communication. The members gained a greater feeling of identity and common purpose through knowing each other. As one respondent described it 'you need that personal relationship if you are to go the extra half mile for someone': the communities members felt that they *knew* who they were dealing with - even if it was via-email. The findings of the case studies show the continued importance of the physical space – it sustains relationships through subsequent communication. Although these relationships need recharging at intervals, this recharging in turn contributes to the further growth and evolution of the team. As the members' confidence and trust in each other increases, they gain legitimacy in each other's eyes and further participation develops (Kimble et al, 2000).

In agreement with Kimble et al (2000) and Wenger (2011) this thesis is calling for a community of practice/knowledge to work with practitioners in the CLs because, as discussed above, practitioners are not co-located or networked with other centres or in a personal way with a person with knowledge somewhere else. Evidenced-based practice gives them reassurance that there is a protocol and there are policies and procedures to follow should anything go wrong. For example, in the middle of the night with only two practitioners on duty and up to four children/young people in the centre, they could refer to this protocol if there was a suicide attempt, a fire or if the house alarm went off. Practitioners are also aware they can use the internet which has the advantage of being easy to access, provides a wide variety of information and can provide a solution to a problem.

The disadvantage of relying on the internet is that it can be confusing because of the volume of information provided, the information may not be reputable and the personal interaction is missing. As discussed above, in older institutions resources were at the ready; someone was always there to assist practitioners. There is a need now to develop the skills to create this knowledge and the knowledge required now is more complex than what was required in the larger institutions. In their interviews, practitioners commented that there is no networking with practitioners in other centres or with other professionals. The only time that teams from the three centres met was when they had a TCI training day and even then not everyone from each team attends the training on the same day.

Access to distributed knowledge in communities of practice will comprise a bottom-up approach to learning, garnered from local practitioners. It can be argued that training provided by CORU involves both of a bottom-up and top-down approach; bottom-up in how they are organising countrywide information sessions for professionals, and top-down in that they are protecting the public and promoting an individual as opposed to collective initiative towards professionals organising their CPD. There can always be opportunities to bring in other professionals (boundary crossing change laboratory) or bring in an expert in the field or someone from senior management. Because of a lack of CPD training practitioners have started to organise free training, where possible, in their centres. The first step in this approach is that a practitioner realises that they do not know everything about a particular topic but how do they go about getting this knowledge? In the future it can be acquired in the CLs through the learning community as there will be a wide range of diverse views amongst professionals where learning can be shared with practitioners in centres who are not familiar with CLs or with the idea of having a learning community/community of practice.

As described above by Wenger, et al, (2002), communities of practice could comprise all professionals, in an area whose work involves caring for children/young people and who can learn from each other through CPD training. Teams could be created by convening CL sessions in centres and in communities; participants in attendance will include all relevant professionals/their representatives, in other words, trans-disciplinary teams (Cedefop 2010, p. 62) to include the child's family, gardaí, social workers, mental health professionals, psychology, criminal justice system, JLOs, lawyers, teachers, judges, youth workers, trainers, senior management and practitioners, who work together/associate with children needing State care – genuine interagency/inter-disciplinary teams. As in Engeström's study, the child/young person, ie the service user/client, could also be included in these CLs, with required ethical safeguards, if it was deemed appropriate and beneficial to the child.

It can be argued that due to the large amounts of personnel on site in the larger institutions, there may have been more support given to practitioners caring for children/young people. A major viewpoint put forward by practitioners in this study, was that their voice was not being heard; they said they were not listened to by senior management when they made suggestions or asked for specific CPD training. Based on the questionnaire data, it seems not much has changed: in terms of the training they needed, practitioners seldom got it unless planned anyway by management. Engeström's CLs brings everyone together in a structured and deliberate way which can include practitioners/social care managers, senior management and trainers; CLs are the ideal place where relationships can be built and where new professionals can gain the trust of others as they continue to meet over time. This is truly a bottom-up approach, while it can be argued that a top-down approach that has become the norm over the past years in the HSE.

Evidence presented in this thesis has shown that the top-down approach has not worked for practitioners as it did not practically provide adequate resources or deliver relevant CPD training; it did not holistically address the needs of the workforce. CLs can provide an environment that will generate more relevant and acceptable solutions to apparent contradictions and a platform for trained practitioners to bolster their confidence to practice and use their training skills to achieve enhanced professionalism and increased accountability in their work. The CLs provide a designated forum specifically for discussing issues affecting practitioners/social care managers. In the CLs, from meeting regularly and having face-to-face contact trust will be built, both between centre members and between them and the interagency teams and this is vital for continued success and progress (Jones, 2014a). Many reports including Buckley (2013) have highlighted the complete absence of interagency collaboration.

In advancing CPD to benefit the children in their care, practitioners together with the aforementioned others, could collaborate in research and development projects that would improve and bolster their CPD participation and ultimately their practice. As discussed above, the CLs, incorporating communities of practice which are central to professionalisation, could be seen as the community's answer to give everyone working with vulnerable children/young people, the knowledge and know-how to enhance their competences that can enable them to address the effects of social change including de-institutionalisation.

7.6.2 Aggressive Behaviour

As demonstrated in contradiction 7.5.7 above, there was a contradiction between TCI physical restraint the HSE/Tusla policy of choice for managing aggressive behaviour in centres versus practitioners desisting from doing physical restraints. To alleviate this, staff in the CLs should discuss with management about what is and what is not working and try to get the ideal balance through appropriate CPD training. At present TCI is the policy of choice of the centres', this is what is rolled out every year. This creates a contradiction between 'practice knowledge' and risk-driven bureaucratic knowledge: the HSE is afraid someone will die, TCI works and it is risk-driven, the HSE are worried that the practice knowledge on the ground says it does not work, this is the contradiction.

In the future, after engaging in CL sessions, practitioners through their knowledge of researching will be enlightened about other forms of CPD training that has been proven, based on evidenced-based practice and that could possibly be tried in the centres to address aggressive behaviour. At present, practitioners/managers meet trainers, only at training days. When trainers engage in CLs, staff will have the opportunity to meet them on a regular basis, in the structured space provided by the CLs where practitioners and trainers can collaborate and devise new forms of training either different to or in conjunction with TCI. The following are CPD training initiatives that could be discussed:

Response Ability Pathways (RAP) CPD training, by Brendtro and du Toit (2005) is based on the circle of courage and encompasses attributes such as belonging, mastery, independence and generosity for the child/young person. Digney (2009) promotes training based on the therapeutic application of humour for connecting with children/young people who display pain based behaviors. He claims that this training is effective with troubled youths. It is based on an understanding of how to connect and remain in relationships and at the same time use our innate and learned skills to help bring about effective therapeutic change. Another useful training for dealing with aggressive behavior is restorative approaches to looking at conflict, bullying, disruption and challenging behavior, based on mutual respect and personal accountability by Hopkins (2009). A training course: *Focusing – the Pause programme* by Derek McDonnell could also be beneficial for staff to practice with young people as it teaches the practice of slowing down and listening which will help to build meaningful relationships. All of these training initiatives are moving away from punitive measures towards talking, trusting and building relationships with the young people while trying to address the underlying causes of the behaviour. These could compliment TCI which looks at crisis and de-escalation.

Expanded learning takes places in the CLs by practitioners researching, coming back, and sharing with their colleagues what they found out about other CPD training initiatives aimed at addressing challenging behaviour. Senior management/trainers will be invited to the CL session once an appropriate type of training has been identified and a collective suggestion made as to proceed with it. Practitioners, by consulting the training map and training agreement will inform participants in the CL, as to who will be delivering the proposed new training.

7.6.3 Professionalisation

The IMPACT union (Nov., 2014) in their newsletter for social care practitioners have said that in 2016, CORU professional registration is due to take place for social care practitioners; registration will include a competency framework. CORU are advancing CPD through registration; simultaneously SCI, in their newsletters, are informing practitioners about upcoming registration including discussions on CPD. Tusla is in the process of finalising a National Strategy for CPD (Cullen, 2014). As previously mentioned, SCI is facilitating CPD information sessions for students and practitioners through their CPD officer. So, important processes have been taking place around CPD. By engaging in CLs practitioners will be taking ownership and control of their own knowledge and development through dialogue with colleagues, senior management, and other professionals from interagency teams.

For practitioners, engaging in the CHAT process is about boosting their professionalisation by consulting with their centre CPD officer/designated training

person, doing research themselves, and suggesting and planning the CPD training they need in conjunction with the chain/channels of communication, described above in figure 7.2. This is what constitutes a professional practitioner: being able to make autonomous decisions about their own work, in the same way that doctors or solicitors can. Moreover, from their experiences and local knowledge practitioners will know of competent professionals who are willing to be trained up and available to do training on different topics. In the past the thinking often was to secure someone to come in from outside to do the training and such people were often costly. While the content of their presentation may have been informative, it may not have been applicable to particular local work areas; it may be better to have people who know the area well.

Working as a residential child care practitioner can sometimes be overwhelming, because on a daily basis staff are taking on the splitting (Klein, 1984), transference and counter-transference (Freud, 1998) of children who are putting their problems onto them. CLs will bolster and enhance relationships, trust and team building through face-to-face contact among staff. As Fewster (2013, cited in Howard and Lyons 2014, p. 63) notes: ‘for staff in centres, there is no pleasure being around people who persistently abuse themselves and others’. In this quote Fewster is not arguing for control, rejection or isolation, but is arguing that we need to move beyond the theories and techniques provided by medicine, psychology and social work, which he refers to as outside-in interventions. He suggests that inside-out methods identifies the workers as the ‘primary agents of change’ (2013, p. 28) and that as a profession, we need to refocus our gaze and move away from deficit or disability thinking, towards a belief that change comes from inside using inner resources and inner potential to effect growth. Therefore, inside-out thinking is the best way to connect relationally with those for whom we are privileged to care (ibid, 2013, cited in Howard and Lyons, 2014, p. 63).

Connecting relationally will be achieved with the conviction of always being mindful of the core values of the profession: including having dignity and respect at all times for the integrity of the vulnerable children/young people that are in our care. This is copper-fastened by always adhering to a child-centred humanistic approach in and through our work and is dependent on language used as discussed by Orohoe, (2014, cited in Howard and Lyons, 2014 p. 73). Orohoe points out that at times staff can take for granted that service users are familiar with terms such as ‘needs’, ‘interventions’, ‘assessments’, ‘outcomes’, ‘self-esteem’, and support’. It is best that child-friendly language is used. Similarly, there is a need for staff to be self-aware and mindful of themselves while working in this caring environment where they need to feel supported. As stated by Winnicott (1988, cited in Ormond 2014, p. 253), ‘it is very hard for any carer to be “good enough” unless they themselves are held and supported’.

CLs will be the ideal forum for practitioners/managers/trainers and management to support each other in a caring environment in which they can re-examine their practises and discuss different types of knowledge: practical knowledge, knowledge from books/reports/literature and managerial knowledge. Social care practitioners can debate and discuss relevant questions around the changes involved in implementing the upcoming registration. Multi-voiced discussions in the CLs will debate the best way to actually do CPD and they can discuss a CPD model for the future; what will this entail? Could it work if each centre were given their own CPD training budget from Tusla? How will this work? It can be argued that this would have a huge impact on the way that centres are run. How will this link into policy? At present, practitioners will require diverse knowledge regarding registration as well as on other issues, such as how to balance the learning required, as well as clarification on the aforementioned questions.

For example, young graduate practitioners may not be interested in doing other training, which is pre-requisite with CORU/registration. They may think they do not need it, having just left college. On the other hand, older, experienced practitioners, working in centres for many years, may be bored with the idea of going to training that they think will be of no benefit to them because they are so long in the job already, as was evident in contradiction 7.5.5 where experienced, older practitioners did not want/were not interested in learning new computer skills. Similarly, questionnaire participants did not seem interested in doing any extra CPD training in line with CORU recommendations. Moreover, if these practitioners were more engaged in supervision and reflection on their work, both cohorts would appreciate the need to have new knowledge about their practice.

Knowledge accumulated from past experiences, regarding the lack of CPD being provided due to a lack of resources, could be discussed as well as sharing knowledge about experiences in sourcing free CPD from local professionals. Also future potential barriers to CPD can be discussed. Practitioners can enquire if there will be a top-down or bottom-up approach to CPD training by asking senior management if CORU are proposing a more systematic approach to social care practitioners' CPD that will involve all centres doing the same training as opposed to all centres sourcing their own relevant CPD training and constructing their own interventions to address contradictions if they arise, as in the TCI intervention.

The CL is the forum to discuss relevant interesting CPD training that would benefit all practitioners. Feedback from the CLs would inform management that there is a need to have an eclectic array of training options to correlate with the changes in the client group and keep up to date with legislation and changes in social care practice. Having this approach will keep all practitioners interested rather than merely doing CPD training, as was done in the past, so that practitioners were compliant for HIQA or to adhere to the organisation's policy, for example doing TCI yearly. In the future, when registration finally comes for

practitioners, it will mean that there will be an onus on them to engage in regular CPD training in which they can accumulate credit points of various values that will be recorded in their CPD portfolio. The portfolio will evidence and represent their CPD for themselves for ongoing use as well as for registration. By participating in the CLs and addressing their learning challenges, practitioners will know, from adapting Engeström's approach, that to better their CPD training will involve them utilising their local, bottom-up approach (Lemos et al, 2013, p. 718).

In relation to CPD credits, a core group can be set up in the CLs to work through and to discuss the process involved. This working group could consist of practitioners/managers, trainers and senior management discussing about what credits should be given to practitioners for professional development practices. It may be decided that to fulfil the 60 CPD credits required by registrants (CORU, 2014) during each 24-month cycle, practitioners could decide that, for example, 10 credits could be given for doing a presentation, 15 for professional supervision, 30 for attending a conference etc. The aforementioned example highlights how it is essential when applying Engeström's theory that professionals work together as part of a multidisciplinary team where two-flow communication is the norm and is emphasised through face-to-face interactions which constitutes the nature of CLs, akin to experiences of working in communities of practice/knowledge, discussed above. This approach has evidenced that when used appropriately it can generate, maintain and sustain change while incorporating the values of respect, inclusiveness, communication, collaboration and empowerment amongst staff.

Findings from this study suggest that practitioners are linking CPD to other aspects of their work such as pay/conditions and recognition issues. When registration for practitioners is introduced, they will have to pay a registration fee. Social workers paid a fee of €100 for registration in their first year in 2013 and the retention fee is currently €100 and is due annually. Similar fees may apply for social care practitioners, who have been expressing concerns about this and, as discussed above, where they commented on observing that colleagues who have obtained masters and other qualifications, have not been rewarded, either financially or otherwise in their posts.

While the aim of CORU is to advise and put structures in place for CPD, issues of concern will arise with regard to it. For example, questions surrounding the practical issues involved in taking part in the CPD such as who decides what CPD they do, who sources it, will they have to travel to it, will they get time off work or will they continue to source free CPD as they had been doing? While questionnaire participants said they were not too familiar with the CORU CPD process as yet, they commented about getting time off to go to CPD given their experiences of their current heavy work schedules with no extra supports or staff available for cover. Also if required to attend conferences, who incurs expenses

for same? Apart from the above questions, further discussion will be generated in the CLs which will encourage others to reflect on what they hear and seek clarification, about issues of concern.

During the TCI intervention (chapter six), practitioners commented on the benefits of having their own space in the CLs to reflect on issues pertinent to them. This comment was re-iterated by respondents to the questionnaire. This collaborative reflection will benefit all practitioners and can be extended to managers/trainers and to senior management alike. The theoretical approach devised from Engeström's theory which incorporates CLs, can be used to advance CPD. This is a format that is easily transferable from one organisation to another as was seen with the transfer from the large hospital setting in Engeström's Helsinki study to the small scale study: TCI intervention in the centre.

This can be achieved through education, training and support. Engeström et al are aware of the importance of these attributes and through the World Wide Web and other media have developed and enhanced learning. Chapter four alluded to recent work that has successfully utilised Engeström's theoretical framework. Most of the work up until now has been in workplaces in Helsinki, however, in an interview with Lemos et al (2013), Engeström talks about collaborating globally with researchers and bringing CHAT and CL interventions to other countries, such as Brazil: 'where perhaps the society is, at the moment, more optimistically and openly facing new challenges than in some parts of Europe and in the United States'. In an excerpt from the interview, Engeström explains that CHAT and in particular the CLs are at the forefront, contributing globally, to education, health and communication:

for Activity Theoretical research to be relevant it must aim at actually influencing people's lives and this increasingly means that we need to somehow get engaged and get involved in important society level transformations and see their impact and see how they are played out in local settings (Lemos et al, 2013, p.727).

This can be interpreted in this study that there is a need now for practitioners to get involved locally in their centres by shaping and having input into the implementation of their own CPD in line with CORU registration. Engeström stresses the importance of:

Activity Theory research being there, where the future is actually being shaped not where people are defensive and completely at a loss. I think that in the next few years we will have an increasing number of research studies, as well as intervention studies also using the Change Laboratory from different countries and we need to compare and bring these together into international publications to look at the experiences and insights

gained when implementing an idea. For instance, we have a colleague in South Africa using Change Laboratory to work with some local villages on the prevention of HIV AIDS and how to work with the villagers among whom this disease is widespread and to help build new ways of prevention. That's a very different challenge from the work in a Finnish hospital or a Finnish school. So, these comparisons and lessons gained across these cultural boundaries will be very, very central (Lemos, et al, 2013, p. 727).

As the above excerpt demonstrates, it is important for practitioners to have a space to reflect, to get engaged and involved (knotworking) and to discuss with each other if and how they are influencing the children's/young people's lives that they are caring for and how to do it better. Also, the CLs provide the space, whereby from engaging with other professionals, practitioners will gain access to societal knowledge where they can compare their practices with similar practice in (an)other country(ies). Societal knowledge will enlighten them to new changes that can impact on their practice at local level.

For example, media reports from the UK could be reporting on how young people are mis-using a certain type of drug, and about how it is affecting them. Information about this could be researched by practitioners and brought to the CLs, which will prepare them should they encounter this in their future practice. The benefit of engaging in structured CL sessions is that from one session to the next, practitioners have time to reflect on what happened and from recording it in their portfolio/journal they can look over it, for example, if not at work, at home or in their free time off work. Staff will know that at the next session they can bring up their contradictions again for discussion. The ongoing CLs give practitioners time to think, to dwell on their dreams and visions and to think strategically for the future of their centre/organisation.

In Figure 7.2 the chain/challenge of proposed communication was constructed as a result of working through the DWR methodology, to include the model/vision, mirror and ideas boards and the expansive learning cycle. Accordingly, the following are suggested steps for an AT-based CPD development process.

7.6.3.1 Suggested steps

- Each practitioner to have and bring their CL portfolio/journal to the CL sessions.
- The CL portfolio will document the starting point on the cycle of learning where practitioners start by asking questions about what is not working at present, following through to the last and seventh stage where they consolidate the new model into their practice.

- It also provides a hard copy record of their presence and includes notes/thoughts on the step by step journey taken in the CLs when discussing a contradiction in which an intervention was used.
- Or the portfolio could simply record basic notes on an experience that could be discussed and debated there immediately or could note the need for specific local attainable CPD training, or suggest it to be referred through figure 7.2 above to a higher authority or a note could be made in the portfolio to remind the practitioner to reflect on it later or get information through researching a topic/idea mentioned
- The portfolio allows for personal as well as professional team reflection and it can be taken further by being brought to the formal six week supervision session where it can form discussion or where issues needing clarification can take place with the supervisor.
- The portfolio can be used when doing an evaluation of each CL while noting points of importance along the continuum of the intervention.
- Recommendations can also be recorded in the portfolio and can be discussed at the next session.

As well as being used by practitioners, the learning from CLs can be expanded to other subjects such as trans-disciplinary teams and to senior management teams. The CLs can provide the necessary space and scheduled time for any group of professionals to explore options and to read and assimilate policies and then report back on them to their superiors and to their work colleagues?

In their interviews practitioners said they were not satisfied with their supervision, some called for external supervision as they were not comfortable being supervised by their centre manager or by their colleagues, the team leaders in their centres, who did the same work as them. The CLs would open up this finding for discussion, thereby causing a fundamental change as to how social care practitioner agencies are run; also, practitioners said they were not afforded time for reflection during supervision. Participation in CLs will prepare practitioners for critical reflection of their work and about how to think about it and what they are doing, which can be extended for further debate in their six week professional supervision session, if this is what they need. Supervision, reflection and learning are cornerstones of professionalisation and go hand in hand by empowering the practitioner which will benefit the children/young people in care, in their centre and will also benefit the organisation.

7.6.4 Paper trail/Accountability

At present, in centres there is a paper trail, involving multiple duplication of information on paper with the added problem of storing it while adhering to data protection protocols, but there is a move towards computerisation across the sector. In the questionnaire study, while commenting on the introduction of formal CPD by CORU, practitioners expressed their dissatisfaction with the extra amount of paper work required since the changeover from the HSE to Tusla and the national reconfiguration of residential child care services. This has resulted in practitioners being asked to complete many more forms. This has implications for CPD and people using the system need to be trained properly. As mentioned previously, RAISE is the online computer system within the HSE/Tusla that can be accessed by practitioners in centres. Computerisation will mean easier access to information and will be beneficial once all staff are trained to use the computer and to access it. It is important to be aware that there are ethical issues involved in sharing information among professionals. There are also key issues around accountability to external bodies, and about performance monitoring.

In the CLs practitioners need to examine issues around bureaucracy and the paper trail. There needs to be CPD training provided that can point to ways to have a proper filing system for centres. For example, as with Engeström's (2001) care calendar, practitioners need to design one-page templates and charts that are easily accessible and that at a glance can show, for example, how many significant event reports (SERs) did the centres have in 2014, 2013 and so on and how many child protection notifications were there? This information could be kept in a statistics folder on the computer and could be available in seconds if required either for a report, for other professionals or if needed at times of inspection. Having this on the computer will reduce duplication and the need to create and store hard copies, thus somewhat reducing the paper trail. Of note is that in the private residential child care sector, for example, Positive Care Ireland (PCI) care service, is backed with a customised IT and administrative system that ensures all registration and regulatory standards are adhered to consistently, at all time (PCI, website 2014). This process lends itself to accountability in terms of time management, professional conduct, team work and performance management.

7.6.5 Communication

Engaging in CLs is communication personified and is an answer to the finding from the interviews where practitioners said that communication was the most important element of their training but there was a lack of communication amongst staff and overall in the sector. The ultimate way to address issues surrounding deficiencies in communication would be, to provide adequate resources so that practitioners/management and representatives from the trans-disciplinary teams could meet at CLs, to discuss contradictions and CPD that is

required in each area. Improved resources would mean that professionals would be more efficient and this would lead to them being more aware of their role and responsibility. While CORU has introduced individual responsibility by requiring each professional to engage in relevant CPD which they will be credited for, the overall outcome of the approach alluded to in (figure 7.2, above) is that it will aid collective accountability. It will be a community of practice approach to CPD rather than an individualistic one. Pursuing a collective responsibility towards the child this also leads to a child/client centred (Rogers, 1980; 1998) approach with the best achievable outcome for the child/young person.

Communication will be enhanced further by practitioners using their CL portfolio/journal. The CL portfolio can provide tangible evidence and a record of communication that could be called upon by trans-disciplinary teams or by the public should there be an enquiry (fitness to practice by CORU) or scrutiny of a particular aspect of work or of a centre. An advantage of using a portfolio/journal is that it can be used to record and to show where accountability was addressed. In collaboration with all present at the CL it will address issues that are pertinent to working with children/young people such as risk culture. As in the practice of writing up children's daily logs, practitioners will be aware that there are two sides to this as regards what they write and it being used as a record for the future. There is a possibility that potential exposure to public scrutiny may have a chilling effect on participation in CLs, if all inputs are documented.

In summary, apart from issues surrounding a lack of proper, continuous and follow-up communication practices. Other issues have been identified, some basic resource issues and some broader, philosophical/political issues, such as issues of power between practitioners/managers and senior management in the HSE. Moreover, if resources were not an issue, in terms of staff, there would be little challenge in providing CPD as there would be cover for staff, for example, to attend conferences where they could receive and take back valuable knowledge to their work teams. The events calendar, training map and the training agreement could be utilised for this purpose, with practitioners deciding on what CPD they required, starting with the most pressing contradiction/requirement and moving down to what would be of benefit later. Employing Engeström's theoretical approach to reconfigure CPD for the future will address the changes that practitioners need to make in their centres.

7.7 CONCLUSION

The literature review identified changing trends in the social care sector, through examining the five overarching themes: the changing field of social care practice, changes in the nature of the client group, professionalisation of the workforce, accountability/risk culture, interagency/inter-professional/collaboration and CPD. I researched these themes to establish the current situation; my research identified

social changes and shifts in societal thinking that were reflected in the following challenges: de-institutionalisation, aggressive behaviour, professionalisation, accountability and communication.

De-institutionalisation was established to have had a significant effect on the nature of the client group because children/young people were moving from a controlled structure to places where they had choices, where they were listened to and where their needs were assessed. This created new challenges for staff; individual issues were identified and established but in order to address these issues properly staff needed to be up-skilled and trained. Investigations into mal-practice in institutions culminated in published reports by academics and the government. These were drivers that instigated the need for changes in practice which included the need to have an educated and trained workforce to work with these children/young people. An educated workforce contributed to increased standards and professionalism.

This had a significant impact on the understanding of the need to be accountable. Accountability is described in terms of one's skills but also in a shift in thinking to a more client-centred approach, for example, a move to bungalows in communities. As opposed to the onsite support synonymous with institutions, practitioners working in such bungalows were often isolated and did not have access to expert knowledge or support. Investigations ensued as to how to improve the situation; published reports promoted the need for interagency/collaborative work practice, however, as stated above, many reports have highlighted the absence of interagency collaboration.

CPD is an important part of the response to these changes but the CPD offered to practitioners/managers was inadequate. This thesis is arguing that a new approach to CPD in the form of Engeström's AT, incorporating CLs, is needed to provide a better CPD outcome for practitioners for the future. In their present busy work schedules, CLs will provide the space for practitioners/managers to collaborate. CLs will give them a scheduled time within a structured environment in which they will have time to think about themselves and their practice as opposed to being at a team meeting or at supervision, where the time can be taken up addressing and discussing crises. As practitioners will know this is their space, it will alleviate the need to rush, or try to assimilate information on the spot. Instead, they can record notes in their CL portfolio/journal that can be referred to later.

In their own time, they can assimilate this information/new knowledge and critically reflect on it and the learning garnered from it. At the next CL, they can come back to their colleagues with their reflected thoughts on the new knowledge, including thinking outside the box, strategically and for the future both of their work, their centre and their organisation. Learning from each other while simultaneously utilising their CL portfolio/journal can be life changing, and

conducive to transformations in practice for practitioners, managers/trainers; it can also be used by senior management to work on a plan of strategic practice for centres and for the future planning of the organisation.

Once registration is enacted for the social care profession, each practitioner will be accountable to the public. They will have a number on the register and be accountable to Fitness to Practice regulations (operationalised on 31st December 2014), including being sanctioned if defined standards of performance and/or conduct are not met. It can be argued that the purpose of registration is to set standards and to put the thinking, responsibility and the accountability back onto the individual practitioner. To pre-empt this, it is vital that practitioners are receiving ongoing relevant CPD training that will enable them to be accountable and to be confident and responsible for what they do and able to discuss and show anyone how they work, how their centre works.

This approach will equip practitioners with competences that will enable them to show how they are providing a professional service to children/young people in their care. The time and space, provided by the CL allows practitioners to step back and accept that they have routine work that has to be done and is ongoing but they can ask themselves and their colleagues questions and apart from starting with stage one, the questioning stage on Engeström's cycle of learning, they can ask questions such as where is this going, what is working, why is it not working and what do we need to do to change it; how can we do it better for the future? Figure 7.2 above, will assist with clarifying these questions.

In the CLs any question (contradiction) can be asked/discussed. For example, a fundamental question clarifying whether child-friendly terms have been used/explained by practitioners to children/young people when they first arrive at the centre and, if not, this can be noted as a priority from then on. CLs can be described as a community's answer to addressing the impacts of de-institutionalisation, (both the practitioners' community and the broader boundary crossing community) because they involve a collaboration of interagency and trans-disciplinary teams. Using this theoretical approach will address the CPD issue for practitioners; CLs are the ideal forum in which it can be done.

In acknowledging relational agency, practitioners will appreciate the creativity and diversity of thinking and beliefs of other staff members that they will encounter at the CLs. Experiencing this knowledge will open up communication and create transformations and change. Questionnaire participants said they experienced this when they took part in the CL intervention. Intuition will be at the fore in the CLs and practitioners cannot but listen; if they do not want to listen and even though they may not like what they are hearing, they will still hear it and maybe after hearing the debates and discussions, they may eventually realise for the first time that what they had been doing all along was not working. As pointed

out by Engeström (2001, p. 142) when discussing the Helsinki study: ‘despite overwhelming evidence, the acknowledgement and articulation of the contradictions was very difficult for the practitioners’

As was seen in the TCI intervention (chapter six) when practitioners were encouraged to give their opinions, they were open-minded and forthcoming in their views. Practitioners’ work is stressful and longer serving practitioners have said that the children/young people coming into care now are more challenging. Instead of internalising feelings of oppression resulting from stresses incurred in their work practices or by demands placed on them by HIQA, in the CLs they know they will have time to debate and explore issues, with colleagues and other professionals who will understand the situation.

By utilising this approach prior to engaging in the process of registration, practitioners will begin to prepare for reconfiguration of CPD. In engaging in the preparations, they will be proactive in investigating how to enhance their profession and the service. Engaging in the CLs will aid the reconfiguration process. It will awaken practitioners’ consciousness and sense of purpose about what they are doing and where they want to go, to progress for the future which will be good for the children/young people in their care but also, as stated by practitioners, for themselves and their centre/organisation. This was experienced by questionnaire practitioners who said they felt empowered at the CLs and encouraged to pursue training courses, for example, in addiction studies, to help them to develop and improve their work practice. The CL space will be ideal to allow practitioners to access knowledge either from their colleagues or from senior management/other professionals about changes in policies that stem from government, academic and peer-reviewed reports and publications.

Adapting and applying Engeström’s theory will lead to a complete change in organisational structure, supported by education and training for the benefit of incorporating a move to inclusive communication between practitioners/managers/trainers and senior management (see figure 7.2). It can be argued that prior to this; a top-down didactic approach had been used by management. This new approach will impact on practitioners as it encourages them to participate and to focus on the CPD that they want. This will encourage them to take ownership of it (as was described by questionnaire participants) as opposed to criticising the CPD suggested by management. As a result, practitioners will be more aware about how best to reconfigure their CPD for the future.

Participants engaging in this theoretical model, in the CLs, will build relationships with their colleagues, trainers and senior managers - a vital component of the work of residential child care practitioners. As a result, practitioners will know that as part of their reconfiguration, they have to take responsibility for their work and their learning which will contribute to them being confident about their

aspirations and suggestions for proper relevant CPD training that will be of benefit to them and their practice. This will involve the process of self-reflection, where they need to be critical at all times of their practice and open to change, while recognising that usually people are conservative about change. This will enable them to reflect better and to debate issues which will alleviate the need for them to immediately start defending their practice when things go wrong, as they will already be one step ahead by thinking critically and strategically, both individually and collectively about what could possibly go wrong and rectifying it instead of what happened in the past.

CLs will be the place where memories will be jogged into reality. Practitioners will give and get inspiration from each other, some people will learn to talk and others will learn to listen because in the CLs everyone gets a chance and everyone is equal. The CL will teach practitioners about what is normal, where they are going and they will learn more about where they need to go to improve their practice. If the session involves a boundary crossing change laboratory (where professionals from other agencies are present) this will extend their knowledge and learning and create beneficial new networks. At all times practitioners need to look to extend their knowledge and expertise strategically and it is this that will nourish them for the future.

A main part of the ethos of the work carried out in CLs is the focus on education and the scope of learning. Education will be the driving force for change in activity systems (centres). It will assist practitioners in achieving transformations which can be transferred across the profession. This will be boosted by practitioners actively using their CL portfolio/journal on a daily basis and for daily reflection. This will be a change for practitioners; those who took part in this study did not have or use a reflective portfolio/journal, which can be used in supervision but have a work diary, to note times of meetings and/or for use with their work rota. It was also evident from questionnaire participants that as of yet they are not using a reflective journal.

Change will include the provision of CPD training in how to appreciate research and how to source articles of interest that will benefit their work practice. This will give a worldwide and holistic view of new and better practices that are taking place in other countries and that can be emulated and tried in their centres. This will keep practitioners up to date with diverse perspectives, developments and changes as they occur. CPD training will include showing older staff members how to use the Internet to research interesting articles in reputable journals so they could partake in sharing of new ideas with their colleagues. One questionnaire participant mentioned that she would like to get CPD training in Information Technology, especially in how to operate a computer. CLs will provide the forum in which each practitioner promotes their agency and where they learn the value of relational agency of their colleagues. This will be further enhanced by the

portfolio which will enable them to be in tune with their daily work including taking responsibility for their actions and their learning.

In the CLs there will be an infusion of knowledge, skills, values, competences and research that will be shared and transferred between professionals. This will booster their development and practice which will enhance and empower the children/young people in their care as well as their colleagues and their organisation. Because of trust built up and relationship building having taken place, practitioners will be at ease and will be confident about discussing errors and mistakes as they will know they will be encouraged, assisted and supported by colleagues and trainers/senior management. As well as being active and integrative in the CLs, practitioners will need to be pro-active and professional in transferring their learning and knowledge to trans-disciplinary teams whom they encounter through their work practice while being aware of the reciprocated knowledge that can be gained from the relational agency of team members.

7.7.1 Activity Theory (AT): the issue of power

In this section (referenced to section 3.12.13) the researcher considers AT and the issue of power. A number of authors: eg Peim (2009), Daniels (2004), Avis (2007), Hartley (2009), Martin and Peim (2009), Blackler (2009); and Kontinen (2004, 2013) claim that Engeström fails to address issues of power in his interventions. In revisiting this section, some of the key issues highlighted by two authors already mentioned, and from their more recent papers: Blackler (2011) and Kontinen (2013), will be discussed.

In *Power, politics, and intervention theory: Lessons from organisation studies*, Blackler (2011) describes how accounts of 'double stimulation' and 'ascent from the abstract to the concrete', as discussed in classroom and workshop studies, tend to overlook the dynamics of power and politics. He claims that such dynamics are more obvious in less controlled settings and uses two reports of collective learning in work settings to illustrate the point (Blackler, 2011, p. 724). In one, the 'germ cell' of a new approach was heavily contested as people manoeuvred to establish the legitimacy of their contrasting positions. In the other, 'ascent' from the germ cell to new practice was contested, with entrenched attitudes and relationships blocking new developments.

The relevance of such issues for Activity Theory (AT) is considered through a review of how power and politics have been theorised in organisation studies. According to Blackler (2011, p. 724) power can be conceptualised as both the medium for, and the product of, collective actions. Its study raises important questions about how learning interventions themselves should be understood and managed.

Blackler (2011) claims that in the field of organisation studies there has been a long-standing interest in the management of change. One sub-theme has been the study of power and organisational politics and their relevance to the conduct of organisational change. He proffers that the notion of power has been occasionally mentioned in the following collection of papers: Engeström (2011) mentions the importance of resistance and subversion in learning; Downing-Wilson, Lecusay, and Cole (2011) note the importance of equalising power differentials between the students and undergraduates in the intervention approach they describe; Clot and Kostulski (2011) emphasise that their intervention method focuses on people's power to act; and Virkkunen and Schaupp (2011) mention the power of theory.

Yet in these papers, as in the broader AT literature, notions of power and politics remain, according to Blackler, largely under-theorised (2011, p. 724-5):

The approach [is] strangely silent on issues that are central to interventions in most of the social settings I have worked in. Double stimulation and the ascent from the abstract to the concrete, central to activity theory, as Sannino's (2011) paper clearly explains, are likely to be contested in many contexts. Outside of the relatively controlled setting of the classroom or workshop, collective development is essentially a political learning process. As will become clear I agree with Sutter's (2011) suggestion ... that CHAT methodology has underestimated the resources that participants, as against researchers, can bring to a development project. ... to deal with this problem it is necessary to rethink the nature of activity theory intervention projects, the role of researchers in them, and the artefacts that are transformed in the process. However, I do not think that it is enough simply to seek out those rare occasions where close, long-term, collaborative relations can be forged between researchers and participants. What is missing from that approach, as indeed in activity theoretical approaches more generally, is an appreciation of power and politics in working relationships and their place in collective development.

Blackler illustrates this point through two case examples, and offers some brief comments on how power and politics have been understood in management and organisation studies. He then considers some issues the discussion raises about AT and related intervention methods.

The first case concerns a large, diversified British organisation in the chemicals industry, Imperial Chemical Industries (ICI), which had enjoyed considerable success through much of the last century (1920s-80s). The case describes the difficulties the ICI top management team had over an extended period in agreeing on how to rework priorities and practices (Blackler 2011, pp. 725-728). Blackler (2011, p.727) claims that whatever one thinks of the transformation achieved in ICI (there undoubtedly were winners and losers), the change was considerable.

Yet, importantly for the theory of activity, the transformation of ICI was neither easy nor straightforward. Blackler (2011, p. 727) contends:

As my notes on the case suggest, different parties within the organisation lobbied energetically in favour of their understandings of what should be done. Intense and uncomfortable debates extended over nearly a decade before, finally, one particular set of ideas won the day. Translated into the terminology of activity theory: the development and formulation of a “germ cell” at Board level about how ICI might best be managed in new, emerging, and unfamiliar circumstances proved to be a highly complex and contested process.

The second example is of a failed reform attempt in the UK public sector: a city’s social services department sought to introduce an 'early intervention service' (EIS) for vulnerable families (Blackler 2011, pp. 728-729). The case suggested that in the absence of evidence that the new scheme was working as originally intended, continued funding proved impossible to justify. Funding was scaled back and then terminated. Translated into AT terms, the basic problem was not the development of a new 'germ cell' of an idea to inspire new activity, as it had been in ICI. It was the 'ascent' from the abstract to the concrete that was contested. Established attitudes and rivalries across organisations and agencies blocked enactment of the EIS vision that had attracted so much initial enthusiasm (Blackler, 2011, p. 729).

For Blackler (2011, p. 729) the dynamics of the above cases are not unusual. He claims that, nonetheless, few significant efforts have been made to consider how power and politics can be incorporated into a theory of collective development. He suggests one reason: that psychology does not often mix well with political sociology. Also he suggests that the terms 'power' and 'politics' are not straightforward and they are not always well understood.

He suggests (2011, p. 729) that in the literature on power and politics, which evolved in the 1950s and 1960s, there was little consensus about how they should be understood. Power was variously equated with coercion, force, authority, status, manipulation, resistance, persuasion, and influence. Such varied notions proved difficult to reconcile and decision making theorist March (1966) articulated a criticism felt by many: power as a concept lacks clarity; it is a 'disappointing' concept, as it gives researchers 'surprisingly little' they can use in models of complex choices. Later students of power were to take a different approach: the concept, they suggested, should not be approached as a precise and unambiguous technical term.

For Blackler (2011, p. 729) power is an everyday notion that people use in a variety of ways. Although used variously, it is not used arbitrarily. Rather than asking 'what is power?' organisation scholars began to realise it was more helpful to enquire 'what kinds of behaviour, relationships, and outcomes does the notion

of power sensitise us to?' In answer to this question, philosopher Peter Morriss (1987, cited in Blackler 2011, p. 729) identified three contexts in which the term 'power' is used:

- in practical discussions about what people can do for themselves or what others might do to them
- in moral discussions about whether or not someone acted responsibly or irresponsibly
- in evaluative discussions about whether or not the distribution of power in any particular situation is acceptable.

According to Blackler (2011, p. 729) practical, moral, and evaluative issues have all featured prominently in discussions about power in organisational change. But just as the concept of power presents difficulties, so too does the concept of organisational politics. Organisational strategy theorist Henry Mintzberg (1983), for example, expressed a profound dislike of politics, which many people probably share. For Mintzberg, politics was irregular and divisive. Managers, in his view, should regard themselves as being *above* politics:

Distilled to its essence politics refers to individual or group behaviour that is informal, ostensibly parochial, typically divisive, and above all, in a technical sense, illegitimate—sanctioned neither by formal authority, accepted ideology, nor certified expertise (although it may exploit any one of those) (p. 172)

To Blackler (2011, p. 729) Mintzberg's outlook is ultimately unconvincing and he asks: who is to decide whether or not a particular influence attempt merits the labels 'divisive', 'illegitimate' or 'unsanctioned'? Why should anyone think that a manager's formal and very direct order 'do this or I'll sack you' should be viewed as anything *other* than a political act? It is true, certainly, that people seek to promote themselves, perhaps at others' expense and, no doubt, are capable of doing that in more or less ethical ways. But as a number of commentators have stressed, it would be a mistake to equate organisational politics merely with self-interested manoeuvring (ibid, 2011, p. 729).

Moreover, Blackler (2011, p. 730) suggests that the point is highly relevant to the theory of collective development as understood in AT. Organisational politics takes place around questions of priorities, policies, and practices. To a greater or lesser extent people in complex work organisations depend on each other; but what is decided and what actually happens will be steered more by some people than others and will affect different members of an organisation in different kinds of ways. If power is conceptualised as the ability to get others (and indeed yourself) to do what you want, politics should be understood as the *exercise of*

power in practice as people try to influence the formulation of 'germ cells' and participate in the 'ascent to the concrete'.

The complexity of the influence different groups can bring to bear on the development and enactment of new ideas is illustrated by the range of issues that have interested organisational scholars concerned with power. Blackler (2011, p. 730) suggests that the following summary should be considered:

(a) In the late 1950s, theorists associated with 'organisational development' (an approach to organisational intervention based on social psychological insights) introduced discussion about the nature of *personal power*: that is, how it is that some individuals are more powerful than others.

(b) By the 1970s, attention shifted to sociological analysis of *collective power* in organisations. The focus at this time was on why some departments in an organisation are more powerful than others, and how different groups deal with the conflict that may develop between them.

(c) Both these strands of inquiry were preoccupied with the *overt* exercise of power: that is, with situations where no one has any doubt that power is being exercised. How concentrated or distributed overt power is in contemporary organisations, and how acceptable such arrangements are, were questions that were widely debated through the 1970s.

(d) Subsequently, much discussion centred on the analysis of power that is exercised in less obvious ways. It was suggested that an analysis of the nature of *unobtrusive power* could explain why disadvantaged groups come to accept their situations willingly.

(e) By the 1980s, there was a growing recognition in management circles of the practical importance of shared, taken-for-granted assumptions. Analysis of unobtrusive power within organisations led some theorists to suggest that the management of *organisational culture* was a key priority in organisational change.

(f) Concerned about the apparent manipulative overtones of the 'culture change' movement, a number of commentators articulated strong moral criticisms of what was being suggested. By the 1990s, this had matured into a self-consciously 'critical' approach, led by scholars who felt that people's understanding of their identity was being swamped by managerial jargon and technique. Their analysis highlighted the importance of *the understanding and management of self*.

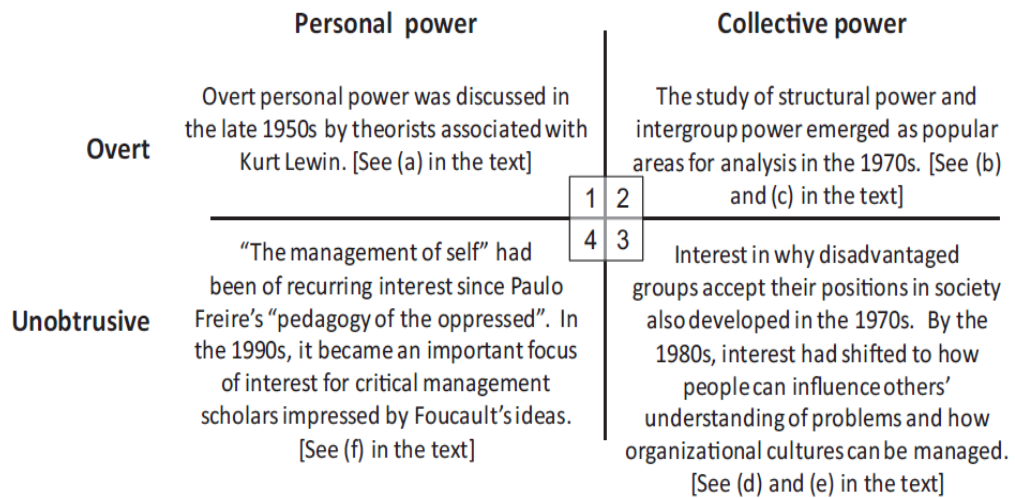


Figure 7.15: Four perspectives on power in organisations (Blackler, 2011, p. 731).

Figure 7.15 summarises these points. *Personal power* (the power an individual may have) is distinguished from *collective power* (the power of a group or functional unit), and *overt power* (which is easy to see) is distinguished from *unobtrusive power* (which may be hard to spot). Research relevant to each of these quadrants has produced its own substantive insights

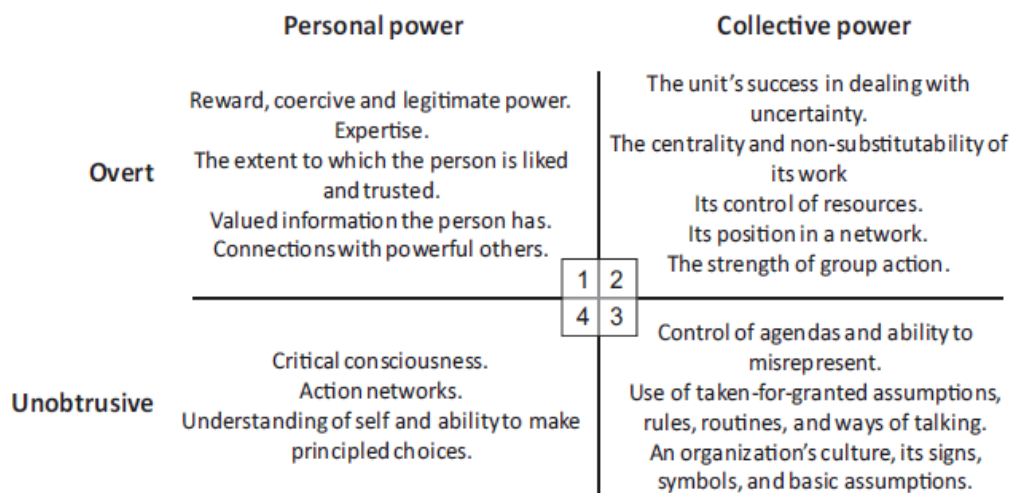


Figure 7.16: The nature of power, as understood by the four perspectives (Blackler, 2011, p. 732).

Figure 7.16 provides some examples of these. Such analysis can be related to the two cases introduced earlier. The ICI example focused on efforts to encourage key staff in the company to recognise that their taken-for granted assumptions needed

to be revised—issues featured in quadrant 3 in Figures 7.15 and 7.16. It featured the role of senior figures on the Board blocking suggestions for change (issues featured in quadrants 1 and 2 in the Figures) and the difficulties people in favour of change had in encouraging their colleagues to rethink their understandings. Some reformers mounted a long campaign: for one a jovial personality and independence of mind gave him the ability to persist over an extended period of time (see quadrant 4 in Figures 7.15 and 7.16). Nonetheless for several years those who were in favour of reform could not agree amongst themselves as to exactly what was necessary. Although there was much debate, they did not agree on a unified alternative policy and did not act as an effective pressure group (quadrant 2) (Blackler, 2011, p. 732).

A similar variety of power/political dynamics was a feature of the EIS case. Here, change was first led by a dynamic and well-connected individual who inspired others with his vision (quadrant 1 on Figures 1 and 2). Key groups involved failed to overcome traditional rivalries between themselves and to develop new ways to collaborate (quadrant 3). Ultimately the EIS group failed to demonstrate success in dealing with a major problem (quadrant 2) and, in tightened circumstances, funding was withdrawn.

That established patterns of practice reflect broader power issues has long been accepted by some practice theorists. John Mohr (1998), for example, wrote:

Any cultural system is structured as an embodiment of the range of activities, social conflicts, and moral dilemmas that individuals are compelled to engage with as they go about negotiating the sorts of everyday events that confront them in their lives (p. 353)

One consequence of emphasising the relevance of power and politics to collective development would be, I suspect, to encourage both a limited and hence perhaps realistic series of expectations about what can be expected from a development intervention such as a sequence of CLs. Power is at its most persuasive when people are doing what they think of as ordinary. Some years ago, organisation theorists Hardy and Clegg (1996) suggested organisational scholars should theorise power as *the medium of collective action*. They should thus:

Treat all forms of power play, including its theorising, as moves in games that enrol, translate, and treat others in various ways, in various situated moralities, according to various codes of honour and dishonour which constitute, maintain, reproduce, and resist various forms and practices of power under their rubric. There is no reason to think that all games will necessarily share one set of rules, or be capable of being generated from the same deep and underlying rule set. Power requires understanding in its

diversity even as it resists explanation in terms of a singular theory.
(Hardy and Clegg 1996, p. 636)

In summary, Blackler (2011, p. 733) suggests AT should take this injunction seriously and consider the implications for intervention methodology. The developmental orientation associated with AT and illustrated well by the papers in his collection suggests, indeed, a further insight to Hardy and Clegg's: power is not just the medium of collective action; power is also the product of collective activity. This way of thinking of power invites the development of methods to help reshape the power/political dynamics that can be identified in particular activity systems. Yet, according to Blackler (2011, p. 733), such a task has yet to be addressed by activity theorists.

Kontinen (2013) provides an alternative perspective on the issues of power in AT. She presents a Gramscian reading of organisational interventions within the framework of developmental work research (DWR). She explains (2013, p.106) that organisational change triggered by designed interventions is at the core of DWR, situated in the tradition of cultural-historical research (Engeström 2001; 2005b; Virkkunen and Schaupp, 2011). DWR and its application, such as Change Laboratories, apply interventionist methodology to organisations conceptualised as activity systems, or, networks of activity systems.

As we have seen in a previous outline of AT, the theoretical groundwork of DWR (Engeström, 1987) innovatively combines psychological accounts of human learning drawing on Vygotsky, Leontjev and Bateson together with the overall Marxian philosophy of praxis and the analysis of contradictions as phenomena related to the economic constellation of capitalism. The fundamental notions of DWR are the *activity system* and the cycle of *expansive transition* (Engeström 1987, p.78, p. 322), further referred to as *expansive learning* (ibid, p. 106). Practical organisational interventions follow the stages of the cycle of expansive learning: historical analysis; actual-empirical analysis; modelling; examining and implementing new models; reflecting on the process; and consolidating the new practice (Engeström 2001; Virkkunen 2004). Kontinen (2013, p.107) uses DWR in reference to organisational intervention, a researcher-designed process in activity systems proceeding in accordance with the stages of expansive learning.

Kontinen (2013, p.107) notes that on the basis of references made to Marx's *Feuerbach theses* (Marx 1998 [1945], p. 574) in support of the need to not merely understand but instead change the world, DWR can be located in the tradition of transformative and critical research. Sawchuk et al. (2006, p. 5) define the meaning of 'critical perspective' as 'approaches that ultimately have an interest in describing, analysing, and contributing to a process of historical change and human betterment along the lines of Marx's Eleventh *Thesis on Feuerbach*, that is

an emphasis on change with a clear-eyed understanding of the social, political, economic, and historical base of material reality'.

In Kontinen's (2013, p.107) view: 'the research that produces socio-critical knowledge can be conceptualised as revolutionary practice which entails the idea of a dialectic relationship between changing circumstances and changing activity'. Kontinen (2013, p.107) draws on Jean Lave (2012) to urge cultural-historical research to become such a revolutionary practice. In her search for new, revolutionary research agendas, Lave (2012) advocates the ideas of Antonio Gramsci (1891-1937), particularly as a basis for a theory of learning and education. Gramscian notions such as transformation of societal relations, engagement in a critical analysis of power as hegemony, and understanding the political aspects of any activity are relevant to cultural-historical research in the contemporary world Kontinen (2013, p.107).

In explaining this Kontinen (2013, p.107) discusses Lave's proposition within the specific context of DWR. She draws on recent research literature which critically discusses the theoretical principles and practical implementation of DWR. These reflections have pointed to the use of the concept of contradiction (Langemeyer 2006); the insufficient analysis of power relations (Blackler 2009; Kontinen 2004; Silvonen 2005); the un-dialectical misconceptions of societal practice in terms of local activity systems and missing the complexity of human practice (Langemeyer and Roth 2006); as well as the overall observation of DWR being a managerial technique of improving work processes to best serve the interests of capital, rather than a transformative practice (Avis 2009; Daniels and Warmington 2007). Moreover, losing the link between Marx's *Capital* and the analysis of concrete work activities is said to bring 'bourgeois sociology to Marx' (Jones 2009, p. 50) (Kontinen, 2013, p.107).

According to (Kontinen, 2013, p.108) the overall tone of the critique has been that DWR has distanced itself from its Marxist philosophical roots and the idea of transformation, and has been domesticated into an approach interested in technically improving work practices within the prevailing capitalist economic system. However, she notes, the theoretical principles of DWR and expansive learning have remained unchanged and any explicit reconsideration of Marxism, for example, has not been called for. In addition, notwithstanding the number of applications of the theory in different areas of activity, and the introduction of notions such as 'knotworking' (Engeström, Engeström and Vähäaho, 1999) and 'runaway objects' (Engeström, 2011), the underlying concepts of activity systems, expansive learning and contradiction have not been significantly reformulated (Kontinen, 2013, p.108).

Inspired by Lave's (2012) suggestions, Kontinen (2013, p.108) proposes a Gramscian direction for revisiting some theoretical notions in DWR. In doing so

(2013, p.108) she affirms that it goes without saying that Gramsci's concepts are subject to continuous contestation and specialised scholarship and far beyond her to delve into these nuanced debates. Kontinen, (2013, p.108) identifies and discusses some Gramscian ideas as being potentially relevant to specific contexts of organisational intervention in contemporary working life and discusses a number of themes in regard to transformative practice in DWR and revisits some selected principles of the approach along with their critical commentaries. She focuses (2013, p.108) on, among others, the notions of power and contradictions in organisational learning in DWR.

In analysing power in organisational intervention Kontinen (2013, pp. 116-117) claims that in organisational interventions based on DWR the issue of power has not been the focus of the analysis. However, she argues, the question of power explicitly emerges in at least three ways (Kontinen 2007, pp. 139-142). First, power has been mentioned as a feature of the historically formed division of labour (Engeström 1993, 67; 2001, 132). In these accounts, power refers to the hierarchies in workplaces, for example between shop-floor workers and management within an activity system. Second, power is mentioned in relation to the notion of contradiction where 'power and domination are at work in contradictions' (Engeström 1999c, 178) but is distanced from asymmetrical relationships.

Third, power has been seen as materialised in the instruments used in activities (Engeström 2005a, 12). In this view, power is perceived as power to do something, the capability to produce and work on the objects. Commenting on the Foucauldian notion of governmentality, Engeström (ibid.) maintains that 'productivity is power' and that in the analysis of power we should ask the following questions: What are the tools and signs available for different participants, and how are they used to construct the object of the activity? Moreover, Engeström (2005a, p. 12) suggests that the analysis of power, if put into focus, does not necessarily mean any normative stand towards the interests of different participants, for example shop-floor workers. The different perspectives are treated as equal voices, and both the ideas of management and the everyday experiences of ordinary workers are made visible in the intervention (In the researcher's study these sentiments were borne out in that the equal voices of participants were made visible in the TCI intervention. This created the impetus for management to act on adapting the centres behavioural management policy). The question of whether a normative stand can be taken towards the capitalist relations is not elaborated on.

The accounts that are critical to activity theory within organisational studies have pointed to the starting point of DWR, namely the object of the activity. The focus on object, it is claimed, leads to a tendency to ignore both the 'hierarchy and disadvantage' that occurs in the reality of organisational life (Blackler 2009, p. 39)

and the tendency for the conflicts to be domesticated (Avis 2009, p. 159). In the same vein, Warmington (2008, p. 12) addresses the tendency of DWR to focus on a horizontal division of labour. Thus, the contradiction between labour and management who, according to him, are the representatives of capital is left untouched. Avis (2009, p. 159) argues that changes in activity resulting from interventions are treated as a process that serves the interests of all participants as if there would not be some interests served better than others in the new models of the activity.

The principle of multivoicedness and assumed dialogue between historically formulated voices is central in DWR. However, one finds little analysis of the actual dialogue from the point of view of the inclusion and exclusion of certain voices, and the historically formulated relationship between the voices (see Blackler 2011; Kontinen 2004; 2007, p. 222). Whilst the conflicts and tensions are acknowledged as important points in learning, the analysis of conflictual interests and their manifestation in negotiations is rare. In organisational interventions, the notions of 'dialogue between voices' and the design of the zone of proximal development tend to be somewhat neutral processes oriented towards the object. However, in an organisational intervention, the qualitative change might be located in the zone shaped by those who have the power to determine the change agenda (Langemeyer and Roth, 2006). Negotiations over the shared and potentially expanded object, however neutral they might be at a first glance, are also sites of struggle with others. In such struggles, some voices are marginalised and excluded from the construction of a shared object, and further, from mapping the potential path in the zone of proximal development (Kontinen 2007, p.141).

While agreeing with the critics, Kontinen's, (2013, p.108) interest is to pave the way to a Gramscian reading of DWR (see also Holma and Kontinen, 2012) in which she proposes selected Gramscian notions such as transformism, hegemony and dialectical pedagogy which, in her view, inspire a re-conceptualisation of DWR. Kontinen, (2013, p.108) discusses how these notions would relate to the stages of organisational intervention in DWR (ibid, 2013, p. 108).

In Kontinen's summary (p.124) she suggests that the theoretical ideas and practices of DWR involve elements of both transformism and transformation understood as the legacy of the 11th Feuerbach Thesis. The detailed analysis of the activities at hand, the in-depth engagement with historical evolution and everyday work, and the identification of tensions and different voices, are principles that clearly distinguish DWR research from consultative approaches interested merely in facilitating a predefined technical improvement in an organisational setting. However, as proposed by the critics reviewed above, the further elaboration and reconsideration of societal complexities in relation to the particular activities under intervention, and the location of particular interventions in the relevant historical situation with its economic, political and ethical

elements, would take DWR in a more transformative direction. Gramsci's concepts offer a promising way for such a development to be continued through empirical examination and further theoretical consideration (ibid, 2013, p. 124).

In summary, while valid points have been made by both critics, in particular regarding the issue of power in AT and both writers have suggested what they think are ways that issues could be changed, it remains (as pointed out by Kontinen 2013, p.124) that the overall success of AT as an intervention approach lies in:

detailed analysis of the activities at hand, the in-depth engagement with historical evolution and everyday work, and the identification of tensions and different voices are principles that clearly distinguish DWR research from consultative approaches interested merely in facilitating a predefined technical improvement in an organisational setting.

The researcher is in agreement with this conclusion. She chose the AT approach as she wanted to find out how CPD for practitioners could be reconfigured. Also, she wanted to show how changes need to be made in conjunction with an in-depth engagement with historical evolution and everyday work practices: when TCI restraint was invented in the 1970s in US it was a new, acceptable approach for dealing with aggressive behaviour. Now, because of historical evolution of everyday work practices over time that have resulted in many conditions that prohibit the use restraint, TCI restraint is no longer suitable or safe and, based on the experiences of staff who used it, they too are in agreement of its non-use. In acknowledging that AT is not an approach to address disturbances and contradictions in a confrontational manner it shows how a working approach based on equality, multi-voicedness and inclusion can lead to a successful collaborative/partnership approach that benefits all parties involved. It is a technique that can also be adapted by managers to address certain situations but it is not a management approach. While it can work with other approaches and styles of working and can be described as an action-focused problem solving approach, it is not a management tool to deal with budgeting/staffing and resources – it could be used as part of this approach.

It may be argued that to conduct AT successfully in an organisation (activity system) may require buy-in. In discussing the issue of power in activity systems, in a 2009 paper Engeström (p. 307) comments that it is indeed not easy to depict and analyse hierarchical power relations within a single activity system and suggests that third generation activity theory may open up new possibilities. He claims that in an organisation, managing is usually best seen as an activity system of its own, relatively independent of the activity systems of primary productive work. He suggests that a useful minimal unit of analysis might in some cases look

at the relationship between the activities of management and work, specifically the flow of rules from management to work units, which can be opened up for scrutiny. Yet these two activity systems and their takes on the potentially shared object are looked at in relation to the activity system of the client. Examination of the horizontal relations with the client should prevent the vertical power relationship from being turned into a closed iron cage (ibid, 2009, p. 307).

In continuing further with the theme of power in AT, when Engeström (2016) was asked (Personal communication, 8th July, 2016) about what critics were saying about how he and his colleagues address the issue of power in AT, he said:

One problem is that these critiques tend to remain at a general conceptual level, not addressing in detail specific statements in specific papers, let alone empirical or interventionist studies published by me and/or my colleagues. I prefer to look at power in its concrete, contested manifestations in real human actions and activities. Obviously my focus has been on finding and nourishing new forms of emancipatory power from below. Recently an interesting attempt to bring conceptualisations of power into activity-theoretical intervention studies has been made by Lotz-Sisitka and her colleagues in South Africa. I attach a recent PowerPoint presentation of theirs.

In studying this PowerPoint presentation it begs the question: if AT can change anything for people on the ground, is it making things better and this presentation answers yes it can? For example, there are examples of changes made by researchers employing the AT approach in Africa. Researchers at the Rhodes University Environmental Learning Research Centre (Lotz-Sisitka, Pesanayi and Chikunda, (2016) have shown in their two case studies in this PowerPoint presentation: *Building Commoning Activity: Navigating Power relations in CHAT Expansive Learning Research in the Building of Two Commoning Activities in Rural South Africa: Communal Food Gardening and Common Property Association Development* how power was given to the local people, proving productive in how they made use of their lands.

The researchers stated that ‘Across the two cases, there was significance of reframing and navigating power relations in transformative agency formation and while the focus of their analysis was on sustainability oriented commonality building activities’, they propose that their paper might have wider resonance as re-claiming the commons is not only a matter of concern for local rural communities in the global South who have been disenfranchised, but is rather a matter of concern for people across the planet who share common good resources such as clean air, water and the planet itself. Commoning activity and an examination of the reframing of power relations in this process would seem to be

an important focus for expansive learning research in such contexts (Lotz-Sisitka, Pesanayi and Chikunda, 2016).

Furthermore, in reference to power in organisations, it can be argued that in order to make worthwhile changes there needs to be a change in the overall structure of the organisation; it may need to be dismantled. As some critics have pointed out, AT is like managerialism (Langemeyer and Roth 2006; Avis 2009; Daniels and Warmington 2007), making systems work better, and from the outside it can look like this but on the inside it is different – it is about the bottom-up approach of bringing in the voices of practitioners working on the ground in the organisation. When this happens as discussed by practitioners with reference to the TCI intervention in this study people feel they are involved and are valued; it is giving power to people who would not have it, as described in the above PowerPoint presentation. People can see how the changes are occurring, people own the decisions.

It can be argued that power is linked to politics; if it is political it can be about dealing with people, feelings, issues and interests. On the other hand it may be apolitical in that things will not change. In my study the area of government is under Tusla; AT in this study was not concerned with addressing Tusla *per se* but was interested in the everyday politics of the workplace in the centre. The application of AT was political in that sense and showed that management could not be sending people off to training that is not relevant for them (TCI restraint). There are limits; mine was limited as it was a small study. In a larger study/organisation there could be other questions. For example, as described in section 5.3.2 practitioners have highlighted numerous complex issues including the changeover from the HSE to Tusla, citing where they were not involved or consulted. In a follow-up to this study it would be worthwhile to conduct a study using AT to look at the overall implementation of Tusla since 2014, looking at what people on the ground, working in the various areas think about it.

While AT is a top-down/bottom-up approach it is not magic. If it hits an immovable barrier - that's an immovable barrier. In my study it did address the issue of TCI restraint and provided the means of dealing with it. I cannot make a contribution to this as it was not my experience. However, what happens if management refuses to be involved in AT, if AT hits a blockage when working in professional groups, in particular in the CL interventions? AT is focused at the organisational level and tends to be implemented with the cooperation of the organisation.

As alluded to above in section 3.5.3, the following paragraphs describe a study by Ripamonti and Galuppo (2016, pp. 206-223) showing how they hit a blockage and had to close a CL:

In exploring expansive learning as a framework for examining organisational changes and transformative learning processes Ripamonti and Galuppo (2016, pp. 206-223) analyse the process of expansive learning and development following the introduction of enterprise resource planning systems (ERPs) in the human resources (HR) department of a multinational pharmaceutical company. The purpose of this study is to introduce the Human Resources (HR) module of the SAP suite in the Italian branch of a leading multinational pharmaceutical company. The SAP Business Suite is an integrated portfolio of software applications for large and mid-sized business (Techtarget (2016). This study can be re-conducted within the interpretive tradition of information technology studies focusing on the attempt to understand and describe how software users in the HR department interpreted the enterprise resource planning (ERP) technology, how they changed their work practices and the changes that occurred in organisational discourses and meanings alongside the process. In this case, people undergo a top-down technological transformation, with strong implications on daily workplace experience.

Findings from the study suggested that implementation of the ERP system caused conflicts and disturbances, aggravating contradictions that already existed between activity systems and introducing new types of contradictions. Pre-existent contradictions become clearer; there is a stronger interconnection between activity systems. The individual agents could experiment with an expansion in their activities if only they will initiate a movement of expansive learning and are not prevented from doing so by coercive control. The natural expansion of the subjects' scope of activity and horizons of possibilities could be sustained by the ERP technology if it is not used as a tool for domination and if the upper management does not try and separate what cannot in actuality be separated: the actors' capabilities of improvised learning, which makes the institution of a new mode of the activity possible, and their capacity to assume collective control of the meaning and direction of the transformation of the activity.

ERPs are technologies that can naturally bring transformations in the activity system and networks where they are introduced but, in some cases, they can easily and in a non-reflective manner be intended as tools for oppression by the upper management. The paper shows how the process of expansive learning can meet turbulence and obstacles, even the closure of a Change Laboratory (CL) intervention process as happened in this study (Ripamonti and Galuppo 2016, p.210). Commenting on this study (Engeström, 2016, cited in Engeström and Scaratti, 2016, p. 170) suggests that: 'The work to detect and clarify contradictions conveys the possibility to achieve a more articulated awareness of the practitioners' system of activity and of the possibilities to deal with it in a more sustainable way'. On the other hand when this question in relation to AT

hitting a blockage was posed to Kajamma, as discussed above, a trained CL facilitator (Personal communication, 2nd July 2016) she said:

I have not really encountered this type of a situation. I would think that if a Change Laboratory has been agreed to be carried out they usually are completed even if the management changes. Then, there may still be locally generated change and development. The danger of course is that the new management then does not get engaged to the process and the results may encapsulate to serve a local group of practitioners or the results may vanish. I think that if a situation becomes very difficult and the management somehow wants the research team to leave the research site, I would of course then withdraw. But as I said, this has never happened to me.

In summary, having used AT what would be my conclusions about it?

1. Yes, it can be applied to a small scale study like the one I did.
2. The questions remain – can it deal with power and resistance? I cannot really say based on my study because it was successful. It did not encounter barriers to implement it but my study was not seeking to change the structure of the Tusla organisation.

Employing Engeström's theoretical approach to reconfigure CPD has many advantages as discussed above, such as, the CLs provide a space for collective discussion and reflection with emphasises on motivation and rationale for individual practitioners. Also it incorporates the multi-voiceness of the whole team while they engage with the new tools, while learning from each other. However, even CLs will not solve everything. In analysing and critiquing AT based on having used it in this study, the researcher would agree with Avis (2009, p. 157) who claims that Engeström's Developmental Work Research (DWR) addresses peripheral contradictions rather than primary contradictions. This is not surprising as primary contradictions are big societal issues which can be governed by economic and politics but, in this study, AT was successful in addressing the peripheral contradiction of TCI restraint which has been a strong symbolic hallmark of the work of residential child care practitioners for years.

A disadvantage of using this theory is that the system cannot anticipate specific contradictions that may cause the practitioner to change/adapt. For example, rates of pay/twilight hours pay/and night premiums will be set through relevant industrial agreements. There are ongoing negotiations with the trade unions about these issues. Another disadvantage can be that for some people, the DWR methodology can be time-consuming expensive (however, cheap compared to the current 'redress' schemes), especially if trained researchers are called in or employed to reconfigure and reconstruct work practices. But if as a result of using

this theory to reconfigure CPD and if practitioners are better trained, it will mean that they will be competent enough and prepared to have a better understanding about things that cannot be changed - this might help them to cope better with issues that occur in their centres. Moreover, this theoretical approach accepts and allows for dissent when a contradiction is being investigated by staff.

As Engeström (2001, p. 137) points out:

As the contradictions of an activity system are aggravated, some individual participants begin to question and deviate from its established norms. In some cases, this escalates into collaborative envisioning and a deliberate collective change effort.

If practitioners do have cause to deviate on an issue and if the issue is not resolved at a particular CL then this can be carried over and debated at the next CL where knots can be tied and untied during the knotworking session until co-configuration is reached on the object. Those objecting to an idea may then see valid reasons to move forward and to change, which in the long run will be seen to benefit everyone. Above all, Engeström's approach brings out the voice of the frontline practitioner. As discussed above, it encompasses a bottom-up as well as top-down approach. Practitioners' knowledge can be fed up along the lines of communication to senior management (figure 7.2), giving a local, micro-thinking perspective that can link into a national macro-thinking perspective and can make an impact that can change future CPD policy on a national scale.

Research has shown that the top-down approach did not work. This is evidenced with the failures of larger institutions depicted in numerous landmark reports. The people on the ground, doing the work in centres, know what is happening and for the process to begin to change and for it to work well, they have to be listened to; it has to be a two-way situation, if changes are to happen, now and in the future. In the larger institutions we saw how the State and the Catholic Church ruled and collaborated but failed miserably, hence the enquiries and numerous scandals. This issue was freshly brought to light yet again (2014) with the press and media reporting of malpractices regarding the mother and baby homes that operated for the past 50 years in Ireland.

When practitioners can voice their opinions and know they will be listened to with their opinions valued both by colleagues and by management, it will empower them, and this will enhance their work in the centres. Questionnaire participants expressed this when commenting on their experiences of the CLs. In the CLs management will also have a chance to express and show their respect and support in how they recognise and value their workers and the work they do. Practitioners will be able to question management about issues such as: if they will be encouraged and funded, as part of their CPD training, to attend

seminars/conferences? Will there be an education fund set up that staff in each centre can use towards furthering their education? Rather than CPD training coming out of the overall HSE/Tusla budget, will CPD be allocated a special overall fund or will there be specific funding for training for each centre? If CPD comes out of an overall Tusla fund, there will be, like in the past, a tendency to take from internal resources so, therefore a training fund for individual centres would be a welcome initiative for the future.

7.7.2 The significance of this study

This study looks at current CPD training and has established that it is not working partly because the communication system between practitioners and interagency staff as well as between practitioners and senior management is poor, not fully coordinated or collaborated and does not operate in a two-way system. The research established that staff, trainers and senior management need to engage in dialogues about future CPD training and about what is relevant for practitioners. The study has shown how interview practitioners/managers were frustrated in trying to cope with challenges because of not having had relevant CPD training but this is changing: questionnaire participants reported on having received extra CPD. Also, the study showed the significance of giving practitioners' a voice through their participation in Engeström's CLs in which they were given freedom to discuss and relay their views about TCI physical restraint to senior management. Again, questionnaire participants reiterated the importance of this when giving positive feedback about the CLs. This culminated in them focusing on and eventually getting their behavioural management policy amended which empowered them and enhanced their competency and professional practice.

The implications of this study are that when management and staff engage in open communication and discussions, thinking becomes enriched (as confirmed by the questionnaire participants). Possibilities become identified and explored and professional practice is developed. This aids professionalisation and accountability between staff, interagency staff and senior management and all to the betterment of the children/young people in care. When practitioners commit to a process such as that involved in the CLs their participation increases and their voices becomes louder; they are aware that they are going to benefit from their involvement, through face-to-face interactions and discussions.

Another implication of the study was that interview practitioners said they were not given time for reflection. This study established that the CL is the ideal forum in which practitioners can reflect on their work, through utilising their CL portfolio, which can also be taken to their professional supervision, if there are issues that need further clarification. This practice will feed into the CORU requirements for reflection on eight pieces of work practice over a 24-month period (CORU, 2013b). The wider implications of this study are that employing

Engeström's AT, in particular use of CLs, can change work culture and organisational behaviour, by changing how CPD training is delivered.

The vision for the future of CPD training is that by adapting Engeström's AT, fundamental changes will be made to the way CPD is configured. This new configuration can easily align with CORU's examples of learning activities, both structured and unstructured, that registrants can use as a guide when deciding on their CPD which is a requirement of all professionals registered with CORU. Once registered, there is a duty on each registrant to engage in CPD and there is an onus on each professional to submit their portfolio's based on their assessment of their participation in CPD activities during the 24 month period.

The vision that this thesis has for the future is that in all centres, apart from having their usual weekly team meetings, staff should allocate time by filtering it into their weekly schedules whereby they have structured CLs to discuss contradictions affecting staff, starting with the most prominent current issue in their activity system. Contradictions will be worked through, by adapting and utilising Engeström's AT tools. While CORU is recommending that individual practitioners be responsible for their own CPD, a designated person should be appointed to oversee practitioners' CPD training. In conjunction with each practitioner, the designated officer, in collaboration with the others in the CL, will refer to and adapt the events calendar, the training map and the training agreement. While doing this, practitioners can study, compare and contrast the training activity guidelines provided by CORU and Tusla and/or suggest their own relevant CPD training, not on either list.

This is different to individuals being left to their own devices to decide on what CPD they should do. Also, due to work constraints, practitioners may not take adequate time to reflect on or tell their supervisor about the specific CPD training they require whereas the designated officer will assist them with this, while making sure that all practitioners are assisted in requiring knowledge and getting CPD training relevant to their contradictions, which will also benefit all other practitioners/managers. In this way, CPD training is planned based on individual practitioners' needs, with practitioners taking ownership and responsibility for it which will contribute to them feeling valued and the organisation will not be wasting money. The training could be delivered in the CLs where the community of practice can benefit from the learning and the knowledge presented. In this way, only relevant CPD training will be proposed and hopefully received as opposed to in the past when practitioners were sent to CPD training that had no relevance for their practice.

The vision also includes practitioners having their own training fund for their centre. This will encourage practitioners to be responsible and accountable and where they can prioritise how best to spend their allocation of funds. For example,

while there will be conferences requiring practitioners to travel to training, they could also have team building days out from time to time. Also they could continue to source professionals to come to their centre to give free training, which would cut down on their costs, as opposed to travelling to venues. As discussed above, sourcing and training locals already in employment will also cut down on costs for the organisation. Being part of the community of practice will allow practitioners/manager to have the CLs in different parts of the community to break the monotony of always having them in their own centre. Practitioners could capitalise on technology/computer by sourcing the knowledge to set up resource bases online that could be accessible to all practitioners to assist them in how to find out how to deal with, for example, addictions/self-awareness. The added value/key contributions of this research in this study are grouped as follows:

7.7.2.1 Added value of the research/key Contributions

A: The capacity to 'scale down' AT to a smaller setting

Despite Engestrom and his teams of trained researchers conducting interventions in large organisations this study has shown how AT, in particular the CLs can be used and transformations resulting from it in a small scale study in a centre.

It is an ideal way for people working in social care organisations to come together to discuss the issues affecting them as practitioners/professionals. Based on its principles of multi-voiceness and collectiveness together with addressing contradictions and making transformations it can provide the ideal forum for moving to an inclusive society.

People working together in such demanding jobs such as in residential child care can take time out to discuss issues of concern that are affecting them in their workplace.

B: How AT can be used to resolve 'stuck' issues in a bottom-up way

AT incorporating the Change Laboratories (CLs) as well as the many tools of AT can be used to refocus thinking and to develop solutions in residential child care centres for practitioners or in any social care organisation where people have become 'stuck' or are not developing and learning.

Participants themselves can learn how to conduct the CLs and how to use Engestroms models; engaging in regular CLs will result in staff

asking for and hopefully getting the relevant, focused and purposeful CPD training that they require.

It is a bottom-up as opposed to a top-down approach to redesigning and improving work places.

C: The step-by-step approach to reconfiguring and re-designing workplace

AT can be adapted to social care settings, once the history and culture of the organisation are considered.

While many reports have suggested the need/benefits of interagency/collaborative working but do not say how it can be done – this approach shows how to do it.

The AT approach provides a detailed plan/structure/process of how to do the research – it has its own methodology that participants can follow, step-by-step.

D: Relationship building approach

AT has the potential to strengthen relationships amongst centre staff who would be meeting regularly in the CLs and amongst interagency staff who would be taking part in the boundary crossing CLs.

Buy-in from all parties would lead to increased morale in the organisation; Once management agrees to utilising AT in their workplace it can create a situation whereby the division (if there is any) between management and staff is reduced and/or possibly eliminated/strengthened.

Overall it could lead to a better workplace because of the healthy relationships created as a result of everyone getting the CPD they want as opposed to what management think they want.

E: Guidelines to support a better future for practitioners

CPD was recognised by participants as a valued concept but also they mentioned that supports in the form of staff and resources need to be put in place if it is to be implemented properly.

The added value of this research is that it showed how people can begin to listen to each other and be listened to by others, in the CL as discussed by questionnaire participants.

In the long run the AT process will help management/the organisation to save money; in the past as mentioned in their interviews staff attended training that was not relevant to them.

In addition to the added value/key competences of the research and the use of the AT approach the following list of questions arose that were new and surprising:

7.7.2.2 Questions that were new and surprising

1. Engeström and his teams of researchers are generally funded when asked to come into an organisation to redesign and reconfigure work practices. As well as using ethnographic material and semi-structured interview data together with evidence presented in the CLs by participants they also a video recorder to video people in the workplace and they use this as 'mirror' data in the CLs. While it was not feasible for me to use videos I also thought it was better not to have used them in this study. The reason why I thought this was that I mentally questioned the use of videos. I surmised that video recordings may have highlighted the 'errors' 'mis-understandings' of one or two people which could have been discussed by everyone taking part on the day in the CL whereas in my study everyone got a chance to say what they wanted to say themselves on the day about TCI. Of course given that it was a small cohort of people added to it.
2. From the outset of this study I had thought about how it could be possible for staff, to have a forum/space to discuss issues affecting them both individually/collectively but I did not want this to take place at the regular team meeting and I was more than surprised to discover and learn about Engestroms AT and in particular the CLs that fitted exactly what I had in mind and I do not know of any other approach/forum in which this is provided
3. While the residential child care centre comprises a small organisation it was surprising how well the AT approach could be adapted to it given that it is mostly used in large organisations/for large projects by Engestrom and his teams of researchers.
4. I thought it would be good if staff could consider having regular CL sessions to discuss ongoing contradictions the way they have regular team meetings?

5. Looking at the timeframes, I wondered if it was realistic to consider the possibility of eliminating some of the CL sessions. Is it necessary to have separate sessions as described in the *cycle of learning* to address each of the seven questions? Or, rather is it better to have the separate session and give practitioners time to reflect on each session and bring their thoughts to the next one?
6. If a longitudinal study was introduced would the approach vary over time and would that impact on the outcomes?

7.7.2.3 Questions to ask Engestrom

1. Why would people agree to this process happening – is there something about some organisations that makes them open to the process? In my case they were willing to take part.
2. Can it work everywhere – if not what types of organisations are the most amenable? In my case maybe CPD is not seen as being too threatening, an AT intervention about making changes for managing or running a residential child care centre could be more controversial.
3. Could AT be brought further, for example in human relations, can it help to solve industrial setting disputes?
4. Could it be incorporated with another approach for use by practitioners, for example with TCI?
5. Would Engestrom be interested in sending a team of trained researchers to a workplace/college in Ireland to help train people up in how to use the AT approach?
6. Could it be used as an academic approach to generate further research and study in a specific discipline like social care, for example studying the addiction and the impacts on parenting/attachment/the parent/child dynamic?
7. Did he think, like me about how valuable it could be to also include a CL portfolio/journal for participants when attending the CLs so they can have a record of it and can refer to it for the next CL session?

In summary, this thesis argues that the way forward for practitioners CPD training is the adaption and application of Engeström's AT, in particular, engaging in CLs which will give practitioners/managers, trainers and senior management the time and space, away from their busy schedules, to make changes that can result in improvements/transformations in their work practices in centres and in their organisations. Having a scheduled time and space in which people can have face-to-face discussions is an important aspect in the provision of CPD training, as highlighted by questionnaire participants. This was also evident in the discussion above on communities of practice/knowledge which are needed to address the difficult work that practitioners are currently asked to do. This space will allow

for practitioners to consider how the changes expressed in the five overarching themes are affecting their professional practice. Working in residential child care can be best described as engaging in an emotional contract that requires relevant ongoing CPD training that can equip practitioners to address the many stressful challenges faced on a daily basis by practitioners working with some of the States' most vulnerable complex children/young people.

7.7.3 Personal perspective

As a practicing practitioner, I have learned a great deal from conducting this research. I experienced many changes in the sector since I started work in the profession. Notable changes include changes in the nature of the client group, where now there are more children placed in care because of being abused, with an increase in children being sexually abused. The level of accountability/risk culture has increased significantly resulting in much time spent in the office, doing the paperwork entailed in this, while the changeover from the HSE to Tusla has also resulted in much more paperwork for staff. If the vision that this thesis has for practitioners is realised, it will feed into the *Tusla Corporate Plan 2015-2017* vision: 'that all children are safe and achieving their potential' (Tusla, Child and Family Agency, 2014, p. 6).

These experiences have caused me to reflect, rethink and re-examine what I do in my practice. Reflection is done informally with colleagues, at handovers and team meetings. While I have professional supervision regularly, there is little time allocated for reflection; time is taken up discussing what has happened over the past weeks, with the children/young people at the centre. Working as part of a team, engaging in reflection, learning from others and being open to new experiences has made me a better practitioner than when I started work in this profession.

Because of the changes in the nature of the client group, the work of practitioners has become much more intensive and can be stressful with practitioners needing much support; every day is a learning curve. Residential child care provides a great service to these children who are often traumatised when they are placed in care. Overall, residential child care has improved greatly from the experiences in the large institutions, as regards training, education and professionalisation and with the onset of registration this will be improving more in the future.

At the time of the interviews in the three centres (January to April 2011) practitioners only received mandatory CPD training: fire safety and TCI and in one centre they had not been receiving this. Since 2012, training on the Children First Guidelines began and then in preparation for the change-over from the HSE to Tusla, more CPD training came on stream, such as ASIST training and alcohol/drugs training among others, and this is ongoing, as we saw: questionnaire

participants are receiving extra CPD training. This is a good time for the reconfiguration of CPD training and engaging in and adapting Engeström's approach is the best way to do this. Engeström's approach, utilising CLs is a personal approach involving people in face-to-face communication with each other where non-verbal communication in the form of body language and nuances can be instantly picked up as opposed to people interacting over the telephone or in emails. Being a practitioner in 2016 requires this type of collaborative action. Questionnaire participants commented on the benefits of face-to-face interactions from their experiences of the CLs.

In their work practice practitioners liaise on a regular basis with social workers. I have heard social workers discussing how they mostly use emails to communicate and as a result they sometimes are emailing a colleague whom they have never met but know they are also involved in the case of a child. I would argue that this important work requires two or more professionals involved in the child's care, all coming together regularly, having face-to-face interactions, giving their views and being listened to and through collaborations, finding a solution to a contradiction. This work with vulnerable children/young people is too important for one person to be making decisions and taking responsibility on their own as social workers said they sometimes do, due to a lack of staff and resources.

This issue of inadequate face-to-face communication was highlighted in the Roscommon abuse case (2010): there was evidence that face-to-face communication was not taking place between the professionals who were liaising and visiting the family at the centre of that case. As pointed out by Engeström (principle three AT) a history needs to be recorded, i.e. past and present; there needs to be more emphasis placed on 'a day in the life', day to day interactions/issues and recordings made of the daily routines including the environments of clients as well as the work done by professionals. Through knotworking, in the CLs this then can easily be checked against future visits/interactions taking place whereby in face-to-face meetings, professionals can refer to their CL portfolio/journal and can relay, discuss and reflect, get feedback and evaluate the past/present interactions and visits with clients/families. Abuse may be detected and possibly eliminated in this way.

From studying various theories in college I gained much knowledge that I have continuously referred to while trying to analyse and interpret situations and problems associated both with children/young people and with other professionals that I have experienced at work. I have found that the experience as a researcher has taught me to think critically about concepts both in terms of research for the thesis but also as regards interactions both with children/young people and with colleagues. For me, research has foregrounded in my mind the need to analyse all aspects of situations when deciding on outcomes that need to be achieved, with

the knowledge that something happening at a global macro level can have an impact and effect issues at local micro levels.

The profession of social care promotes the practice of research which is good for the development and professionalisation of the profession. This can be seen through the initiatives of SCI and by many researchers and academics working in this field. However, being a practicing practitioner can be risky and tricky when conducting research, in the field, because the researcher is both an ‘insider’ and can be an ‘outsider’ at the same time. Working part-time, as I have done, with gaps sometimes of weeks/months of not working, could equate to me having an ‘outsider’ status. Practicing practitioners can have benefits from being an ‘insider’. I was aware of my position when I embarked on the study and to address my position I decided that I would stand back in as far as I possibly could and be as objective as possible, especially during the data collection and analysis phases. I was careful not to initiate responses or voice my own opinions and I got clarification on issues so that I would be clearer about their responses. I documented their exact responses, some of which appears in excerpts/quotes throughout the thesis.

The best part of the research that I most enjoyed was meeting the practitioners/managers and engaging in dialogue with them while conducting the semi-structured interviews. Practitioners were glad to be asked questions and to be listened to; many said it was the first time they were asked for their views and they were open, honest and forthright in their responses. I am confident that they will be the same when they engage in the CLs while discussing relevant CPD to enable them to address problems they encounter in their practice which I know will lead to a better type of workplace, with practitioners who are better able to cope with the demands of this important job, working at the frontline, caring for vulnerable children/young people. Ultimately, the CLs will help to address the Social Change Problem identified by Tusla Stakeholders consultation for the *Tusla Corporate Plan 2015-2017*. They cited the problem as: ‘a lack of long-term, evidence-informed planning and insufficient resources leads to disjointed services and inadequate supports for children and families’ (Tusla, Child and Family, 2014, p. 4).

In terms of the application of AT in this study – it worked well as I followed the step-by-step instructions of the approach. It was worth doing because as a result of the intervention practitioners could desist from using TCI restraint. What was good about the AT approach was that practitioners themselves were involved, they were part of the decisions and they felt they owned it but for this approach to work well there needs to be an anchor person who is there to guide it and persist with it. To succeed with this process, participating practitioners must be motivated to uncover inherent contradiction in their activity systems of which care and learning are both part. Facilitators must be willing to spend time analysing both

historical care plans/logs, current data on practice and organisational issues that might hamper a transformative learning environment (Skipper et al, 2016, p. 11). Also, as described by Skipper et al (2016, p. 11) instruments and theoretical models are needed in order to break away from the standard practices in the organisations of health care services and solving challenges within work practices and organisations. Practices and work routines, including the training of future practitioners, are deeply embedded in the context and the organisation of the work. The interventional and developmental capability of an organisation can be improved by using the expansive learning cycle and the methods outlined in the CL interventions (ibid, 2016, p. 11). This method can work again in any organisation once the culture and the history of the organisation is taken into account.

7.7.4 Future research

- A follow-up study could involve practitioners and representatives from multi-disciplinary teams employed by Tusla and together with senior management they could take part in the AT process and have discussions in the CLs about the historical, current and future directions/contradictions of the organisation.
- Research could be undertaken with young people who have had experiences of residential child care that could identify the aspects of care/of the service that was important and made an impression on them. In particular, research could examine how they reacted and emotionally dealt with different issues that occurred on a daily basis. For them and for the agencies, this will be valuable information.
- Research could be undertaken with senior managers who run centres to get the perspective of these diverse groups and to learn what changes they would suggest that could be incorporated into the reconfiguration of CPD for the future.
- ‘Mentoring’ could be tried as a possible way to encourage workers to engage in research. With mentoring the worker becomes a research partner with an academic or student on placement. The worker is the link to practice using his/her experience as evidence (Howard and Lyons, 2014, p. 3).

7.7.5 Recommendation

As noted by Walsh (2014, p. 210 cited in Howard and Lyons, 2014):

Challenging behaviour can be exhibited in many forms and with such a high likelihood that social care workers will come into contact with challenging behaviour, it is surprising that very few third-level institutions offer modules on challenging behaviour as part of social care education. Many social care workers therefore leave their studies unprepared for

incidents of challenging behaviour, only learning from practice how to approach or manage such incidents and many organisations no longer have sufficient funding for training and this can create further difficulties.

In light of Walsh's comment I recommend that modules on challenging behaviour should be included on social care courses in all third level institutions.

REFERENCES

- Access to success: lifelong guidance for better learning and working in Europe (2010) Cedefop: European Centre for the Development of Vocational Training@<http://www.cedefop.europa.eu/EN/publications/15762.aspx> [Accessed July 29th 2011]
- Ainsworth, F. (1981) 'The training of personnel for Group Care with Children', in Ainsworth, F. and Fulcher, L. (Eds) (1981) *Group Care for Children Concept and Issues*, New York: Tavistock
- Akrani, G. (2010) [Maslow's Hierarchy of Needs - Theory of Human Motivation](http://kalyan-city.blogspot.com/2010/06/maslow-hierarchy-of-needs-theory.html), online@<http://kalyan-city.blogspot.com/2010/06/maslow-hierarchy-of-needs-theory.html> [Accessed 28th February 2014]
- Alderson, P. (2004) 'Ethics' in Fraser, S. Lewis, V. Ding, S. Kellett, M. and Robinson, C. (Eds) *Doing Research with Children and Young People*, London: Sage: 97-112
- Altheide, D. and Johnson, J. (1994) 'Criteria for assessing interpretive validity in qualitative research', in N. Denzin and Y. Lincoln (eds) *Handbook of qualitative research*, Thousand Oaks, CA: Sage Publications: 485-499
- American Psychological Association (APA) (2002) Ethical principles of psychologists and code of conduct (Amended February 20, 2010), in *American Psychologist*, 57, 1060-1073.
- Andrews, T. and Du Toit, L. (2010) Utilising Activity Theory and Illuminative Evaluation as a Theoretical Framework for ACTS Learning Spaces, project website: <http://www.swinburne.edu.au/spl/learningspacesproject/> online@http://www.swinburne.edu.au/spl/learningspacesproject/outcomes/files/ACTS_Evaluation_Theoretical_Framework.pdf [Accessed November 28th 2010]
- Argyris, M. and Schön, D. (1974) *Theory in Practice: Increasing professional effectiveness*. San Francisco: Jossey-Bass
- Argyris, C. and Schön, D. (1978) *Organizational learning: A theory of action perspective*, Reading Mass: Addison Wesley
- Association of Secondary Teachers in Ireland (ASTI, undated) online@ <http://www.asti.ie/pay-and-conditions/pay/allowances/> [Accessed, 23rd October 2015]
- Avis, J. (2007) 'Engeström's version of activity theory: a conservative praxis?' in *Journal of Education and Work* 20(3): 161-177
- Avis, J. (2009) Transformation or transformism: Engeström's version of activity theory? Online@ <http://dx.doi.org/10.1080/00131910902844754> *Educational Review*, 61(2): 151–165 [Accessed March 23rd 2010]
- Bart, A. (2002) *the Presence Approach: An Introductory Sketch of Practice*, The Netherlands: Catholic Theological University
- Bart, A. (2003) Ongemakkelijk – zoals hoort, in *Sociale interventie*, 12(2): 6–94
- Babbie, E. and Mouton, J. (2006) *The practice of Social research South African edition*, Oxford University Press, South Africa: Cape Town
- Babbie, E. (2008) *The Basics of Social Research (4th Ed)*, CA: Belmont: Thomson
- Baker, N., and Rogers, S. (2015) 'Child Agency facing a crisis year', in *Irish Examiner*, @ <http://www.irishexaminer.com/ireland/child-agency-facing-a-crisis-a-year-343462.html> [Accessed 20th October 2015]

- Bakhtin, M. (1981) *The dialogic imagination: Four essays*, in M. Holquist (Ed) Austin: University of Texas Press
- Bakhurst, D. (2009) 'Reflections on activity theory', *Educational Review*, 61(2):197-210
- Banks, S. (2004) *Ethics, Accountability and the Social Professions*, Basingstoke: Palgrave Macmillan.
- Banks, S. (2006) *Ethics and values in social work*, Palgrave: Macmillan
- Barker, L. and Wiseman, G. (2006) 'A Model of Intrapersonal Communication', in *Journal of Communication*, vol. 16, Issue 3: 172-179
- Barnardos (2016) *Child Welfare and Protection*, online@ <http://www.barnardos.ie/what-we-do/campaign-and-lobby/the-issues/child-welfare-and-protection.html> [Accessed, 4th July 2016]
- Basharina, O. (2007) 'An activity theory perspective on student-reported contradictions in International tele-collaboration', in *Language Learning and Technology*, vol. 11, No.2: 36-58 [Accessed, 17th April 2013]
- Bateman, N. (2000) *Advocacy Skills for Health and Social Care Professionals*, London: Jessica Kingsley Publishers.
- Bateson, G. (1972) *Steps to an ecology of mind: Collected essays in anthropology, Psychiatry, evolution, and epistemology*, New York: Ballantine Books
- Bauman, Z. (1994) *Alone again: ethics after certainty*, London: Demos
- Berg, B. (2004) *Qualitative research methods for social science*, Boston: MA: Pearson
- Berridge, D. and Brodie, E. (1998) *Children's homes revisited*, London: JessicaKingsley
- Berridge, D. Biehal, L. and Henry, L. (2010) *Living in Children's Residential Homes*, online@ <https://www.gov.uk/government/uploads/...data/.../DFE-RR201.pdf>[Assessed 3rd October 2013]
- Better Outcomes Brighter Futures (2014-2020) online@ <file:///C:/Users/user/Documents/BetterOutcomesBetterFutureReport.pdf> [Accessed, 4th July 2016]
- Blackler, F. (2009) 'Cultural-historical activity theory and organisation studies', in *Learning and Expanding with Activity Theory*, Cambridge: University Press
- Blackler, F. (2011) 'Power, politics, and intervention theory: Lessons from organization studies', in *Theory and Psychology*, pp: 724-734, online@ <http://tap.sagepub.com/content/21/5/724.short> [Accessed, 10th July 2016]
- Blaikie, N. (2000) *Design social research: the logic of anticipation*, Cambridge: Polity Press
- Blumer, H. (1969) *Symbolic Interactionism: Perspective and Method*, Englewood Cliffs, Prentice hall
- Blumer, H. (1972) 'Symbolic Interaction: An approach to human communication', in *Approaches to Human Communication*, Bude and Ruben (Eds) NY: Spartan Books: 401-419
- Bolam, B. Gleeson, K. and Murphy, S. (2003) 'Lay person' or 'health expert'? Exploring theoretical and practical aspects of reflexivity in qualitative health Research, in *Qualitative Sozialforschung / Forum: Qualitative Social Research* [On- line Journal] 4(2):1-34 <http://www.qualitative-research.net/fqs-texte/2-03/2-03bolametal-e.htm> [Accessed 18th April 2011]

- Boote, D. and Beile, P. (2005) 'Scholars before researchers: On the centrality of the dissertation literature review in research preparation', in *Educational Researcher* 34(6): 3-15
- Boud, D. Keogh, R. and Walker, D. (1996) 'Promoting Reflection in Learning: A Model' in R. Edwards, A. Hansom and P. Raggatt (Eds) in *Boundaries of Adult Learning*, New York: Routledge: 32-56
- Bowlby, J. (1988) *A secure base: Parent-child attachment and healthy human development*, Tavistock Professional Book, London: Routledge
- Bowlby, J. (2000) 'A Secure Base in Clinical Application of Attachment Theory', in *Policy* vol. 83: 60-77, London: Routledge
- Brendtro, L., and du Toit, L. (2005) 'Response Ability Pathways (RAP) – restoring bonds of respect'. *Child and Youth Care Agency for Development*. South Africa: Circle of Courage.
- Brown, K. and Rutter, L. (2008) *Critical thinking for social work*, Exeter, Learning Matters
- Brennan, J. (2015) Nurses, teachers and gardaí priced out of property market by strict lending rules, in *Irish Independent*, @ <http://www.independent.ie/irish-news/home-truths/nurses-teachers-and-garda-priced-out-of-property-market-by-strict-lending-rules-31539979.html> [Accessed January 2016]
- Bryman, A. (2001) *Social Research Methods*, New York: Oxford University Press
- Bryman, A. (2004) (2nd Ed) *Social Research Methods*. USA: Oxford University Press
- Bryman, A. and Bell, E. (2007) (2nd Ed) *Business research methods*. USA: Oxford University Press
- Bryman, A. (2008) *Social Research Methods* (3rd edn) UK: Oxford University Press
- Buachanan D. and Bryman, A. (2009) *The Sage Handbook of Organisational Research Methods*, London: Sage Publications
- Buckley, H. (2013) National Independent Review Panel Annual Report ([2012] 2013) online @ <http://www.hse.ie/eng/services/Publications/Children/nrp/nrpannrpt12.pdf> [Accessed 15th November 2013]
- Burke, S. (2011) *Eliminating Health Inequalities – A Matter of Life and Death*, Available online @: <http://issuu.com/tascpublications/docs/healthweb?mode=embed&layout=http%3A%2F%2Fskin.issuu.com%2Fv%2Fflight%2Flayout.xml&showFlipBtn=true&proShowSidebar=true> [Accessed 15th June 2011]
- Business Journal (2015) Ireland's economy should soon be back where it started – Except for all that debt, available online @ <http://businessetc.thejournal.ie/ireland-economy-recovery-1915744-Feb2015/> [Accessed September 30th 2015]
- Byrne, L. (2000) 'Practice Placement in Social Care Worker Education', Unpublished Master's Thesis, Cork Institute of Technology
- Byrne, J. and McHugh, J. (2005) 'Residential Care', in Share, P. and McElwee, N. *Applied Social Care: An Introduction*, Dublin: Gill and Macmillan: 313-321

- Byrne, C. (2014) Report on findings of Social Care Workers' CPD needs assessment survey. Online@ <http://socialcareireland.ie/continuing-professional-development/continuing-professional-development-report/> [Acc. 12th June 2014]
- Candy, P. (1989) Alternative paradigms in educational research, in *Australian Educational Researcher*, Sept. 1989, vol. 16, Issue 3: 1-11
- Cannon, M. Coughlan, H. Clarke, M. Harley, M. and Kelleher, I. (2013) 'The Mental Health of Young People in Ireland': a report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group Dublin: Royal College Surgeons, online@ www.rcsi.ie/20131009042046_PERL%20ResearchReport_041013PRI.pdf [Accessed 11th October 2013]
- Carr, W. and Kemmis, S. (1986) *Becoming Critical: education, knowledge and action Research*, Lewes, Falmer
- Casey, K. (1993) *I Answer With My Life: Life Histories of Women Teachers working For Social Change*. New York: Routledge
- Cavanagh, S. (1997) 'Content analysis: concepts, methods and applications', in *Nurse Researcher*, 4 (3): 5-16
- Cedefop (2010) Quality Assurance in the Social Care Sector, research paper, no. 7: – The Role of Training, in *European Centre for the development of vocational training Luxembourg*, online@ <http://www.cedefop.europa.eu/en/publications/16821.aspx> [Accessed. 21st June 2011]
- Central Council for the Education and Training of Social Workers (1995) *Rules and Requirements for the Diploma in Social Work*; CCETSW Paper 30 revised Edition, London: CCETSW
- Centre for Research Activity and Learning CRADLE (Undated) <http://www.helsinki.fi/cradle/> [Accessed 2012]
- Cha, T. Kuo, E. and Marsh, J. (2006) 'Useful knowledge for social work practice', In *Social Work and Society* 4(1): 367-414
- Chaiklin, S. Hedgegaard, M. and Jensen, U. (Eds) (1999) *Activity Theory and Social Practice*, Aarhus: University Press
- Chambers Etymological Dictionary of the English Language (2005) Chambers Press: London
- Charleton, M. (2014) *Ethics for Social Care in Ireland*. Dublin: Gill Education.
- Charon, J. (2001) *Symbolic Interactionism: an introduction, and interpretation, an Integration*, Upper Saddle River, New Jersey: Prentice Hall
- Chartered Accountants Ireland (2015) Available online@ <https://www.charteredaccountants.ie/CPD/Requirements/> [Accessed October.2015]
- Chesebro, J. and Borisoff, D. (2007) What makes qualitative research qualitative? in *Qualitative Research Reports in Communication*, 8(1): 3–14
- Chia, R. (2002) A 'Rhizomic' Model of Organizational Change and Transformation: Perspective from Metaphysics of Change, in *British Academy of Management*, 1999, vol. 10, Issue 3: 209-227
- Child Care Law Report Project (2015) reports available online@ <http://www.childlawproject.ie/publications/> [Accessed 30th October 2015]
- Child Protection and Welfare Practice Handbook (2011) available online@ http://www.tusla.ie/uploads/content/CF_WelfarePracticehandbook.pdf [Accessed, 12th November 2015]

- Children's Rights Alliance (2009) 'Learning from the past: responding to the Recommendations of the commission to inquire into child abuse', in *Children's Rights Alliance*, <http://www.inclusionireland.ie/documents/ChildrensRightsAllianceLearningfr> [Accessed 6th May 2010]
- Christie, A. (1998) 'Balancing Gender' as men social workers, in *Irish Social Worker* Vol. 16, Issue 3: 4-6
- Christou, E. and Anastasiadou, C. (2008) 'Research Methodology in hospitality Industry: The role of the inquiry paradigms', online@ <http://www.ul.edu.lb/fthm/papers/3rd%20Axis/Methodology%20greece.doc> [Accessed, 23rd June 2010]
- Clarke, L. (2003) 'Overcoming Ambivalence: The challenges of exploring socially charged issues', in *Qualitative Health Research*, 13 (5): 718-735
- Clough, R. (2000) *The Practice of Residential Work*, London: Macmillan Press
- Clough, R. Bullock, R. and Ward, A. (2006) *What work in residential Childcare? A review of research evidence and the practical consider actions*, London: Children's Bureau
- Coffey, A and Atkinson, P. (1996) *Making sense of qualitative data: Complementary research strategies*, Thousand Oaks, CA: Sage Publications
- Cole, M. (1988) 'Cross-Cultural Research in the Socio-Historical Tradition', in *Human Development* 31: 137-151
- Cole, M. and Y. Engestrom, (1993) 'A Cultural-Historical Approach to Distributed Cognition', in: Salomon, G. (Ed) in *Distributed Cognitions: Psychological and Educational Considerations*, Cambridge: University Press: 1-46
- Cole, M. (1996) *Cultural Psychology: A Once and Future Discipline*, Belknap: Harvard
- Colton, M. (2002) 'Factors associated with abuse in residential child care institutions', in *Children and Society*, Vol. 16, Issue 1: 33-44
- Colton, M and Roberts, S. (2006) 'Factors that contribute to high turnover among residential child care staff', in *Child and Family Social Work*, vol. 12:2 <http://onlinelibrary.wiley.com.libgate.library.nuigalway.ie/doi/10.1111/j.1365-2206.2006.00451.x/pdf> [Accessed 8th April 2013]
- Commission to Inquire into Child Abuse (2009) 'Ryan report', online@ <http://www.childabusecommission.com/rpt/pdfs/CICA-Executive%20Summary.pdf> [Accessed 25th March 2010]
- Commission to Inquire into Child Abuse (2009) Chapter 7: St Joseph's Industrial School, Artane ('Artane'), 1870-1969, *CICA Investigation Committee Report*, Vol. I, online@ <http://www.childabusecommission.com/rpt/pdfs/CICA-VOL1-07.PDF> [Accessed 8th November 2014]
- Connors, A. (2010) 'Recession causing surge in drug and alcohol abuse', in *the Irish Medical Times*, November 18th 2010. Available online@ <http://www.imt.ie/news/uncategorized/2010/11/recession-causing-surge-in-drug-and-alcohol-abuse.html> [Accessed 19th November 2010]

- Cordingley, P., Bell, M., Thomason, S., Saunders, L., Hagger, H., Sturgis, J. And Robinson, K. (2003), *The impact of collaborative CPD on classroom teaching and learning*, available online@ http://eppi.ioe.ac.uk/eppiwebcontent/reel/review_groups/cpd/cpd_protocol_2.pdf [Accessed 26th October 2015]
- CORU (2013a) *Regulating health and Social Care Professionals*, online@ www.coru.ie [Accessed 12th March 2013]
- CORU (2013b) Framework for Registration Boards Continuing Professional Development: Standard and Requirements, vol. 2, 25th July 2013, online@ <https://www.iasw.ie/attachments/b564fddd-1c67-4576-9324-a0341a630035.PDF> [Accessed 23rd July 2014]
- CORU (2013c) Public Consultation Report Development of CORU's Statement of Strategy 2013-2016 December 2013-2016, online@ http://www.coru.ie/uploads/documents/CORU_-_Final_Consultation_Report_-_Statement_of_Strategy_2013_-_2016_web.pdf [Accessed, 29th Sept. 2015]
- CORU (2013d) The Development of a Framework for Continuing Professional Development Standards and Requirements for Registrants under the Health and Social Care Professionals Act (as amended). Online@ <http://coru.ie/uploads/documents/CPDResearchReport2013.pdf> [Accessed, 29th Sept. 2015]
- CORU (2014a) *Regulating health and Social Care Professionals* online@ www.coru.ie [Accessed 11th January 2014]
- CORU (2014b) Social Workers Registration Board Standards of Proficiency and Practice Placement Criteria, available online@ [file:///C:/Users/user/Documents/SOPsandpractice_placement_criteriaforSocialWorker-Approved210114%20\(1\).pdf](file:///C:/Users/user/Documents/SOPsandpractice_placement_criteriaforSocialWorker-Approved210114%20(1).pdf)[Accessed, 10th November 2015]
- CORU (2015a) About CORU Available online@ http://www.coru.ie/en/about_us/what_is_coru [Accessed 30th Oct. 2015]
- CORU (2015b) Guide to CPD for Employers online@ [https://www.iasw.ie/attachments/Guide_to_CPD_for_Employers_\(1\).pdf](https://www.iasw.ie/attachments/Guide_to_CPD_for_Employers_(1).pdf) [Accessed 31st October 2015]
- CORU (2015c) Education, research and publications, available online@ http://www.coru.ie/en/education/cpd_publications [Accessed 29th October 2015]
- CORU (2015d) CPD Portfolio template, available online@ http://coru.ie/uploads/documents/CPD_Portfolio_Template.docx [Acc. Oct.2015]
- CORU (2015e) CPD Supervision information, available online@ https://www.iasw.ie/attachments/CORU_Registration_and_Professional_Supervision_Info_for_IASW_Members_24_09_15.pdf [Accessed 29th October 2015]
- CORU (2015f) CPD Education information for social workers, available online@ http://www.coru.ie/en/education/cpd_for_social_workers [Accessed, October 2015]
- CORU (2015g) Social Care Workers Registration Board Appointed, online@ http://coru.ie/en/news/details/social_care_workers_registration_board_established_by_minister_for_health_1 [Accessed 29th October 2015]

- CORU (2015h) Fitness to Practice Launch – Ginny Hanrahan CEO/Registrar’s Speech, available online@ <http://www.coru.ie/en/news/details/corufitnesstopracticiselaunchginnyhanrahanceoregistrarspeech> [Assessed 30th October 2015]
- CORU (2015i) Guide to Continuing Professional Development, available online@ <http://coru.ie/uploads/documents/GuidetoCPD.pdf> [Accessed, 10th October 2015]
- CORU (2015j) Social Care Workers Registration Board Appointed, available online@ <http://www.coru.ie/en/news/details/socialcareworkerregistrationboardestablishedbyministerforhealthl> [Accessed, 2nd December 2015]
- Coulter, C. (2013) ‘Reports on child protection cases will shed light on State care system’, in *Irish Times*, April 6th 2013, online@ <http://www.irishtimes.com/news/social-affairs/reports-on-child-protection-cases-will-shed-light-on-state-care-system-1.1347941> [Accessed 11th April 2013]
- Crausaz, J. (2014) Establishing and Sustaining Journal Clubs, paper given at Continuing Professional Development Conference, Our Lady’s Hospice Harold’s Cross, Dublin, 20th March 2014
- Crimmens, D. (1998) ‘Training for residential child care workers in Europe: Comparing approaches in The Netherlands, Ireland and the United Kingdom’, in *Social Work*
- Creswell, J. (1994) *Research designs: Qualitative and quantitative approaches*, Thousand Oaks, CA: Sage Publications
- Creswell, J. (1998) *Qualitative Inquiry and Research Design: Choosing among five Approaches*, Thousand Oaks, CA: Sage Publications
- Creswell, J. (2003) *Research Design. Qualitative, quantitative and mixed methods approaches*. Thousand Oaks, CA: Sage Publications
- Creswell, J. (2007a) *Designing and conducting mixed methods research*, Thousand Oaks, CA: Sage Publications
- Creswell, J. (2007b) *Qualitative Inquiry and Research Design: Choosing among five Approaches*, Thousand Oaks, CA: Sage Publications
- Creswell, J. and Clark, V. (2007) *Designing and conducting mixed- methods*, UK: London, Sage Publications
- Creswell, J. Hanson, W. Plano Clark, V. and Morales, A. (2007) ‘Qualitative Research Design: Selection and Implementation’, in *The Counselling Psychologist* Vol. 35 No.2: 236 – 264
- Creswell, J. (2008) *Research design: Qualitative, quantitative, and mixed methods Approaches*, (3rd Ed) Thousand Oaks, CA: Sage Publications
- Creswell, J. (2012) *Qualitative inquiry and research design: Choosing among five Approaches*. Thousand Oaks, CA: Sage.
- Crotty, M. (1998) *The Foundation of Social Research: Meaning and Perspectives in the Research Process*, London: Sage Publications
- Crotty, M. (2007) *The Foundation of Social Research: Meaning and Perspectives in the Research Process*, London: Sage Publications
- [CSO] Central Statistics Office (2011a) *Census of Population 2011 Preliminary Results*, 30th June 2011 <http://www.cso.ie/census/documents/Prelim%20complete.pdf> [Accessed 13th .July.2011]

- [CSO] Central Statistics Office, (2011b) *Women and Men in Ireland*
<http://www.cso.ie/en/media/csoie/releasespublications/documents/otherreleases/2011/Women%20and%20Men%20in%20Ireland%202011.pdf>
 [Accessed February 28th 2013]
- [CSO] Central Statistics Office (2012) This is Ireland highlights from Census 2011(2) online@
<http://www.cso.ie/en/media/csoie/census/documents/thisisirelandpart2census2011/This%20is%20Ireland%20Highlights,%20P2%20Full%20doc.pdf>
 [Accessed June 21st 2014]
- Daniels, H. (2001) *Vygotsky and pedagogy*, New York: Routledge/Falmer
- Daniels, H. (2004) 'Cultural historical activity theory and professional learning', in, *International Journal of Disability, Development and Education*, 51(2): 185–200
- Daniels, H. Leadbetter, J. Warmington, P. Edwards, A. Martin, D. Popova, A, Apostolov, A. Middleton, D. and S. Brown, (2007) 'Learning in and across the Professions', in *Oxford Review of Education*, vol. 33, No. 4: 521-538, online@ <http://www.jstor.org/stable/20462353>
 [Accessed 30th March 2013]
- Daniels, H. Edwards, A. Engeström, Y. Gallagher, T. and Ludvigsen, S. (2009) *Activity Theory Practice: Promoting Learning across boundaries and agencies*, London: Routledge
- Darmody, M. McMahon, L. Banks, J. and Gilligan, R. (2013) Education of Children in Ireland: an Exploratory Study, Commissioned by the Ombudsman for Children, online@
http://www.oco.ie/assets/files/11873_Education_Care_SP.pdf May 2013
 [Accessed 28th January 2014]
- Davydov, V. (1988) 'Problems of developmental teaching', in *Soviet Education*, 30: 8-10
- Davydov, V. (1990) *Types of Generalization in Instruction: Logical and psychological problems in the structuring of school curricula*, Reston: Council of Teachers
- Davydov, V. (1999) 'A new approach to the interpretation of activity structure and content', in S. Chaiklin, M. Hedegaard, and U. Jensen, (Eds) *Activity theory and social practice*, Aarhus: University Press: 39-50
- Dempsey, M. Halton, C. and Murphy, M. *The use of self in social work: opportunitites for reflection during professional traing*. Online@
<https://www.iasw.ie/attachments/62c9097f-5181-44b6-8988-ed76417ed743.PDF>. [Accessed, 2nd July 2016]
- Denscombe, M. (2003) *The Good Research Guide: for Small Scale Research Projects*, Philadelphia: Open University Press
- Denzin, K. and Y. Lincoln, (1998) *Strategies of qualitative inquiry*, Thousand Oaks, CA: Sage Publications
- Denzin N. Lincoln Y. (2000) *Handbook of qualitative research*, Thousand Oaks, CA: Sage Publications
- Denzin, N. and Lincoln, Y. (Eds) (2005) *Handbook of qualitative research* (3rd ed) Thousand Oaks, CA: Sage Publications
- Department of Children and Youth Affairs (2011a) *Children First - National Guidance For the Protection and Welfare of Children*. Dublin: Government Publications, online@
<http://www.dcy.gov.ie/viewdoc.asp?DocID=1589> [Acc. October 2011]

- Department of Children and Youth Affairs (2011b) 'Minister Fitzgerald challenges lack of inter-agency working in child protection', online@ <http://www.dcy.gov.ie/viewdoc.asp?DocID=2889> [Accessed 16th September 2013]
- Department of Education and Science (2009) 'Developing the workforce in the early childhood care and education sector', background discussion paper, online@ http://www.education.ie/en/schools-colleges/information/early_years/eye_background_discussion_paper.pdf [Accessed 16th October 2014]
- Department of Health and Children, (2001) *National Standards for Residential Child Care Centres*, online@ http://www.dohc.ie/publications/national_standards_for_childrens_residential_centres.html [Accessed 12th December 2009]
- Department of Health and Children (2002) Joint Committee on Social Care Professionals *Final Report of the Joint Committee on Social Care Professionals*, online@ <http://www.lenus.ie/hse/bitstream/10147/46110/1/10672.pdf> [Accessed 27th June 2010]
- Department of Health and Children (2011) *Review of adequacy for HSE children and family Services*, online@ <http://www.hse.ie/eng/services/Publications/services/Children/reviewofadequacy.html> [Accessed 12th May 2013]
- Department of Health and Children (2012) *Review of adequacy for HSE children and family Services 2010*, online@ http://www.tusla.ie/uploads/content/Publications_reviewofadequacy2010.pdf [Accessed 23rd April 2014]
- Department of Justice Equality and Law Reform (2009) *The Dublin Archdiocese Commission of Investigation, Murphy report*; online@ <http://www.irishtimes.com/focus/2009/diocese/1234.pdf> [Accessed September 24h 2011].
- Department of Justice and Equality (2011) *Report by Commission of Investigation into Catholic Diocese of Cloyne*, online@ <http://www.justice.ie/en/JELR/CloyneRpt.pdf/Files/CloyneRpt.pdf> [Accessed. September 6h 2011]
- Department of Justice and Equality (2011) Joint statement by the Minister for Justice, Equality and Defence, Mr. Alan Shatter, T.D and the Minister for Children and Youth Affairs, Ms. Frances Fitzgerald, T.D. on the publication of the *Commission of Investigation Report into the Catholic Diocese of Cloyne*, 13th July 2011, online@ http://www.justice.ie/en/JELR/Pages/Cloyne_Joint_Statement [Accessed 3rd October 2011]
- DeVaus, D. (2001) *Research Design in Social Research*, London: Sage Publications
- Digney, J. (2009) 'Humour and Connecting with Kids in Pain', in *Reclaiming Children and Youth*, 18, 3: 54-57
- Dewey, J. (1933) *How we think: A restatement of the relation of reflective thinking to the educative process*, Boston, MA: Houghton-Mifflin
- Downe-Wamboldt, B. (1992) 'Content analysis: Method, applications, and issues', in *Health Care for Women International*, 13: 313-321

- Driedonks, B. Gevers, J. and Van Weele, A. (2010) 'Managing sourcing team effectiveness: the need for a team perspective in purchasing', in *Journal of Purchasing and Supply Management*, Vol.16, Issue 2: 109-117
Dublin Institute of Technology, School of Social Sciences and Law (2013) What is Social Care? Defining Social Care; online
<http://www.dit.ie/socialscienceslaw/socialsciences/whatisocialcare/>
[Accessed May 30th 2013]
- Dublin Institute of Technology (2015) Social Care, available online@
<http://dit.ie/studyatdit/undergraduate/programmescourses/allcourses/socialcaredt571.htm>[Accessed, 12 January 2015]
- Dubois, D. and Rothwell, W. (2004) 'Competency-based or a traditional approach to training? A new look at ISD models and an answer to the question, what's the best approach?' in *CBS Business Network*, online@
http://findarticles.com/p/articles/mi_m0MNT/is_4_58/ai_n6121342/
[Accessed November 8th. 2010]
- Duhan, J. (2013) *Vive le Proletariat: The 1968 Revolt of French Workers and Students*, @ www.scholarworks.wmich.edu/cgi/viewcontent.cgi?article=3381&context.. Accessed 7th October 2014]
- Early Childhood Ireland (2013) Supporting Children with Additional Needs Survey, online@ <http://www.earlychildhoodireland.ie/policy-advocacy-and-research/results-of-the-special-needs-survey/>
[Accessed 20th May 2013]
- Easterby-Smith, M. Thorpe, R. and Lowe, A. (1991) *Management Research: An Introduction*, London: Sage Publications
- Eaton, K. Brookes, J, Patel, R. Batchelor, P. Farzeela, M and Narain, A. (2011), *The Impact of Continuing Professional Development in Dentistry: a Literature Review*, online@
<http://www.gdcuk.org/Aboutus/policy/Documents/Impact%20Of%20CPD%20In%20Dentistry.pdf> [Accessed 20th May 2013]
- Economic and Social Research Institute (ESRI) and Trinity College Dublin (2013) *Growing up in Ireland: Development from Birth to Three Years report*, online@ <http://www.growingup.ie/index.php?id=61>
[Accessed 22nd September. 2013]
- Economic and Social Research Institute (ESRI) (2015) *Growing Up In Ireland study online@* <http://www.esri.ie> [Accessed 29th October 2015]
- Eden, C., and Huxham, C. (1996). 'Action research for the study of organizations', in S. Clegg, C. Hardy, and W.R. Nords (Eds.), *Handbook of Organizational Studies*, 526-42. Thousand Oaks: Sage Publications.
- Edwards, A. and R. Talbot, (1999) (2nd Ed) *The Hard – Pressed Researcher*, England: Pearson Education Limited
- Edwards, A. (2004) 'The new multi-agency working: collaborating to prevent the social exclusion of children and families', in *Journal of Integrated Care*, 12(5): 3–10
- Edwards, A. (2005) 'Relational agency: learning to be a resourceful practitioner', in *International Journal of Educational Research*, 43(3): 168-82
- Edwards, A. and Mackenzie, L. (2005) 'Steps towards participation: the social support of learning trajectories', in *International Journal of lifelong Education*, 24(4): 287-302
- Edwards, A. (2007) 'Relational Agency in Professional Practice: A CHAT Analysis' in *International Journal of Human Activity Theory*, No. 1: 1-17

- Edwards, A. and Apostolov, A. (2007) 'A cultural-historical interpretation of resilience: The Implications of practice', in *Outlines: Critical Social Studies* 9 (1): 70-84
- Edwards, A. Daniels, H. Gallagher, T. Leadbetter, J and Warmington, P. (2009) *Improving Inter-professional Collaborations: Multi-agency working for children's wellbeing*, Oxford: Routledge
- Edwards, A. (2011) Cultural Historical Activity Theory (CHAT), online@ http://www.bera.ac.uk/files/2011/06/culturalhistoricalactivity_theory.pdf [Accessed 30th May 2011]
- Edwards, E. (2014) 'Quarter of Women report sexual or physical violence', in *Irish Times*, Thursday, March 6th, online@ <http://www.irishtimes.com/news/social-affairs/quarter-of-irish-women-have-been-victims-of-violence-1.1713672> [Accessed March 6th 2014]
- Ehigie B. and Ehigie, R. (2005) 'Applying qualitative methods in organisations: a Note For industrial/organisational psychologists', in *Qualitative report*, 10(3): 621-638
- Elliot, R. Fischer, C. and Rennie, D. (1999) 'Evolving guidelines for publication of qualitative research in psychology and related fields', in *British Journal of Clinical Psychology*, 38(3): 215-29, online@ <http://www.ncbi.nlm.nih.gov/pubmed/10532145> [Accessed 2nd June 2010]
- Engelsted, N. Hedegaard, M. Karpatschop, B. and Mortensen, A. (Eds) (1993) *The Societal Subject*, Aarhus: University Press
- Engeström, R. (2014) 'The Interplay of Developmental and Dialogical Epistemologies', in *Outlines-Critical Practice Studies*, No. 15(2), online@ <http://www.outlines.dk> [Accessed 23rd April 2014]
- Engeström, Y. Hakkarainen, P. and Hedegaard, M. (1984) 'On the methodological basis of research in teaching and learning', in Hedegaard, M. Hakkarainen, P. and Engeström, Y. (Eds) *Learning and teaching on a scientific basis*, Aarhus, Denmark: Universitat Psykologisk Institute: 119-183
- Engeström, Y. (1987) *Learning by expanding: an activity—theoretical approach to developmental research*, online@: <http://lchc.ucsd.edu/mca/Paper/Engestrom/expanding/toc.htm> [Accessed June 8th 2011]
- Engeström, Y. (1993) 'Developmental studies of work as a test bench of activity theory: The case of primary care medical practice', in Lave, J. and Chaiklin, S. (Eds) *Understanding practice: Perspectives on activity and context*. Cambridge: University Press: 64-103
- Engeström, R. (1995) 'Voice as Communicative Action', in *Mind, Culture, and Activity*, 2(3):192-215
- Engeström, Y., Engeström, R. and Kakkainen, M. (1995) 'Polycontextuality and Boundary Crossing in Expert Cognition: Learning and problem solving in complex work activities', in *Learning and Instruction*, 5: 319-336.
- Engeström, Y. (1996a) 'Work as a test bench of activity theory', in: Chaiklin, S. and Lave, J. (Eds) *Understanding practice, perspectives on activity and context*; Cambridge, University Press: 64-103
- Engeström, Y. (1996b) 'The tensions of judging: Handling cases of driving under the influence of alcohol in Finland and California', in Engeström, Y. and Middleton, D. (Eds) *Cognition and communication at work* New York: Cambridge University Press: 199-232

- Engeström, Y. (1996c) 'Developmental work research as educational research: Looking ten Years back and into the zone of proximal development', in *Nordisk Pedagogik* 16(3): 131–43
- Engeström, Y. and Middleton, D. (Eds) (1996) *Cognition and communication at work*, UK: [Cambridge University Press](#) [Accessed, 18th June 2012]
- Engeström, Y. Virkkunen, J. Helle, M. Pihlaja, J. and Poikela, R. (1996) 'The Change laboratory as a tool for transforming work', in *Lifelong Learning in Europe*, 1(2):10-17, online@ <http://gerrystahl.net/teaching/spring09/782readings/EngestromChangeLab.pdf> [Accessed 12th June 2011]
- Engstrom, Y. and Miettinen, R. (1999) 'Introduction', in Engstrom, Y. Miettinen, R. and Punamaki, R. (Eds) *Perspectives on Activity Theory*; Cambridge: Uni.Press: 1-18
- Engeström, Y. (1999a) *Outline of three generations of activity theory*, online@ <http://www.bath.ac.uk/research/liw/resources/Models%20and%20principles%20of%20Activity%20Theory.pdf> [Accessed 16 June 2011]
- Engeström, Y. (1999b) 'Activity theory and individual and social transformation', in *Perspectives on activity theory*, (Ed) Engeström, Y. Miettinen, R. and Punamäki, R. Cambridge: University Press: 19-38
- Engeström, Y. (1999c) 'Innovative Learning in Work Teams: Analysing cycles of Knowledge creation in Practice', in Engeström, Y. Miettinen, R. and Punamaki, R. (Eds) *Perspectives on Activity Theory*, Cambridge: University Press: 377-404 [Accessed 16 June 2011]
- Engeström, Y. (1999d) *Learning by expanding: ten years after*; Introduction to the German Edition of learning by expanding, online at: <http://lhc.ucsd.edu/MCA/Paper/Engestrom/expanding/intro.html> [Accessed June 29th 2011]
- Engeström, Y. (1999e) 'Expansive visibilization of work: An activity-theoretical perspective', in *Computer Supported Cooperative Work*, 8: 63–93 [http://miranda.ingentaconnect.com/vl=379335/cl=12/nw=1/rpsv/cgi-bin/linker?ext=a&reqidx=/09259724^28^298L.63\[aid=580511,erg164062\]](http://miranda.ingentaconnect.com/vl=379335/cl=12/nw=1/rpsv/cgi-bin/linker?ext=a&reqidx=/09259724^28^298L.63[aid=580511,erg164062]) [Accessed 19 June 2011]
- Engestrom, Y. (1999f) 'Learning by expanding: Ten years after', foreword to the Japanese edition of *Learning by Expanding*, Tokyo: Shin-yo-sha.
- Engeström, Y. Engeström, R. and Vähäaho, T. (1999) 'When the centre does not hold: The importance of knotworking', in Chaiklin, S. Hedegaard, M. and Jensen, U. (Eds) *Activity theory and social practice: Cultural–historical approaches*. Aarhus: University Press: 345-374
- Engeström, Y. (2000a) 'Activity theory as a framework for analyzing and redesigning work', in *Ergonomics*, 43(7): 960–974 <http://courses.ischool.berkeley.edu/i2903/s05/papers/Activitytheoryasafameworkforanalyzingandredesigningwork.pdf> [Accessed 11th June 2011]
- Engeström, Y. (2000b) 'Making expansive decisions: an activity theoretical study of practitioners building collaborative medical care for children', in Allwood, K. And Selart, M. (Eds) *Decision Making: Social/Creative Dimensions*. Amsterdam: Kluwer

- Engeström, Y. (2000c) 'From Individual Action to Collective Activity and Back: Developmental Work Research as an Interventionist Methodology', in Luff, P., Hindmarsh, J. and Heath, C. (Eds): *Workplace Studies: Recovering Work Practice And Informing System Design*: Cambridge: University Press: 150-168
- Engeström, Y. (2001) 'Expansive Learning at Work: Toward an Activity Theoretical Conceptualization', in *Journal of Education and Work* 14 (1): 133-156
<http://www.handover.eu/upload/library/jimaw6szeyuluh4tho6oq.pdf>
 [Accessed June 17th 2011]
- Engeström, Y. and Ahonen, H. (2001) *On the materiality of social capital: an activity-theoretical exploration*, in: Hasan, H. Gould, E. Larkin, P. and Vrazalic, L. (eds) *Information systems and activity theory, Vol. 2: Theory and practice*, Wollongong, University Press: 115-129
- Engeström, Y. (2002) 'New forms of expansive learning at work: the landscape of co-configuration', *Computer support for collaborative learning: Foundations for a CSCL community*. Hillsdale: Erlbaum
 [Accessed 1st April 2013]
- Engeström, Y. Engeström, R. and Suntio, A. (2002) From paralysing myths to expansive action: building computer-supported knowledge into the curriculum from below, CSCL 2002 Proceedings, Lawrence Erlbaum Associates, Inc. Hillsdale, New Jersey, USA: 318-325
- Engeström, Y. Engeström, R. and Kerosuo, H. (2003a) 'The discursive construction of collaborative care', in *Applied Linguistics*, 24: 286–315
- Engeström, Y. Puonti, A. and Seppänen, L. (2003) 'Spatial and temporal expansion of the object as a challenge for reorganizing work', in Nicolini, D. Gherardi, S. and Yanow, D. (Eds) *Knowing in organizations: A practice-based approach*: 151–186, Armonk: M. E. Sharpe
- Engeström, Y. (2003) 'The horizontal dimension of expansive learning: Weaving a texture of cognitive trails in the terrain of health care in Helsinki', in Achtenhagen, F. and John, E. (Eds) *Milestones of vocational and occupational education and Training, vol.1: The teaching–learning perspective*. Bielefeld: Bertelsmann: 153-180
- Engeström, Y. (2004a) 'New forms of learning in co-configuration work'. Paper presented at the ICTs in the Contemporary World Seminar, January 22, in London School of Economics, London, cited in Warmington, P. (2011) 'Divisions of labour: activity theory, multi-professional working and intervention research', in *Journal of Vocational Education and Training*, online@
<http://www.tandfonline.com/doi/pdf/10.1080/13636820.2011.561930>
 [Accessed 10th November 2011]
- Engeström, Y. (2005a) *Developmental work research: expanding activity theory in practice*, Germany: Docupont
- Engeström, Y. (2005b) 'Knotworking to create collaborative intentionality capital in fluid Organizational fields', in *Collaborative capital: Creating intangible value*, ed. Beyerlein, M. Beyerlein, S. and Kennedy, F., Amsterdam: Elsevier: 307-336

- Engeström, Y. (2006) 'Activity theory and expansive design', in Bagnara, S. and G. Crampton-Smith, (Eds) *Theories and practice of interaction design*: 1-22 Hillsdale: Lawrence Erlbaum, online@ <http://projectsfinal.interactionivrea.org/20042005/symposium%202005/communication%20material/activity%20theory%20and%20expansive%20designengstrom.pdf> [Accessed 16th July 2011]
- Engeström, Y. (2007a) 'Enriching the theory of expansive learning: Lessons from journeys towards co-configuration', in *Mind, Culture and Activity* 14(1–2): 23–39 <http://www.helsinki.fi/cradle/documents/Engestrom%20Publ/Enriching%20Expansive%20Learning.pdf> [Accessed, May 11th 2011]
- Engeström, Y. (2007b) 'Putting Vygotsky to work: The change laboratory as an application of double stimulation', in *The Cambridge Companion to Vygotsky*, ed. Daniels, H. Cole, M. and J. Wertsch, Cambridge: University Press: 363–82
- Engeström, Y. and Kerosuo, H. (2007) 'From workplace learning to inter-organisational learning and back: The contribution of activity theory', in *Journal of Workplace Learning*, 19: 336–342
- Engeström, Y. (2009) 'The Future of Activity: a rough draft'. In A. Sanninio, H. Daniels, and C. Gutierrez (Eds) *Learning and expanding with activity theory* (pp. 303-328) Cambridge, UK: Cambridge University Press <http://lhc.ucsd.edu/mca/Paper/ISCARkeyEngestrom.pdf> [Accessed, 3rd July 2016]
- Engeström, Y. and Sannino, A. (2010) 'Studies of expansive learning: Foundations, findings and future challenges', in *Educational Research Review*, vol. 5: 1-24
- Engeström, Y. (2010a) 'The Future of Activity Theory: A Rough Draft' in Sannino, A. Daniels, H. et al., *Learning and Expanding with Activity Theory*: Cambridge: University Press: 303-328
- Engeström, Y. (2010b) 'Activity Theory and Learning Work': 74-89, online@ <http://www.helsinki.fi/cradle/documents/Engestrom%20Publ/Chapter%20for%20Malloch%20book.pdf> [Accessed 13th August 2013]
- Engeström, Y. and Scaratti, G. (2016), "Editorial", *Journal of Workplace Learning*, Vol. 28 Iss 4 pp. 170 – 173, Online@ <http://www.emeraldinsight.com/doi/pdfplus/10.1108/JWL-03-2016-0018> [Accessed, 8th July 2016]
- Engineers Ireland (2015) Available online@ <https://www.engineersireland.ie/CPD-Training.aspx> [Accessed 19th October, 2015]
- Erlanson, D.A., Harris, E.L., Skipper, B.L. & Allen, S.D. (1993). *Doing naturalistic inquiry: a guide to methods*. Newbury Park, CA: Sage.
- Etherington, K. (2007) 'Ethical research in reflexive relationships', in *Journal of Qualitative Inquiry*, 13(5): 599-616
- European Anti Poverty Network (EAPN) Ireland (2013) [EAPN Ireland press release on new CSO Poverty Figures](http://www.eapn.ie/eapn/category/press-release), online@ <http://www.eapn.ie/eapn/category/press-release> [Accessed 23rd September 2013]

- European Commission, (2008) Progress towards the Lisbon objectives in education and training: indicators and benchmarks, Commission Staff Working Document,
http://ec.europa.eu/education/lifelong-learning-policy/doc1522_en.htm
 [Accessed 13th July 2011]
- European Council (2000) *Presidency conclusions*, Lisbon, 23-24 March
http://www.europarl.europa.eu/summits/lis1_en.htm
 [Accessed 19th June 2011]
- Farzanfar, R. (2005) *Using Qualitative Research Methods to Evaluate Automated Health Promotion/Disease Prevention Technologies: A Procedures' Manual*, Boston University Robert Wood Johnson Foundation
- Ferguson, H. and O'Reilly, M. (2001) *Keeping Children Safe: Child Abuse, Child Protection and the Promotion of Welfare*: Dublin: A and A Farmar
- Ferns Report (2005) In Government Publications Dublin: Retrieved from
<http://www.ferns.ie/FernsReport.html> [Accessed 21st October 2011]
- Fink-Samnack, E. (2006) 'Fostering a Sense of Professional Resilience: Six Simple Strategies', in *the new social worker Online--Magazine For Social Work Students and Recent Graduates--Articles, Jobs, and More; online@*
http://www.socialworker.com/home/Feature_Articles/Professional_Development_%26_Advancement/Fostering_a_Sense_of_Professional_Resilienc_e%3A_Six_Simple_Strategies/ [Accessed 2nd March 2010]
- Finlay, L. (2008) *Reflecting on 'Reflective practice', PBPL paper 52, A discussion paper prepared for PBPL CETL*, online@ www.open.ac.uk/pbpl
 [Accessed 2nd November 2009]
- Finlay, F. (2015) Investment in Children in Budget 2016: A Positive First Step, online@
<http://www.barnardos.ie/media-centre/news/latest-news/investment-in-children-in-budget-2016-a-positive-first-step.html>
 [Accessed, 24th October 2015]
- Fitzpatrick, J. (2006) *Encyclopaedia of Nursing Research* (2nd Ed) New York: Springer Publications Co.
- Focus Ireland (1996) 'Focus on Residential Child-Care in Ireland: Twenty Five Years since the Kennedy Report', Dublin: Focus Ireland
- Focus Ireland (2009) Annual Report, available online@
<https://www.focusireland.ie/files/annual%20report%202009.pdf>
 [Accessed, 23rd March 2010]
- Fook, J. (Ed) (1996) *The Reflective Researcher: Social Workers' theories of practice Research*, Sydney: Allen and Unwin
- Fook, J. (1999) 'Critical reflectivity in education and practice', in Pease, B. and J. Fook (Eds), *Transforming social work practice: Postmodern critical perspectives*: New York: Routledge
- Foot, K. (2001) 'Cultural-Historical Activity Theory as Practical Theory: Illuminating the Development of a Conflict Monitoring Network', in *Communication Theory*, Vol. 11, No. 1, February 2001: 56-83
 [Accessed, 12th July 2012]
- Fontana, A. and Frey, J. (2000) 'The Interview: From Structured Questions to Negotiated Text', in Denzin, N. and Lincoln, Y. (Eds) *Handbook of Qualitative Research*: London, Sage Publications: 645-672

- Ford, J. and Reutter, L. (1990) 'Ethical dilemmas associated with small Samples', in *Journal of Advanced Nursing*, 1990, 15: 187-191
- Franklin, B. And Parton, N. (eds) (1991) *Social work, the media and public relations*, London: Routledge
- Freifeld, L. (2012) Does Traditional Performance Management Work? online@ <http://www.trainingmag.com/content/does-traditional-performance-management-work> [Accessed 12th December 2013]
- Freud, S. (1998) 'Sigmund Freud: The Beginnings of Psychoanalysis' in *An Introduction to Object Relations*, London: Free Association Books.
- Furlong, A. and Cartmel, F. (1997) *Young People and Social Change: Individualization and Risk in Late Modernity*. Buckingham: Open University Press.
- Gaffney, M. (2010) The Psychology Matters: Flourishing Under Fire, lecture Thursday 3rd September 2010, at National College of Ireland, Dublin
- Garda Siochána (2009) Online@ www.garda.ie [Accessed, January 2009]
- Garfat, T. (2003) *A Child and youth care approach to working with families*, New York : Haworth Press
- Garfat, T., Fulcher, L. & Digney, J. (Eds) (2013) *The therapeutic use of Daily Life Events with families*, available online@ <http://www.transformaction.com/docs/dle-families.pdf> [Accessed, 23rd November 2015]
- Gargan, J. (2015) The Shocking Reality of a System in Crisis, available online@ <http://www.epiconline.ie/the-shocking-reality-of-a-system-in-crisis/> [Accessed 23rd October 2015]
- Gartland, F. (2014) Domestic violence applications up 20 per cent, new court figures show, in *Irish Times*, 7th April, online@ <http://www.irishtimes.com/news/crime-and-law/courts/domestic-violence-applications-up-20-per-cent-new-court-figures-show-1.1752374> [Accessed 8th April 2014]
- Gershoff, E. (2003) *Living at the Edge: Low Income and the Development of America's Kindergartners*, Research Brief No 4. New York: National Centre for Children in Poverty, Mailman School of Public Health, Columbia University
- Gibson, J. Leonard, M. and Wilson, M. (2004) 'Changing Residential Child Care: A Systems Approach to Consultation Training and Development', in *Child Care in Practice*, vol. 10, Issue 4: 345-357
- Gibson, J. (2012) A Positive view of residential child care, online@ <http://www.gibsoncathcart.com/a-positive-view-of-residential-child-care/> [Accessed 12th October 2012]
- Gibbons, N. (2010) Roscommon child care case, report of the inquiry team to the Health Service Executive, Dublin: The Stationery Office
- Giddens, A. (1989) *Sociology*, Oxford: Polity press
- Gilligan, R. (1998) 'Enhancing the resilience of children and young people in Public care by mentoring their talents and interests', in *Family and Social Work*, vol. 4(3): 187-186
- Gilligan, R. (2005) 'Resilience and Residential Care for Children and Young People', in Crimes, D. and Milligan, I. (Eds) *Facing Forward: Residential child care in the 21st century*, Dorset: Russell House Publishing: 105-115
- Ginnott, H. (1972) *Between Teacher and Child: a Book for Parents and Teachers*, New York: Macmillan

- Giorgi, A. (1985) (Ed.) *Phenomenology and psychological research*. Pittsburg, PA: Duquesne University Press.
- Glaser, B. (1992) *Basics of grounded theory analysis*. Mill Valley, CA. Sociology Press
- Global Finance (2013) 'The World's Richest and Poorest Countries'. Available online@ <http://www.gfmag.com/component/content/article/119-economic-data/12529-the-worlds-richest-and-poorest-countries.html#axzz2iZSvduua> [Accessed October 3st.2013]
- Gouda, P., Kitt, K., Evans, D., Goggin, D., McGrath, D., Last, J., Hennessy, M., Arnett, R., O'Flynn, S., Dunne, F and O'Donovan, D. (2015) *Ireland's medical brain drain: migration intentions of Irish medical students*, available online@ <http://www.human-resources-health.com/content/13/1/11/abstract> [Accessed, 2nd November 2015]
- Gould, N. and Baldwin, M. (2004) *Social Work, Critical Reflection and the Learning Organisation*, England: Ashgate
- Government of Ireland (1996) *Interim report of the Joint Committee on the Family Kelly - A Child is Dead*. Report of a Committee of Inquiry, @ <http://lenus.ie/hse/handle/10147/50273> [Accessed 21st January 2010]
- Government Publications Office (2006) *Towards 2016 Ten-Year Framework Social Partnership Agreement 2006-2015* Online@) http://www.taoiseach.gov.ie/attached_files/Pdf%20files/Towards2016PartnershipAgreement.pdf also from the Stationery Office Dublin [Accessed 10th February 2013]
- Gray, D. (2004) *Doing Research in the Real World*, London: Sage
- Gray, D. (2009) (2nd Ed) *Doing research in the real world*, London: Sage publications
- Griffin, P. and Cole, M. (1984) 'Current activity for the future: the zo-ped', in: Rogoff, B. and Wertsch, J. (Eds) *Children's Learning in the Zone of Proximal Development*, San Francisco: Jossey-Bass: 45-63
- Griffin, E. Arensman, E. Wall, A. Corcoran, P. and Perry, I. (2013) National Registry of Deliberate Self Harm Ireland: Annual Report 2012, online@ <http://www.nsrif.ie/reports/Reports2013/2012NRDSHExecSummaryReport.pdf> [Accessed 20th November 2013]
- Guba, E. and Lincoln, Y. (1989) *Fourth Generation Evaluation*, Newberry Park CA: Sage
- Guba, E. and Lincoln, Y. (1994) 'Competing paradigms in qualitative research', in Denzin, N. and Lincoln, Y. (Eds) *Handbook of qualitative research*, London: Sage: 105-117
- Guba, E.G. & Lincoln, Y.S. (2005) Paradigmatic controversies, contradictions, and emerging confluences. in N.K Denzin & Y.S. Lincoln (eds.) *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks: pp 191-215
- Halton, C. Powell, F. and Scanlon, M. (2013) Continuing Professional Development in Social Work, Presentation@ UCC, October 2013, at the Biennial Child Protection and Welfare Social Work Conference
- Halton, C. (2014a) Understanding Continuing Professional Development Conference,
- Halton, C. Powell, F. and Scanlon, M. (2014b) *Continuing Professional Development in Social Work*, University of Bristol: Policy Press

- Hamlyn, D. (1995) *Epistemology, history of Oxford*, Oxford University Press
- Hammersley, M. and Atkinson, P. (1983) *Ethnography: Principles in Practice*: London: Routledge
- Hancock, B. (2002) *An introduction to Qualitative research*
http://faculty.cbu.ca/pmacintyre/course_pages/MBA603/MBA603_files/IntroQualitativeResearch.pdf [Accessed, 12th April 2013]
- Happer, C. and Greg, P. 'The Role of the Media in the Construction of Public Belief and Social Change', in *Journal of Social and Political Psychology* (2013) vol.1(1) 321–336, online@
<http://jspp.psychopen.eu/article/view/96/37> [Accessed, 3rd July 2016]
- Haraway, D. (1991) *Simians, cyborgs, and women: the re-invention of nature*. New York: Routledge
- Harris, R. Guthrie, H. Hobart, B. and Lundberg, D. (1995) *Competency-Based Education and Training: Between a Rock and a Whirlpool*. South Melbourne: Macmillan Education Australia
- Hawkins, P. and Shohet, R. (2007) *Supervision in the helping professions*. UK: Open University Press
- Heckman J. (2004) 'Invest in the very young' in: Tremblay, R. Barr, R. and Peters, R. (Eds) *Encyclopaedia on Early Childhood Development* Montreal, Quebec: Centre of Excellence for Early Childhood Development: 1-2, online@:
<http://www.excellenceearlychildhood> [Accessed 15th October 2008]
- Heckman J. and Masterov, D. (2004) 'The Productivity Argument for Investing in Young Children: Working Paper 5, Invest in Kids Working Group Committee for Economic Development', online@
<http://jenni.uchicago.edu/Invest/FILES/dugger2004-12-02dvm.pdf> [Accessed 23rd .October 2008]
- Heckman, J. and Cunha, F. (2005) 'Credit Constraints, Family Constraints and Optimal Policies to reduce Inequality and Promote Productivity', Study presented at the International Meeting of Early-Childhood Education, held at Centro de Políticas Sociais da Fundação Getúlio Varga (FGV), online@:
<http://www.fgv.br/ibre/cps/>. [Accessed 18th October 2008]
- Heiman, G. (2001) (Ed) *Understanding Research Methods and Statistics – An Integrated Introduction for Psychology*: Boston NY: Houghton Mifflin Co
- Helle, M. (2000) 'Disturbances and contradictions as tools for understanding work' in *Scandinavian Journal of Information Systems* 12: 81–113
- Helle, M. and Töyry, M. (2009) 'Media Concept as a Tool for Analyzing Change in Media' in, Oittinen, P. and Saarelma H., *Print Media. Principles, Processes and Quality* Helsinki: Paper Engineers' Association/Paperi ja Puu Oy: 497-530
- Helliwell, J. Layard, R. and Sach, J. (2013) *World Happiness Report*, online@
<http://unsdsn.org/files/2013/09/WorldHappinessReport2013online.pdf> [Accessed 23rd October 2013]
- Henderson, R and Pochin, M. (2001) *A Right Result? Advocacy, Justice And Empowerment*. UK: Bristol: The Policy Press
- Heron, B. (2005) 'Self-reflection in critical social work practice: Subjectivity and the Possibilities of resistance', in *Reflective Practice*, 6(3), 341–351
- Hesse-Biber, S. and Leavy, P. (2006) *The practice of qualitative research*, Thousand Oaks, CA: Sage Publications
- Higham, P. (2009) *Post-qualifying social work practice*, London: Sage

- Higher Education and Training Council (HETAC) *Assessment and Standards* (2009), online@ [http://www.hetac.ie/docs/Assessment and Standards 2009%20Published.pdf](http://www.hetac.ie/docs/Assessment_and_Standards_2009%20Published.pdf) [Accessed 5th January 2010]
- Higher Education and Training Council (HETAC) *Awards Standards – Social Care Work* (2010), online@ [http://www.hetac.ie/docs/B.2.95.5 Awards Standards Social Care Work 2010.apdf](http://www.hetac.ie/docs/B.2.95.5_Awards_Standards_Social_Care_Work_2010.apdf) [Accessed 1st November 2010]
- Hill, R. Capper, P. and Wilson, K. (2007) ‘Workplace learning in the New Zealand apple industry network: A new co-design method for government peace-making’ in *Journal of Workplace Learning*, 19: 359–376
- HIQA: Health Information and Quality Authority (2012) *National Standards for Safer Better Healthcare*, Available online@ <http://www.hiqa.ie/standards/health/safer-better-healthcare> [Accessed June 12th 2013]
- HIQA: Health Information and Quality Authority (2012) *National Standards for the Protection and Welfare of Children*, July 2012, @ www.hiqa.ie [Accessed July 10th 2012]
- HIQA: Health Information and Quality Authority (2013) Available online@ <http://hiqa.ie/about-us> [Accessed November 12th 2013]
- HIQA: Health Information and Quality Authority (2013a) *Overview of findings of 2012 Children’s Inspection activity: foster care and children’s residential services*. July 2013, online@ <http://www.hiqa.ie/system/files/Analysis-2012-Childrens-Inspections.pdf> [Accessed 10th October 2013]
- HIQA: Health Information and Quality Authority (2013b) *Inspection of a Children’s High Support Unit in the HSE Dublin North East Region* (September 2013) www.hiqa.ie/system/files/inspectionreports/643.pdf [Accessed 28th January 2014]
- HIQA: Health Information and Quality Authority (HIQA) (2013c) [National Quality Standards: Residential Services for Adults and Children with Disabilities 2013](http://www.hiqa.ie/system/files/inspectionreports/643.pdf) [Accessed, 10th April 2014]
- HIQA: Health Information and Quality Authority (2014) *A Follow up Inspection Report of a Children’s Residential Centre in the Health Service Executive Dublin Mid Leinster Area* (January 20th 2014) www.hiqa.ie/system/files/inspectionreports/676.pdf [Accessed 28th January 2014]
- Hoepfl, M. (1997) ‘Choosing qualitative research: a primer for technological Education Researchers’, in *Journal of Education Technology*, 9 (1): 47-63
- Holden, M.J. (with Endres, T., Garbarino, J.F., Gibson, J., Holden, J.C., Kuhn, I.F. et al). (2007). *Children and residential experiences (CARE): Creating conditions for change*. Ithaca, NY: Residential Child Care Project, Cornell University.
- Holden, M. (2009a) *Therapeutic Crisis Intervention TCI* (6th Ed) New York: Cornell University
- Holden, M. (2009b) *Children and residential experiences: Creating the conditions for Change*, online@ <http://www.human.cornell.edu/bio.cfm?netid=mjh19> [Accessed 11th October 2012]

- Holland, K. (2012) 'High levels of burnout' in child protection staff', in *Irish Times*, Tuesday, May 15, 2012, online@<http://www.irishtimes.com/newspaper/ireland/2012/0515/1224316130132.html> [Accessed 16th May 2012]
- Holland, K. (2014a) Impact of austerity set down in report, in *Irish Times*, 26th Feb. online@<http://www.irishtimes.com/news/social-affairs/ordinary-people-tell-of-poverty-due-to-years-of-austerity-1.1704707> [Accessed 28th February 2014]
- Holland, K. (2014b) State repeatedly failing children in care, in same ways, says Ombudsman's Office, in *Irish Times*: Tuesday: 05/03/2014 online@<http://www.irishtimes.com/news/social-affairs/state-repeatedly-failing-children-in-care-in-same-ways-says-ombudsman-s-office-1.1712760> [Accessed. 5th March 2014]
- Hollway W. and Jefferson T (2000) *Doing Qualitative Research Differently: Free Association, Narrative and the Interview Method*. London: Sage.
- Holmes, L. (1992) *Understanding Professional Competence: Beyond the Limits of Functional Analysis*, paper presented at the Institute of Personnel Management Course Tutors' Conference, Manchester, online@<http://www.re-skill.org.uk/re-skill/profcomp.htm> [Accessed 15th July 2009]
- Holsti, O. (1968) Content analysis, in G. Lindzey and E. Aaronson (Eds) *The Handbook of Social Psychology*, Reading, MA: Addison-Wesley
- Hopkins, B. (2009) *Just Care: Restorative Justice Approaches to Working with Children in Public Care*. Published: Jessica Kingsley Publishers
- Hough, J. (2011a) HIQA criticises number of agency staff at care centre, in *The Examiner*, 6th July 2011, online@<http://www.examiner.ie/ireland/hiqa-criticises-number-of-agency-staff-at-care-centre-160111.html> [Accessed 16th July 2011]
- Hough, J. (2011b) Charity warns of HSE plans, in *Irish Examiner*, Saturday, October 8th, 2011 online@<http://irishexaminer.com/ireland/health/charity-warns-of-hse-plans-169910.html> [Accessed 6th November 2011]
- Howard, N. (2003) 'The Irish Association of Care Workers 1972-2003, a brief informal History', Dublin: Irish Association of Care Worker
- Howard, N. (2010) 'Deficiency' in System, says Child Watchdog', in Smyth, J *Irish Times*, 5th March 2010. Dublin: Irish Times Offices
- Howard, N. (2012) "The Ryan Report (2009). A Practitioner's Perspective on Implications for Residential Child Care," *Irish Journal of Applied Social Studies*: Vol. 12(1), Article 4, online@:<http://arrow.dit.ie/ijass/vol12/iss1/4> [Accessed 12th October 2013]
- Howard, N. and Lyons, D. (2014) (Eds) *Social Care: Learning from Practice*, Dublin: Gill and Macmillan
- HSE: Health Service Executive (2006) *Guide to Good Research Practice*. Online@<http://www.hse.ie/eng/staff/LeadershipEducationDevelopment/NationalInstituteofHealthSciences/NIHSPDFs/GuidetoGoodResearch.pdf> [Accessed November 18th. 2014]

- HSE: Health Service Executive: Best Practice Guidelines in the Use of Physical Restraint (Child care: residential units) (2006), online@ http://www.dcy.gov.ie/docsdb/documents/SRSB_report.pdf [Accessed July 3rd 2014]
- HSE: Health Service Executive (2008) *Research Ethics Committee*, online @ <http://www.lenus.ie/hse/bitstream/10147/112693/1/ReviewofResearchEthics.pdf> [Accessed 29th November 2014]
- HSE: Health Service Executive (2010) *Report of the task force for children and families social services: principles and practices*, Dublin
- HSE: Health Service Executive (2011) *Review of Adequacy for HSE Children and Family Services*, online@ <http://www.tusla.ie/uploads/content/Publicationsreviewofadequacy2011.pdf> [Accessed March 20th 2014]
- HSE: Health Service Executive (2012) Children and Families Social Services Staff Supervision Policy Document Reference No: WOSP2012. Staff Supervision Team Workforce Development Education, Training and Research Office, CFSA: Dublin
- HSE: Health Service Executive (2012[2010]) *Review of Adequacy for HSE children and family Services*. online@ http://www.tusla.ie/uploads/content/Publications_reviewofadequacy2010.pdf [Accessed 10th October 2013]
- HSE: Health Service Executive (2013a) Consolidated Salary Scales, online@ http://www.hse.ie/eng/staff/Benefits_Services/pay/July%202013.pdf [Accessed 8th November 2013]
- HSE: Health Service Executive (2013) National Service Plan. Available online@ <http://www.hse.ie/eng/services/Publications/corporate/NSP2013.pdf> [Accessed 20th Sept 2013]
- HSE: Health Service Executive (2013) Performance Management in the HSE, online@ http://www.hse.ie/eng/staff/Benefits_Services/Performance_Management/ [Accessed 24th September 2013]
- Humphreys, J. (2013) Stress and burnout increasingly common in brave new world of changing workplace, in *Irish Times*, Monday 14th January 2013; online@ <http://www.irishtimes.com/news/stress-and-burnout-increasingly-common-in-brave-new-world-of-changing-workplace-1.957901> [Accessed 15th January 2013]
- Hunter, N. (2011) HSE to shed 6,000 more jobs- CEO, in *Irishhealth.com*, Monday 03/10/2011. @ <http://www.irishhealth.com/article.html?id=19825> [Accessed .November 13th 2011]
- Husserl, E. (1970). *Logical Investigation*. New York: Humanities Press.
- Hussey, J. and Hussey, K. (1997) *Business research: A practical guide for undergraduate and postgraduate students*. London: Macmillan.
- Hussey, J. and Hussey, R. (2003) *Business research: A practical guide for undergraduate and postgraduate students*, (2nd Ed.). London: Macmillan Press.
- Ilyenkov, E. (1977) *Dialectical logic: Essays in its history and theory*, Moscow: Progress
- Ilyenkov, E. (1982) *The dialectics of the abstract and the concrete in Marx's 'Capital'*, Moscow: Progress
- IMPACT (1998) *Submission to the Expert Review Group on behalf of care workers*. Dublin: IMPACT

- IMPACT (2014) IMPACT Newsflash for Social Care Practitioners, newsletter, vol.1, Issue 1,
<https://dub126.mail.live.com/mail/ViewOfficePreview.aspx?messageid=mgxsowBPdo5BGTxwAiZMHTdA2&folderid=flinbox&attindex=0&cp=-1&attdepth=0&n=99312793> [Accessed 10th November 2014]
- Inglis, T. (1998) *Moral Monopoly: The Rise and Fall of the Catholic Church in Modern Ireland*. Dublin: UCD. Pp 243-259. Chapter 10
- Inskipp, F. and Proctor, J. (1995) *Art, Craft and Tasks of Counselling Supervision: Pt.2: Making the Most of Supervision*, Twickenham, Middlesex: Cascade publications
- Institute of Technology, Sligo (2008) *Code of Practice for the Quality Assurance of Postgraduate Research*, online@
<http://itsligo.ie/files/2010/03/CODE-OF-PRACTICE-A-2008.pdf>
 [Accessed. 29th November 2014]
- Institute of Technology, Sligo: Courses, social care (2013) online@
<http://courses.itsligo.ie/business-and-social-sciences/social-care/ba-hons-social-care-practice/> Accessed, 12th June 2013]
- Irish Association for Counselling and Psychotherapy (IACP) (2015) online@
<http://www.irish-counselling.ie/Continuing-Professional-Development-Framework>[Accessed 9th October 2015]
- Irish Association of Social Care Educators (IASCE) Practice Placement Manual
 online@<http://staffweb.itsligo.ie/staff/pshare/IASCE/Placement%20Manual%2029mar09.pdf> [Accessed, 2nd July 2016].
- Irish Association of Social Workers (IASW) (2013a) Continuing Professional Development Policy (2012) online@
<http://www.iasw.ie/attachments/86a42d72-f785-4f25-9aba-ed7a17c23342.PDF>[Accessed 15th October 2013]
- Irish Association of Social Workers (IASW) (2013b) Submission to CORU Consultation on Continuing Professional Development: Standards and Requirements Framework Document, 23rd April 2013, online@[Accessed 31st October 2014]
- Irish Association of Social Workers (IASW) Continuous Professional Development (CPD) (2015a) online@ <https://www.iasw.ie/cpd.aspx>
 [Accessed, 22nd October 2015]
- Irish Association of Social Workers (IASW) (2015b) Social Workers Registration Board: Standards and Requirements for Continuing Professional Development, Available online@
https://www.iasw.ie/attachments/CPD_Framework_SWRB.pdf
 [Accessed 18th October 2015]
- Irish Association of Social Workers (IASW) (2015c) Guidance for Supervisees who are Seeking Private Supervision/Consultation; online@
<https://www.iasw.ie/attachments/0e3e90cf-d2c5-4ffb-ac77b811ac4bf930.PDF> [Accessed 18th October 2015]
- Irish Association of Social Workers (IASW) (2015d) List of supervisors, online@
[https://www.iasw.ie/attachments/List_of_Supervisors_\(UD06072015\).pdf](https://www.iasw.ie/attachments/List_of_Supervisors_(UD06072015).pdf)
 Accessed 18th October 2015]
- Irish Association of Social Workers (IASW) (2015e) online@
<https://www.iasw.ie/event.aspx?contentid=4572>
 [Accessed 29th October 2015]

- Irish Association of Social Workers (IASW) (2016) online@
<https://www.iasw.ie/cpd.aspx?contentid=922>
 [Accessed, 4th July 2016]
- Irish Dental Association, (2015) online@
<http://www.dentist.ie/professional-development.24.html>
 [Accessed October 2015]
- Irish Employment Monitor (2013) Press Release. Available online@
<http://www.morganmckinley.ie/press-releases/press-release-irish-employment-monitor-july-2013> [Accessed 14th August 2013]
- Irish Prison Service (IPS) Information Booklet 2008, @ www.ips.ie
 [Accessed 23rd July 2009]
- Irish Prison Service (IPS) (2011) Annual Report, online@
<http://www.irishprisons.ie/images/pdf/annualreport2011.pdf>
 [Accessed 25th March, 2013]
- Irish Qualitative Data Archive (IQDA) (2014), online@
<http://www.iqda.ie/content/about-us> [Accessed 29th November 2014]
- Irish Statute Book (1995) S.I. No. 259/1995 - Child Care (Placement of Children in Residential Care) Regulations, 1995, online@
<http://www.irishstatutebook.ie/1995/en/si/0259.html>
 [Accessed, May 12th 2010]
- Irish Statute Book (2013) Health and Social Care Professionals Act 2005, online@
<http://www.irishstatutebook.ie/2005/en/act/pub/0027/sched3.html>
 [Accessed 24th July 2012]
- Irish Statute Book (2011) Code of Professional Conduct and Ethics for Social Workers bye-law (2011) online@
<http://www.irishstatutebook.ie/pdf/2011/en.si.2011.0143.pdf>
 [Accessed 2nd March 2013]
- Issroff, K. and Scanlon, E. (2002) 'Using technology in higher education: An activity Theory perspective', in *Journal of Computer Assisted Learning*, 18(1): 77-83
- Jerome, N. (2013) 'Application of the Maslow's hierarchy of need theory; impacts and implications on organizational culture, human resource and employee's performance', in *International Journal of Business and Management Invention*, online@ www.ijbmi.org, vol. 2(3): 39-45
 [Accessed 2nd March 2014]
- Jones, S. (2006). *Antonio Gramsci*. London: Routledge.
- Jones, P. (2009) 'Breaking away from Capital? Theorizing activity in the shadow of Marx'. in *Outlines*1, 45-58.
- Jones, J. (2014a) 'Building of trust is vital for proper interagency working', in *Irish Times Health and Family*, Tuesday January 21st 2014, online@
http://article.wn.com/view/2014/01/22/Second_Opinion_Building_of_trust_is_vital_for_proper_interag/#/related_news [Accessed 21st January 2014]
- Jones, J. (2014b) The Catholic Church still does not get child abuse, in *Irish Times Health and Family*, Tuesday 8th July 2014, online@
<http://www.irishtimes.com/life-and-style/health-family/second-opinion-the-catholic-church-still-does-not-get-child-abuse-1.1858320>
 [Accessed 8th July 2014]
- Jones, S., and Gelling, L. (2013). *Participation in action research*. Nurse Researcher, 21(2):6

- Joseph, J. (2000). *Ethics in the Workplace*: Available online@ <http://www.asaecenter.org/PublicationsResources/articledetail.cfm?ItemNumber=13073> [Accessed, 16th August 2010]
- Joyce P, and Cowman S. 'Continuing professional development: investment or expectation?' in *Journal of Nursing Management* (2007):15; pp. 626-333. Online@ <http://epubs.rcsi.ie/cgi/viewcontent.cgi?article1009&context=ilhmarr> [Accessed 21st October 2015]
- Kadushin, A. (1992) *Supervision in Social Work* (3rd. edn), New York: Columbia University Press, revised fourth edition published 2002
- Kajamma, A. (2016) Personal communication, 2nd July 2016
- Kaptelinin, V. (1996) 'Activity Theory: Implications for Human-Computer Interaction' in, Nardi, B. (Ed) *Context and Consciousness: Activity Theory and Human-Computer Interaction* Cambridge: The MIT Press: 53-59
- Kaptelinin, V. Nardi, B. and Macaulay, C. (1999) 'The activity checklist: A tool For representing the 'space' of context', in *Interactions*, Jul/August: 27-39
- Karban, K. and Frost, N. (1998) 'Training for residential care: Assessing the impact of the Residential Child Care Initiative' in *Social Work Education*, vol. 17(3): 287-300
- Keehan, G. (2014) Child and Family Agency has difficult task ahead, in *Irish Times*, Monday 3rd February. 2014. Dublin: Irish Times Offices
- Kelpie, C. (2011) Recession to blame for rise in stress and anxiety health problems, in *Irish Independent*, 13th June 2011, online@ <http://www.independent.ie/lifestyle/health/recession-to-blame-for-rise-in-stress-and-anxiety-health-problems-26742083.html> [Accessed 14th December 2012]
- Kennedy, E. (1970) *The Kennedy Report*, online@ <http://www.lenus.ie/hse/handle/10147/77793> [Accessed 5th June 2011]
- Kennedy, S. (1996) 'Child Care in Ireland', in *The Furrow*, Vol. 47(5) (May, 1996):270-276, online@ <http://www.jstor.org/stable/27663177> [Accessed. 2nd December 2008]
- Kennefick, D. (1998) 'Managing Social Services', in Joyce, L. (Ed), *A Healthier Future* Dublin: Gill and Macmillan
- Kennefick, P. (2006) 'Aspects of Personal Development' in O'Connor, T. and Murphy, M. *Social Care in Ireland: Theory, Policy/Practice*: Cork: CIT Press: 213-226
- Kerosuo, H. and Engeström, Y. (2003) 'Boundary Crossing and Learning in Creation of New Work Practice', in *Journal of Workplace Learning* 15(7/8): 345-351
- Kerosuo, H. (2006) 'Boundaries in action: An activity-theoretical study of development, learning and change in health care for patients with multiple and chronic illnesses', Helsinki: University of Helsinki, online@ <http://www.helsinki.fi/cradle/documents/Doctoral%20dissertations/Kerosuo%202006%20Boundaries%20in%20action.pdf> [Accessed 23rd January 2013]
- Kerosuo, H. Kajamaa, A. and Engeström, Y. (2010) 'Promoting innovation and Learning through Change Laboratory: An example from Finnish Health care', in *European Journal of Public Policy*, Special Issue on Knowledge Governance, 4(1):110-130, online@ <http://www.cejpp.eu> [Accessed 13th March 2013]

- Kimble, C. Li, F. and Barlow, A. (2000) 'Effective Virtual teams through communities of Practice', in *Management Science, theory, Method and Practice*, research paper no.9, online@ http://papers.ssrn.com/sol3/papers.cfm?abstract_id=634645 [Accessed 8th November 2014]
- Klaus, G., and Buhr, M. (Ed.). (1987). *Philosophisches Wörterbuch, Band 1-2*. Berlin (West): Das Europäische Buch.
- Klein, M. (1984) [The Psycho-Analysis of Children \(The Writings of Melanie Klein\)](#), vol. 2
- Klieman, S. (2004) 'Phenomenology: to wonder and search for meanings', in *Nurse Researcher* 11(4): 7-19
- Kolb, D. (1984) *Experiential learning: experience as the source of learning and Development*, Englewood Cliffs, N.J.: Prentice-Hall
- Kondracki, N. and Wellman, N. (2002) 'Content analysis: Review of methods and their applications in nutrition education', in *Journal of Nutrition Education and Behaviour*, 34: 224-230
- Kontinen, T. (2004) 'Intervention negotiated? Production of shared object and power relations', in the planning of a development co-operation *project*, in Kontinen, T. (Ed): 82-104
- Kontinen, T. (2013) 'A Gramscian perspective on developmental work research: Contradictions, power and the role of researchers reconsidered', in *Outlines: Critical Practice Studies*, vol. 14(2): 106-129, online@ <http://ojs.statsbiblioteket.dk/index.php/outlines/article/view/9795> [Accessed 23rd February 2014]
- Koshy, E. Koshy, V and Waterman, H. (2011) *Action Research in Healthcare*, London: Sage Publications
- Kuutti, K. (1996) 'Activity theory as a potential framework for human-computer interaction research', in Nardi, B. (Ed), *Context and consciousness: activity theory and human-computer interaction*, Cambridge: The MIT Press: 17-44, online@ www.dwr.bth.se/KariLKuutti%20Nardi_book.PDF [Accessed 19th June 2011]
- Kvale, S. (1996) *Interviews: An introduction to Qualitative research interviewing*; CA: Thousand Oaks, CA: Sage Publications
- Lalor, K. (2009) *Audit of Social Care Student Numbers and Programme Providers in Ireland Dublin Institute of Technology*, online@ http://www.socialstudies.ie/docstore/dls/resource/196_studentnos.pdf?service=0&pagid=1&useid=wen1209663627d3&urlid=196&seaid [Accessed 1st January 2010]
- Lalor, K. and Share, P. (2013) *Applied Social Care: An Introduction for Students in Ireland*, (3rd Edn), Dublin: Gill and Macmillan
- Laming, H. (2003) 'The Victoria Climbié inquiry: report of an inquiry', presented to Parliament by the Secretary of State of Health and the Secretary of State for the Home Department by Command of Her Majesty, January (Cm 5730)
- Laming, H. (2009) *The Protection of Children in England: a progress report*, London: The Stationery Office

- Langemeyer, I. (2006) 'Contradictions in expansive learning: Towards a critical analysis of self-dependent forms of learning in relation to contemporary socio technological change', in *Forum: Qualitative Social Research*, 7(1), online@ <http://www.qualitative-research.net/index.php/fqs/article/view/76/156> [Accessed March 12th 2014]
- Lave, J. and Wenger, E. (1991) *Situated learning: Legitimate peripheral Participation* Cambridge: University Press
- Lave, J. (1996) 'The practice of learning', in: Chaiklin, S. and Lave, J. (Eds) *Understanding practice, perspectives on activity and context*, Cambridge: University Press: 3–32
- Law Society of Ireland (2015) Online@ <https://www.lawsociety.ie/Courses-- Events/cpd/> [Accessed 22nd October 2015]
- Leadbetter, J. (2006) 'New Ways of Working and Ways of Being: Multi-agency Working and Professional Identity', *Educational & Child Psychology*, 23(4): 47-59
- Leadbetter, J. Daniels, H. Edwards, A. Martin, D. Middleton, D. Popova, A. Warmington, P. Apostolov, A. and Brown, S. (2007) 'Professional learning within multi-agency children's services: researching into practice', in *Educational Research*, 49:1, 83-98 [Accessed 12th March 2013]
- LeCompte, M. and Goetz, J. (1982) 'Problems of Reliability and Validity in ethnographic Research', in *Review of Educational Research*, 52: 31-60
- Learning Theories Knowledge Base (2010) *Activity Theory* at Learning-Theories.com online@ <http://www.learning-theories.com/activity-theory.html> [Accessed June 15th 2011]
- Learning while working: Success stories on workplace learning in Europe (2011) in *The Centre for the Development of Vocational Training* (Cedefop) http://www.cedefop.europa.eu/EN/Files/3060_en.pdf [Accessed 23rd July 2011]
- Leedy, P. (1997) *Practical Research Planning and Design* (6th Ed) Upper Saddle River; New York: Prentice Hall
- Legard, R. Keegan, J. and Ward, K. (2003) 'In-depth Interviews', in Ritchie, J. and Lewis, J. (Eds) *Qualitative Research Practice: a guide for Social Science students and Researchers*: UK: London: Sage
- Lemos M. Pereira-Querol M. Almeida I. (2013), [The Historical-Cultural Activity Theory and its contributions to Education, Health and Communication: interview with Yrjö Engeström](#) [Accessed February 20th 2014]
- Leont'ev, A. (1978) *Activity, consciousness, and personality*, Englewood: Prentice Hall
- Leont'ev, A. (1981) *Problems of the development of the mind*, Moscow: Progress Publishers
- Lester, S. (1999) 'Professional bodies, CPD and informal learning: the case of conservation', in *Continuing Professional Development*, 3(4): pp 110-21, cited in Halton, C. Powell, F. and Scanlon, M, (2014) *Continuing Professional Development in Social Work*, University of Bristol: Policy Press

- Letherby, G. (2003) *Feminist Research in Theory and Practice*, UK: Open University Press
- Lewis, R. (1997) 'An Activity Theory framework to explore distributed communities', in *Journal of Computer Assisted Learning*, 13: 210-218
- Lincoln, Y. and Guba, E. (1985) *Naturalistic Inquiry*, London: CA: Sage
- Lindsey R. (1984) 'Informed consent and deception in psychotherapy research an ethical Analysis', in *The Counselling Psychologist* 12(3-4): 79-86
- Logan, E. (2014) The Meta-analysis of Repetitive Root Cause Issues Regarding the provision of Services for Children in Care, (05/03/2014), online@ [http://www.oco.ie/assets/files/publications/complaints_and_investigations/OCOMETAAANALYSISOF%20SERVICESFORCHILDRENINCARE.PDF](http://www.oco.ie/assets/files/publications/complaints_and_investigations/OCOMETAA%20ANALYSISOF%20SERVICESFORCHILDRENINCARE.PDF) [Accessed 5th March 2014]
- Lombard, D. (2010) 'Social care staff run high risk of assault, new figures reveal', in Communitycare.co.uk, @ <http://www.quelltraining.com/social-care-staff-run-high-risk-of-assault-new-figures-reveal/2566/> [Accessed, 18th December 2010]
- Lompscher, J. (2004) 'Learning culture and competence development in a cultural–historical Perspective, adult learning in the process of work' Berlin: Lehmanns Media
- Long, T. and Johnson, M. (2007) *Research ethics in the real world: issues and solutions for health and social care*, Edinburgh: Churchill Livingstone/Elsevier
- Lotz-Sisitka, H. Pesanayi, T. And Chikunda, C. (2016) [*Building Commoning Activity: Navigating Power relations in CHAT Expansive Learning Research in the Building of Two Commoning Activities in Rural South Africa: Communal Food Gardening and Common Property Association Development.*](#) Rhodes University Environmental Learning Research Centre. Powerpoint Presentation
- Loughry, R. and O'Donovan, D. (2000) *Supervision: Practitioners in Social Context*, Dublin: Irish Youth Work Centre
- Luria, A. (1976) *Cognitive development*, Cambridge: Harvard University Press
- Lyons, D. (2009) 'Exploring the Importance of Self-awareness Training in Social Care Education', in Share P. and Lalor, K. (Eds) *Applied Social Care: an Introduction for Students in Ireland*, (2nd Edn), Dublin: Gill & Macmillan: 122-137
- Lyons, N. (2010a) *Handbook of reflection and reflective inquiry: Mapping a way of knowing for professional reflective inquiry*, New York: Springer
- Lyons, N. (2010b) 'Reflection and reflective inquiry: Critical issues, involving conceptualizations, contemporary claims and future possibilities', Lyons, N. (Ed), *Handbook of reflection and reflective inquiry: Mapping a way of knowing for professional reflective inquiry*, New York: Springer: 3–22
- Lyons, N. (2010c) 'Reflective inquiry: Foundational issues – 'A deepening of conscious life'', in Lyons, N. (ed.), *Handbook of reflection and reflective inquiry: Mapping a way of knowing for professional reflective inquiry*, New York: Springer: 25–44
- Lyons, D. (2014) 'Social Care Education and the Irish Association of Social Care Educators', in Howard, N. and Lyons, D. *Social Care: Learning from Practice*, Dublin: Gill and Macmillan: 24-37
- Macionis, J and Plummer, K. (2008) *Sociology: a global introduction* (4rd Ed), Essex: Pearson Education

- MacIntyre, A. (1999) *Dependent Rational Animals: Why Human Beings Need the Virtues*, London: Duckworth
- Mack, N. Woodson, C. MacQueen, K. Guest, G. and Namey, E. (2005) *Qualitative research methods: a data collector's field guide*, North Carolina: Family Health International
- Mack, S. (2014) What are the Advantages and Disadvantages of a Performance Management System? online@ <http://smallbusiness.chron.com/advantages-disadvantages-performance-management-system-71639.html> [Accessed 1st March 2014]
- Marczyk, G. DeMatteo, D. and Festinger, D. (2005) *Essentials of Research Design and Methodology*, New Jersey: John Wiley and Sons, Inc
- Martin, D. and Peim, N. (2009) Special Issue: 'Critical Perspectives on Activity Theory', in *Educational Review*, vol. 61(2): 131-138
- Marsh, D. and Stoker, G. (2002) *Theory and Methods in Political science* (2nd Ed) UK: Palgrave MacMillan
- Marshall, N. and Brady, T. (2001) 'Knowledge management and the politics of knowledge: Illustrations from complex products and systems,' in *European Journal of Information Systems*, 10(2): 99
- Marshall, C. and Rossman, G. (1999) *Designing Qualitative Research* (3rd Ed), Thousand Oaks, CA: Sage Publications
- Marx, K. (1972) 'XI Thesis on Feuerbach', in *Marx and Engels basic writings on politics and philosophy*, (Ed) S.L. Feuer. London: Fontana
- Maslow, A. (1970) *Motivation and Personality* (3rd Ed.) New York: Harper and Rowe
- May, T. (2001) *Social research: Issues, methods and process*, Buckingham: University Press
- Maynard, M. (1994) *Methods, practice and epistemology: The debate about feminism and Research*, London: Taylor and Francis
- Mayring, P. (2000) 'Qualitative content analysis', in *Forum: Qualitative Social Research*, 1(2) online@ <http://www.qualitative-research.net/fqs-texte/2-00/02-00mayring-e.htm> [Accessed 10th March 2011]
- McCormack, C. (2015) 'Porn in the playground' fuels rise in 'child-on-child' sex assaults in *Sunday Independent*, 8th Feb. 2015, online@ <http://www.independent.ie/irish-news/news/porn-in-playground-fuels-rise-in-childonchild-sex-assaults-30973446.html> [Accessed, 9th February. 2015]
- McClelland, D. (1973) 'Testing for competence rather than intelligence', in *American Psychologist* 28: 1-14
- McDonald, B. (2013) 'Four HSE staff sacked for abuse of sick leave', online@ <http://www.irishexaminer.com/ireland/four-hse-staff-sacked-for-abuse-of-sick-leave-226647.html> [Accessed 25th October 2013]
- McDonnell, D. Fostering Focusing, available online@ <https://www.focusing.org/eshop/10Expand.asp?ProductCode=DVD-NL-FF> [Accessed, 13th February 2016]
- McElwee, N. (1998) 'In search of the Holy Grail', in *Irish Journal of Applied Social Studies*, 1(1): 79-99
- McEvaney, R. Tatlow-Golden, M. Webb, R. Lalor, E. and Merriman, B. (2013) *Someone to Care: The Mental Health Needs of Children and young people with experience of care and youth justice systems*, online@ <http://www.childrensmentalhealth.ie/wpcontent/uploads/2013/07/SOMEONETOCARE2013.pdf> [Accessed 28th January 2014]

- McGuinness, C. (1993) *Kilkenny Incest Investigation: report presented to Mr. Brendan Howlin T.D., Minister for Health by South Eastern Health Board*, Dublin: Stationery Office
- McHugh, J. and Meenan, D. (2009) 'Residential Child Care', in Share P. and Lalor, K. (Eds) *Applied Social Care: an Introduction for Students in Ireland*, (2nd Edn) Dublin: Gill and Macmillan: 291-305
- Means, R. Richards, S. and Smith, R. (2008) *Community Care*, London: Palgrave
- Melton, R. (1994) 'Competences in perspective', in *Educational Research*, vol. 36(3), Winter 1994, online@ <http://medicina.iztacala.unam.mx/medicina/Competences%20in%20perspective.pdf> [Accessed 3rd June 2010]
- Merriam, S. (1998) *Qualitative research and case study applications in education*, San Francisco: Jossey-Bass
- Merriam, S. (2009) *Qualitative research: A guide to design and implementation*. San Francisco: Jossey-Bass
- Mertens, D. (1998) *Research methods in Education and Psychology: Integrating diversity with quantitative and qualitative approaches*, London: Sage Publications
- Mezirow, J. (1981) 'A critical theory of adult learning and education' in *Adult Education*, 32 (1): 3-24
- Miles, M. and Huberman, A. (1994) *Qualitative data analysis: An expanded sourcebook*, Thousand Oaks, CA: Sage Publications
- Milligan, I. (2003) 'A new route to professionalism? The development of a residential child care DipSW in Scotland', in *Social Work Education*, vol.22 (3): 283-295
- Moffatt, K. (1996) 'Teaching social work as a reflective process', in Gould, N. and Taylor, I. (Eds) *Reflective learning for social work research, theory and practice*. Aldershot: Arena: 46-61
- Moon, J. (2006) *Learning journals: A Handbook for Reflective Practice and Professional Development*, UK: Taylor and Francis
- Moon, J. (2014) 'Reflective Learning, Learning Journals, Epistemological Development Workshop', Paper given at Continuing Professional Development, Conference Harold's Cross, Dublin, 20th March 2014
- Mooney, S. (2014) 'Adult Disclosures of Childhood Sexual Abuse to Child Protection Services: Current Issues in Social Work Practice', in *The Irish Social Worker Spring Summer 2014*, pp. 7-12, available online@ <https://www.iasw.ie/attachments/a7baafd8-c047-418e-8dee-7c53085423c3.PDF> [Accessed, 12th November 2015]
- Moore, N. (1997) (2nd Edn.) *How to do Research*, London: Library Association Publishing
- Morgan, D. (1993) 'Qualitative content analysis: A guide to paths not taken', in *Qualitative Health Research*, 3: 112-121
- Morrison, T. (1993) *Staff Supervision in Social Care, an Action Learning Approach*, England: Longman
- Morrison, T. (2003) *Staff Supervision in Social Care*: Ashford Press: Southampton
- Morse, J. (1994) *Critical Issues in Qualitative Research Methods*. Thousand Oaks, CA: Sage Publications
- Morse, J. and Field, P. (1995) *Qualitative research methods for health professionals* (2nd Edn.), Thousand Oaks, CA: Sage Publications

- Moss, P. and Petrie, P. (2002) *From Children's Services to Children's Spaces: Public Policy, Children and Childhood*, New York: RoutledgeFalmer
- Moustakas, C. (1994) *Phenomenological Research Methods*, London: Sage Publication
- Mukute, M. (2009) 'Cultural Historical Activity Theory, Expansive Learning and Agency in Permaculture Workplaces', in *Southern African Journal of Environmental Education*, online@ <file:///C:/Users/user/AppData/Local/Temp/14.+Cultural+Historical+Activity+Theory+Expansive+Learning+and+Agency+in+Permaculture.pdf> [Accessed October 30th 2014]
- Muldoon, N. (2015) Ombudsman for children Annual report [2014], online@ <https://static.rasset.ie/documents/news/oco-annual-report-2014.pdf> [Accessed November 1st 2015]
- Munro, A. Manthei, B. and Small, J. (1989) *Counselling: The Skills of Problem Solving*, London: Routledge
- Munro, E. (2011) *The Munro Review of Child Protection: Final Report, a Child Centred System*, (Cm 8062) London: The Department of Education, online@ <http://www.officialdocuments.gov.uk/document/cm80/8062/8062.pdf> [Accessed 12th November 2013]
- Munson, C. (2002) (3rd Edn) *Handbook of Clinical Supervision*, NY: Howorth Social Work Practice Press
- Murphy, Z. and Graham, G. (2002) *Life Space Intervention Training Video and Manual for Residential Care*, Dublin: Institute of Technology
- Murphy, C. (2010) *From Justice to Welfare: The Case for Investment in Prevention and Early Intervention*, in Irish Penal Reform Trust, September 2010, online@ http://www.iprt.ie/files/FromJusticetoWelfare_-_TheCaseforInvestmentinPreventionandEarlyIntervention.pdf [Accessed October 10th 2010]
- Murphy, M. Dempsey, M. and Halton, C. (2010) 'Reflective inquiry in social work education' in Lyons, N. (ed.) *Handbook of reflection and reflective inquiry: Mapping a way of knowing for professional reflective inquiry*, New York: Springer: 173–188
- Mutch, C. (2005) *Doing Educational Research: A Practitioner's Guide to Getting Started* Wellington: NZCER Press
- Nardi, B. (Ed) (1996) 'Studying Context: A Comparison of Activity Theory, Situated Action Models, and Distributed Cognition', in Nardi, B. (Ed) *Context and Consciousness: activity theory and human-computer Interaction*, Cambridge. MA: The MIT Press
- Nastasi, B. and Schensul, S. (2005) 'Contributions of qualitative research to the validity of intervention research', in *Journal of School Psychology*, 43: 177-195
- National Association of Principals and Deputy Principals (NAPD) (2014) *Cyber-bullying Survey*, online@ <http://www.napd.ie/cmsv1/> [Accessed April 1st 2014]
- National Framework of Qualifications (NFQ) (2010), online@ <http://www.nqai.ie/> [Accessed 15th September 2010]
- National Standards for Children's Residential Centres (2001), available online@ <http://health.gov.ie/blog/publications/national-standards-for-childrens-residential-centres/> [Accessed, 10th June 2014]

- National Standards for Residential care for Young people: Government Publications(2004), @<http://www.hiqa.ie/system/files/Standardschildrencryoungpeoplesversion.pdf> [Accessed 17th March 2013]
- Neuman, W. (2003) *Social Research Methods: Qualitative and Quantitative Approaches* (5th Ed.), Boston: Allyn and Bacon
- Newman, T. (2004) What works in building resilience? online@ http://66.102.9.132/search?q=cache%3ApTzmUAtdRP8J%3Awww.barnardos.org.uk%2Fwhat_works_in_building_resiliencesummar1.pdf+professional+resilience+%2B+barnardos&hl=en&gl=ie [Accessed 26th February 2010]
- Newman, M. (2009) Professional Values and Ethics, in *Professional Ethics Report*, vol. 22(3), online@ <http://www.aaas.org/spp/sfml/per/newper> [Accessed April 2010]
- Niehaves, B. Stahl, B. (2006) ‘Criticality, Epistemology, and Behaviour vs. Design – Information Systems Research across Different Sets of Paradigms’, in *ECIS Proceedings*: 1–12
- Northern Ireland Post-Qualifying Education and Training Partnership: Guidance For Candidates on the individual assessment route (2008), online@ http://www.nipqetp.com/downloadfiles/080422guidanceforcandidateson_theindividualassessmentroute.pdf [Accessed 3rd May 2009]
- Northern Ireland Social Care Council (NISCC) (2002) *Codes of Practice*, online@ <http://www.niscc.info/> [Accessed 5th June 2010]
- Nurses and Midwifery Board of Ireland (2015) online@ <http://www.nursingboard.ie/en/cpd-directory.aspx> [Accessed 12th October 2015]
- Oakley, A. (1981) ‘Interviewing women: A contradiction in terms’, in Roberts, H. (Ed), *Doing Feminist Research*, London: Routledge: 30-61
- O’Brien, C. (2010) ‘HSE Under Pressure as enquiry urged on teens death’, in *Irish Times*, Saturday 6th March 2010, online@ www.irishtimes.com [Accessed May 20th 2010]
- O’Brien, C. (2013) ‘29 inquiries into State’s handling of child abuse’, in *Irish Times*, Thursday 19th Sept., online@ <http://www.irishtimes.com/news/social-affairs/state-s-mishandling-of-child-abuse-has-led-to-29-inquiries-and-550-recommendations-1.1532262> [Accessed 26th September 2013]
- O’Brien, C. (2014a) Vacant beds for children in care cost taxpayer €20m, in *Irish Times* online@ <http://www.irishtimes.com/news/social-affairs/vacant-beds-for-children-in-care-cost-taxpayer-20m-1.1769338> [Accessed 23rd April 2014]
- O’Connell, O. (2014) ‘Exploring the policy to practice gap: Social workers’ experience of embedding child protection policy into their practice’. A thesis submitted to the School of Applied Social Studies in partial fulfilment of the requirements for the degree of Masters in Social Policy at the National University of Ireland, Cork October 2014. Pp. 1-78. Online@ file:///C:/Users/user/Documents/July%202016%20PhD/Exploring_the_policy_to_practice_gap.pdf [Accessed, 6th July 2016]
- O’Gorman, C. (2011) Abuse of children in Irish institutions amounted to torture, 26th online@ <http://www.amnesty.ie/news/abuse-children-irish-institutions-amounted-torture> [Accessed 27th September 2011]

- O'Hagan, K. (1998) (Ed.) *Competence in Social Work Practice: A Practical Guide for Professionals*, London: Jessica Kingley Publishers
- OMCYA: Office of the Minister for Children and Youth Affairs (2009) Report of the Commission to Inquire into Child Abuse, implementation plan, Dublin: The Stationery Office
- Oko, J. (2008) *Understanding and Using Theory in Social Work*, Exeter: Learning Matters
- O'Neill, E. (2009) 'Using Professional Supervision in Social Care', in Share P. and Lalor, K. (Eds) *Applied Social Care: an Introduction for Students in Ireland*, (2nd Edn), Dublin: Gill and Macmillan:182-196
- O'Neill, B. and Dinh, T. (2013) 'Cyberbullying among 9-16 year olds in Ireland, Digital Childhoods Working Paper Series (No.5), Dublin: Dublin Institute of Technology, online@ <http://arrow.dit.ie/cserrep> [Accessed 12th January 2014]
- One Family (2014) Key facts and figures about one-parent families in Ireland, and about social welfare benefits, online@ <http://www.onefamily.ie/policy-campaigns/facts-figures/> [Accessed 30th March 2014]
- O'Regan, M. (2013) Referrals to child protection services up by a quarter in 2012@ <http://www.irishtimes.com/news/ireland/irish-news/referrals-to-child-protection-services-up-by-a-quarter-in-2012-1.1528796> [Accessed 20th September 2013]
- Ormond, P. (2014) 'Thoughts on the Good enough Worker', in Howard, N. and Lyons, D. *Social Care: Learning from Practice*, Dublin: Gill and Macmillan: 251-263
- O'Shea, K. (2012) 'Over 100 children in Ireland vanished from State care', in *Irish Central*, online@ <http://www.irishcentral.com/news/Over-100-children-in-Ireland-vanished-from-State-care-144871055.html> [Accessed 13th October 2013]
- O'Sullivan, E and O'Donnell, I. (2012) *Coercive Confinement in Post-Independence Ireland: Patients, Prisoners and Penitents*, Manchester: University Press
- O'Toole, J. (2009) 'Gender and Social Care: mapping a Structural Analysis', in Share P. and Lalor, K. (Eds) in *Applied Social Care: an Introduction for Students in Ireland*, (2nd Edn), Dublin: Gill and Macmillan: 137-150
- Owen, C. (2008) 'Analysing joint work between activity systems', in *Activities*, vol. 5(2): 52-69, online@ <http://www.activites.org/v5n2/v5n2.pdf> [Accessed. 2nd March 2014]
- Oxford Advanced Learners Dictionary (2013) online@ https://elt.oup.com/catalogue/items/global/dictionaries/oxford_advanced_learners_dictionary_8th_edition/?cc=global&selLanguage=en [Accessed January 2nd 2013]
- Paavola, S. Lipponen, L. and Hakkarainen, K. (2004) 'Models of innovative knowledge communities and three metaphors of learning', in, *Review of Educational Research*, vol.74: 557-576
- Parton, N. and O'Byrne, P. (2000) *Constructive social work: Towards a new practice*, Basingstoke: Macmillan Press
- Patton, M. (1990) *Qualitative Evaluation and research methods* (2nd Ed.) Thousand Oaks, CA: Sage Publications
- Patton, M. (2002) (3rd Edn) *Qualitative research and evaluation methods*, ThousandOaks, CA: Sage Publications

- Payne, C. and Scott, T. (1982) *Developing Supervision of Teams in Field and Residential Social Work*, England: National Institute of Social Work
- Payne, M. (2005) *Modern social work theory*, Hampshire: Palgrave Macmillan
- Payne, G. and M. Williams (2005) 'Generalization in Qualitative Research', in *Sociology* 39(2): 295-314
- Peim, N. (2009) 'Activity Theory and Ontology', *Educational Review*, vol. 61(2):167-180
- Penny, L. (2005) *Continuing Professional Development: Quantifying the views of Occupational Therapist Managers in an Irish context*, available online@ <http://www.lenus.ie/hse/bitstream/10147/116211/7/thesisarticleAOTL.pdf> [Accessed 29th October 2015]
- Peyton, L. (2012) A Review of Practice and Audit of the Management of Cases of Neglect online@ <http://www.hse.ie/eng/services/Publications/services/Children/reviewcases/neglect.pdf> [Accessed 10th October 2013]
- Pharmaceutical Society Ireland, (2015) @<http://www.thepsi.ie/gns/education/cpd.aspx> [Accessed 20th October 2015]
- Phelan, A. (2009) 'Death of teen failed by the system was preventable', in *the Herald* Monday, 17th August, online@ <http://www.herald.ie/news/death-of-teen-failed-by-the-system-was-preventable-1861941.html> [Accessed 29th September 2009]
- Positive Care Ireland (2013/2014), online@ <http://positivecare.ie> [Accessed 10th October 2014]
- Psychological Society of Ireland (2015) online@ <http://www.psihq.ie/psi-continuing-professional-development> [Acc. Oct. 2015]
- Publication manual of the American Psychological Association (2003) (5th Edn), Washington, DC: American Psychological Association
- Public Policy and Management Institute [PPMI]: An Assessment of the impact of ongoing reforms in education and training on adult learning* FINAL REPORT (2010) <http://ec.europa.eu/education/more-information/doc/2010/reforms.pdf> [Accessed 15th July 2011]
- Punch, K. (2005) *Introduction to Social Research, Quantitative and Qualitative Approaches*, London: Thousand Oaks
- Quality and Qualifications Ireland (2014), online@ <http://www.qqi.ie/Pages/default.aspx> [Accessed 25th September 2014]
- Quality and Qualifications Ireland (2015) available online@ [http://www.qqi.ie/Pages/National-Framework-of-Qualifications-\(NFQ\).aspx](http://www.qqi.ie/Pages/National-Framework-of-Qualifications-(NFQ).aspx) [Accessed 18th October 2015]
- Quinn, S. (2011) *Code of Professional Conduct and Ethics for Social Workers Bye-Law* Dublin: The Stationery Office, online@ [http://www.coru.ie/uploads/1%20Statement%20of%20Outcomes/SI%20n0%20143%20of%202011%20\(code%20of%20conduct\).Pdf](http://www.coru.ie/uploads/1%20Statement%20of%20Outcomes/SI%20n0%20143%20of%202011%20(code%20of%20conduct).Pdf) [Accessed 18th October 2011]
- Raftery, M. and O'Sullivan, E. (1999) *Suffer the Little Children: The Inside Story of Ireland's Industrial School*, Dublin: New Island

- Rafferty, M and Colgan, A. (2009) Organisational case studies of inter-agency co-operation in the delivery of children's services: CAAB research report: 5. online@<http://www.caab.ie/getdoc/ec699cf1-837a-44aa-b54e-38ad2a38f3f7/Org-Case-Studies.aspx> [Accessed 14th May 2013]
- Rager, K. (2005) 'Self-care and the qualitative researcher: when collecting data Can Break your heart', in *Educational researcher*, 34: 23-27.
- Redmond, B., Guerin, S., Nolan, B., Devitt, C and Egan, A. (2012) *The Retention of Social Workers in the Health Services: An Evidence-Based Assessment*, UCD.Online@
<http://www.ucd.ie/t4cms/UCD%20Retention%20of%20Social%20Workers.pdf> [Accessed, 16th May 2012]
- Reed, J. (2014) Supervision workshop at Continuing Professional Development Conference, 20th March 2014 @ Our Lady's Hospice Dublin
- Reilly, J. (2012) Debt burdens have led to disturbing rise in depression, in *Sunday Independent*, January 15th 2012, online@
<http://www.independent.ie/national-news/debt-burdens-have-led-to-disturbing-rise-in-depression-2989312.html>
[Accessed 19th June 2012]
- Riessman, C. K. (1994) *Qualitative studies in social work research*. Sage Publications.
- Riegel, R. (2011) 'Number of children in care up by almost 20 per cent', in *Sunday Independent*, Sunday October 30th, online@
<http://www.independent.ie/national-news/number-of-children-in-care-up-by-almost-20-per-cent-2921088.html> [Accessed 1st November 2011]
- Ripamonti, S. C. and Galuppo, L. (2016), 'Work transformation following the implementation of an ERP system: An activity-theoretical perspective', in *Journal of Workplace Learning*, Vol. 28 Iss: 4, pp.206 – 223
online@
<http://www.emeraldinsight.com/doi/abs/10.1108/JWL-01-2016-0005>
[Accessed, 7th June 2016]
- Ritchie, J. and Lewis, J. (2003) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, London: Sage Publications Ltd
- Ritchie, J. Lewis, J. and Elam, G. (2003) 'Designing and selecting samples', in Ritchie, J. and Lewis, J. (Eds) *Qualitative research practice. A guide for social science students and researchers*: 109-137, UK: London: Sage
- Robson, C. (2002) *Real World Research: A Resource for Social Scientists and Practitioner Researchers*, Oxford: Blackwell
- Rodgers, C. and Raider-Roth, M. (2006) 'Presence in teaching' in *Teachers and Teaching: Theory and Practice*, 12(3), 265–287
- Rogers, C. (1980) *A way of being*, Boston: Houghton Mifflin
- Rogers, J. (1990) *Caring for People: Help at the Frontline*, UK: Open University Press
- Rogers, C. (1998) *Client Centred Therapy*, London: Constable Company
- Rolfe, G. (2006) 'Validity, Trustworthiness and rigor: Quality and the idea of qualitative Research', in *Journal of Advanced Nursing*, 53(3): 304-310
- Royal College of Surgeons Ireland (2015) online@
<http://www.rcsi.ie/cpdacc> [Accessed 19th October 2015]

- RTE News (2011) *The National Review Panel has said the HSE is responsible for a considerable failing in a lack of a standard method for assessing the needs of children*, 18th October 2011, online@ <http://www.rte.ie/news/2011/1018/children.html> [Accessed 19th October 2011]
- RTE Radio One News (2014) *Family Agency faces €30 million cut*, reported 7th July 2014, @ <http://www.rte.ie/radio1/morning-ireland/> [Accessed 7th July 2014]
- Rubinstein, S. (1957) *Being and Consciousness: on the place of the psychic in the general Interconnection of the phenomena of the material world*, Moscow: Publishing House of the USSR Academy of Sciences
- Rückriem, G. (2009) 'Digital technology and mediation: A challenge to activity theory', in Sannino, A. Daniels, H. and Gutiérrez, K. (Eds) *Learning and expanding with activity Theory*, Cambridge: Cambridge University Press
- Rutter, M. (2000) in Shonkoff, J. and Meichels, S. (Eds) *Handbook of Early Childhood Intervention* (2nd edn), Cambridge: Cambridge University Press
- Ryan, A. (2006) 'Methodology: Collecting data', in Antonesa, M. Fallon, H. Ryan, A. Walsh, T. and Borys, L. (Eds) *Researching and writing your thesis: A guide for post graduate students*, NUI Maynooth: MACE: 70-89
- Sannino, A. Daniels, H. and Gutierrez, K. (2009) *Learning and expanding with Activity theory*, Cambridge: University Press
- Sarantakos, S. (1988) (2nd Ed) *Social Research*, New York: Palgrave
- Sarantakos, S. (2005) *Social Research* (3rd Ed.) Melbourne: Macmillan Education
- Saunders, M. Lewis, P. and Thornhill, A. (2007) *Research methods for business Students* (4th Edn), London: Prentice Hall
- Schön, D. (1983). *The reflective practitioner: How professionals think in action*, New York: Basic Books
- Schön, D. (1987) *Educating the reflective practitioner: toward a new design for teaching and learning in the professions*, San Francisco (CA): Jossey-Bass Publishers
- Schostak, J., Davisb, M., Hansonc, J., Browne, T., Driscolif, P., Starkeg, I. and Jinkins, N. (2010) *The Effectiveness of Continuing Professional Development: Final report*, online@ http://www.aomrc.org.uk/doc_view/213-effectiveness-of-cpd-final-report [Accessed 23rd October 2015]
- Schwandt, T. A. (2000) 'Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social construction', in N. K. Denzin and Y. S. Lincoln, (Eds) *Handbook of qualitative research*, p. 189-213. Thousand Oaks, CA
- Seale, C. (1999) *The quality of qualitative research*, London: Sage
- Shannon, G. (2011) [Fifth Rapporteur Report on Child Protection](http://www.dcy.gov.ie/documents/publications/5RapporteurRepChildProtection.pdf) <http://www.dcy.gov.ie/documents/publications/5RapporteurRepChildProtection.pdf> [Accessed 15th August 2013]
- Shannon, G. and Gibbons, N. (2012) *Report of the Independent Child Death Review Group Government Publications: Department of Children and Youth Affairs*, online@ http://www.dcy.gov.ie/documents/publications/Report_ICDRG.pdf [Accessed 3rd October 2013]

- Share, P. (2009) 'Social Care and the Professional Development Project', in Share P. and Lalor, K. (Eds) *Applied Social Care: an Introduction for Students in Ireland*, (2nd edn), Dublin: Gill and Macmillan: 58-77
- Share P. and Lalor, K. (2009) (Eds) *Applied Social Care: an Introduction for Students in Ireland*, (2nd Edn), Dublin: Gill and Macmillan
- Sharpe, C. (2009) 'Residential child care can do with the assistance it can get', in *Irish Journal of Applied Social Studies*, vol. 8: pp. 30-50
<http://arrow.dit.ie/cgi/viewcontent.cgi?article=1003&context=ijass&sei-redir=1#search=%22residential%2bchild%2bcare%2bcan%2bdo%2bwith%2bthe%2bassistance%2bit%2bcan%2bget%252c%2bin%2b%2509irish%2bjournal%2bof%2bapplied%2bsocial%2bstudies%2b%22>
 [Accessed. 1st January 2010]
- Share, P (2013) 'Social Care Practice, professionalism and post-professionalism', in Lalor, K. and Share, P. *Applied Social Care: an Introduction for Students in Ireland*, (3rd Edn) *Applied Social Care: an Introduction for Students in Ireland* Dublin: Gill and MacMillan: 42-59
- Shatter, A. (2010) Dail Transcript: The Death of Children in the Care of the State since 2000: Statements, March 4th 2010,
 @<http://www.alanshatter.ie/?p=1160>. [Accessed .April 30th .2010]
- Sheahan, F. (2012) Children's Referendum passed by thin margin of 58c to 42pc In *Irish Independent*, 3rd December, 2012, online@
<http://www.independent.ie/irish-news/childrens-referendum-passed-by-thin-margin-of-58c-to-42pc-28895069.html> [Accessed 4th December 2012]
- Sheehan, M. (2014) Garda Pulse records were 'altered' says whistleblower, in *Irish Independent*, published 25th May 2014, online@
<http://www.independent.ie/irish-news/garda-pulse-records-were-altered-says-whistleblower-30302108.html> [Accessed 26th May 2014]
- Shenton, A. (2004) 'Strategies for ensuring trustworthiness in qualitative research projects', in *Education for Information* 22: 63–75
- Shirley, J. and Gelling, L. (2013) 'Participation in action research', in *Nurse Researcher*, vol. 21(2): pp 6-7
- Shulman, L. (1999) (4th Edn) *The Skills of Helping Individuals, Families and Groups*, F.E. Peacock Publishers, Inc., Itasca, IL
- Sinacore, A., Blaisure, K., Healy, P., & Brawer, S. (1999). 'Promoting reflexivity in the Classroom', in *Teaching of Psychology*, 26(4), 267-70
- Skills for Care (2013) Qualifications and Training UK, online@
http://www.skillsforcare.org.uk/qualifications_and_training/N_V_Q/NVQ_and_knowledge_sets.aspx [Accessed April 15th 2013]
- Skillnets (2013) *Training Needs Analysis (TNA) Guide*, online@
http://www.skillnets.ie/sites/skillnets.ie/files/imce/u7/tna_guide_2013.pdf
 [Accessed 25th September 2013]
- Skipper, M, Musaeus, P and Hohn, S. B. 'The paediatric change laboratory: Optimising postgraduate learning in the outpatient clinic', in *BMC Medical Education*, 16:42
- Smit, B. (2002) Atlas for qualitative data analysis, in *Perspectives in Education*, 20(3): 65-75
- Smith, M. (2009) *Rethinking Residential Child Care*, Bristol: Policy Press
- Smith, J. Flowers, P. and Larkin, M. (2009) *Interpretive phenomenological analysis: Theory, method and research*, Thousand Oaks, CA: Sage Publications

- Smith, M. (2010) 'A brief history of (residential child care) ethics', in *Scottish Journal of Residential Child Care*, vol. 9(2): 2-11
- Smith, E. (2010) 'A review of twenty years of competency-based training in the Australian vocational education and training system', in *International Journal of Training and Development* Vol. 14(1): 54-64
- Smith, M., Fulcher, L. and Doran, P. (2013) *Residential Child Care in Practice: Making a Difference*. Bristol: Policy Press;
- Smyth, J. (2010) 'HSE's childcare inadequacies in spotlight yet again', in *Irish Times*, 16th December 2010
<http://www.irishtimes.com/newspaper/ireland/2010/1209/1224285100563.html> [Accessed 26th January 2011]
- Snape, D. and Spenser, L (2003) 'The foundations of qualitative research', in Ritchie, J. and Lewis, J. (Eds) *Qualitative research practice: a guide for social science students and researchers*, UK: London: 1-23
- Sobh, R. and Perry, C. (2006) 'Research design and data analysis in realism research', in *European Journal of Marketing*, vol. 40(11/12): 1194 - 1209
- Social Care Ireland (SCI) (2014) Continuing Professional Development Bulletin, February, vol. 2(2), online@ www.socialcareireland.ie [Accessed February 10th 2014]
- Social Care Ireland (SCI) (2015a) Continuing Professional Development Available online@ <http://socialcareireland.ie/workers/cpd-registration-social-care-workers/> [Accessed 10th October 2015]
- Social Care Ireland (SCI) (2015b) Continuing Professional Development, Policy and Portfolio, @ <http://socialcareireland.ie/social-care-ireland-cpd-policy-and-portfolio/> [Accessed 2nd December 2015]
- Social Services Workforce Analysis (2003) *Main Report*, Social Care and Health Workforce Group Employers' Organisation for Local Government London
- SWTF (Social Work Task Force) (2009) *Building a safe, confident future: the final report of the Social Work Task Force*, Nov.2009, London, online@ <http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eorderingdownload/01114-2009dom-en.pdf> [Accessed. June 23rd 2012]
- Stecley, L. (2012) 'Touch, Physical Restraint and Therapeutic Containment in Residential Child Care', in *Br J Soc Work*, vol. 42 (3): 537-555, [Accessed 5th March 2014]
- Stemler, S. (2001) An overview of content analysis, in *Practical Assessment, Research and Evaluation*, 7(17): 3-16
- Stringer, E. (2007) *Action Research* (3rd Edn) London: Sage Publications
- Stockwood, G. (Ed) (2010) *In it Together II: Redefining Value in Children's Services: Children's Services Development Group*, in collaboration with Donald Hirsch, @ <http://www.csdg.org.uk/images/pdfs/CSDG%20In%20it%20Together%20II%20-%20Redefining%20Value%20in%20Children's%20Services.pdf> [Accessed .December 20th .2011]
- State of the Nation's Children (2012) online@ <http://www.dcy.gov.ie/documents/research/StateoftheNationsChildren2012.pdf> [Accessed, June 2nd 2013]
- Strydom, H. (2005) The Pilot study, in De Vos, A. Strydom, H. Fouche, C. and Delpont, B. (Eds) in *Research at Grass Roots for the Social Sciences and Human Service Professions*, (3rd Edn) Pretoria: Van Schaik

- Suter, E. (2009) 'Role understanding and effective communication as core competencies for collaborative practice', in *Journal of inter-professional care*, Vol. 23(1): 41-51
- Taylor, B.J., Mullineux, J.C. and Fleming, G. (2010) 'Partnership, service needs and assessing competence in post qualifying education and training', *Social Work Education*, 29(5): 475-89
- Teaching Council Ireland (2015) online@ <http://www.teachingcouncil.ie/en/Teacher-Education/Continuing-Professional-Development/> [Accessed October 20th 2015]
- Techtarget (2016) 'SAP Business Suite', online@ <http://searchsap.techtarget.com/definition/SAP-Business-Suite> [Accessed, 7th July 2016]
- Tesch, R. (1990) *Qualitative research: Analysis types/tools*, New York: Falmer
- The New Child and Family Agency (2013) Staff Supervision Policy, July 2013, in Joint Committee on Health and Children, online@ http://www.dcy.gov.ie/documents/jointcommittee_20131219.pdf [Accessed July 21st 2013]
- Tippelt, R. Maximilian, L. and Amoras, A. (2003) 'Competency-based training Compilation of seminar subject matter: Training the trainers' in, *WEnt – Capacity Building International, Training Division 4.01 Käthe-Kollwitz-Straße 15 68169* <http://starwww.inwent.org/starweb/inwent/docs/Lehrbriefengl.pdf> [Accessed May 25th 2010]
- Titchen, A. and Dawn, H. (2005) 'Phenomenology', in Somekh, B. and Lewin, C. (Eds) in *Research Methods in the Social Sciences*, New Delhi: Sage: 121-130
- Tomlinson, P. (2004) *Therapeutic Approaches in Work with Traumatized Children and Young People: Theory and Practice*, London: Jessica Kingsley Publishers
- Training Needs Assessment Survey (2014), online@ <http://www.hr-survey.com/TrainingNeeds.htm> [Accessed 29th February 2014]
- Training Organisation for the Personal Social Services England (2004) *State of the Social Care Workforce in England*, Training for the Personal Social Services, London
- Tuli, F. (2010) 'The Basis of Distinction between Qualitative and Quantitative Research in Social Science: Reflection on Ontological, Epistemological and Methodological Perspectives', in *Ethiop. J. Educ.Sc.* vol. 6(1) 2-16
- Tuomi-Gröhn, T. Engeström, Y. and Young, M. (2003) 'From transfer to boundary-crossing between school and work as a tool for developing vocational education: An introduction', in, Tuomi-Grohn, T. and Engeström, Y. (Eds) *Between school and work: New perspectives on transfer and boundary-crossing*, Kidlington, UK: Elsevier Science: 1-15
- Tusla, Child and Family Agency, (2014) Corporate Plan 2015-2014. @ www.tusla.ie [Accessed, 24th May 2015]
- Tusla (2015a) *Integrated Performance and Activity Report, QUARTER 1*, online@ http://www.tusla.ie/uploads/content/Quarter_1_Performance_and_Activity_Report.pdf [Accessed October 28th 2015]

- Tusla (2015b) *Corporate Plan (2015-2017)* online@ [http://www.tusla.ie/uploads/news/Tusla_Corporate_Plan_2015 - 2017.pdf](http://www.tusla.ie/uploads/news/Tusla_Corporate_Plan_2015_-_2017.pdf) [Accessed October 31st 2015]
- Ulin, P. Robinson, E. and Tolley E. (2004) *Qualitative Methods in Public Health: A Field Guide for Applied Research*, San Francisco: Jossey-Bass
- University College Dublin (2015) online@ <http://www.ucd.ie/registry/academicsecretariat/progscpd.htm> [Accessed October 26th 2015]
- Unluer, S. (2012) 'Being an Insider Researcher While Conducting Case Study Research', *The Qualitative Report* 2012 Volume 17, Article 58, 1-14, <http://www.nova.edu/ssss/QR/QR17/unluer.pdf> [Accessed, 10th July 2016]
- Van Maanen, J. (1983) *Qualitative Methodology*, Beverly Hills, CA: Sage Publications
- Van Manen, M. (1990) *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*, Ontario, Canada: University of Western Ontario
- Vasilyuk, F. (1991) *The Psychology of Experiencing: The Resolution of Life's Critical Situations*, London: Hemel Hempstead
- Victor, B. and Boynton, A. (1998) *Invented here. Maximizing your organization's internal growth and profitability*, Boston: Harvard Business School Press
- Visser, J. (2002) 'External verities: the strongest links', *Emotional and Behavioural Difficulties*, vol. 7(2): 68-84
- Virkkunen, J. Ahonen, H. (2004) 'Transforming learning and knowledge creation on the shop floor', in *Human Resources Development and Management*, vol. 4(1): 57-72
- Virkkunen J, Vilela RADG, Querol MAP, Lopes MGR. (2014) 'The change laboratory as a tool for collaborative transforming work activities' - interview with Virkkunen, J. *Sociedade, S. S.* 2014; 23(1):336-44 cited in <http://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-016-0563-y> [Accessed, 2nd May 2016]
- Vygotsky, L. (1978) *Mind in Society: The development of higher psychological processes*, Cambridge, MA: Harvard University Press
- Vygotsky, L. (1986) *Thought and Language*, Cambridge MA: MIT Press
- Vygotsky, L. (1997) 'The history of the development of higher mental functions', in Rieber, R. (Ed) in *The collected works of L. S. Vygotsky*, vol. 4: The history of the development of higher mental functions, New York: Plenum
- Ward, A. (1998) 'Patterns of psychological presence and absence in training for residential child care', in *Social Work Education*, vol. 17(3): 375-388
- Ward, A and McMahon, L. (Eds) (1998) *Intuition is not Enough. Matching Learning With practice in therapeutic childcare*, London: Routledge: 28-39
- Warmington, P. Daniels, H. Edwards, A. Brown, S. Leadbetter, J. and Middleton, D. (2004) 'Interagency Collaboration: a review of the literature', online@ http://www.bath.ac.uk/research/liw/resources/Microsoft%20Word%20-%20Interagencycollaborationreview_of_the_literature_initial.pdf [Accessed September 7th.2012]

- Warmington, P. (2008) 'From 'activity' to 'labour': commodification, labour power and contradiction in Engeström's activity theory': 4-18, paper presented to the 1st International Congress of the ISCAR, 'Acting in Changing Worlds: Learning, Communication, and Minds in Intercultural Activities', Seville, 24th Sept. 2005
- Warmington, P. (2011) 'Divisions of labour: activity theory, multi-professional working and intervention research', *Journal of Vocational Education and Training*, vol. 63(2): 143–157
- Webb, S. (2006) *Social Work in a Risk Society: Social and Political Perspectives*, London: Palgrave Macmillan
- Weber, M. (1946) 'Bureaucracy' *From Max Weber: Essays in Sociology*, Gerth, H. and Wright Mills, C. (Eds), New York: Oxford University Press
- Weber, M. (1979 [[1914]) *Economy and Society*, edited by Wittich, C. and Roth, G., CA: University of California Press: 196-244
- Weber, R. (2004) 'Editors comments: the rhetoric of positivism versus interpretivism: a personal view', in *MIS Quarterly*, 28(1): iii–xiii
- Wenger, E. (1998) *Communities of practice: Learning, meaning and identity*, Cambridge: University Press
- Wenger, E. (2011) 'Communities of practice: A brief introduction', online @ <https://scholarsbank.uoregon.edu/xmlui/handle/1794/11736?showfull> [Accessed November 8th 2014]
- Wenger E, McDermott R, Snyder W. (2002) *Cultivating communities of practice: A guide to managing knowledge*. Boston, MA: Harvard Business School Press
- Wertsch, J. (1991) *Voices of the mind: A sociocultural approach to mediated Action* Cambridge, MA: Harvard University Press.
- Westberry, N. (2009) 'Moving between workplace and online learning spaces: an activity Theory perspective', in Proceedings, *ASCILTE 2009, same places, different spaces*, Auckland
- Williams Committee (1967) 'Caring for People: Staffing Residential Homes' – *the report of the Committee*, in National Council for Social Services, London: Allen & Unwin
- Williams, D. and Gilligan, R. (2011) 'Self Injury and the Challenges of Responding to Young People in Care: The Experiences of a Sample of Social Care Workers', in *Irish Journal of Applied Social Studies*, vol.11 (1) Article 2: 13-25 Available online @ <http://arrow.dit.ie/ijass/vol11/iss1/2> [Accessed December 31st 2011]
- Williams, D. and Lalor, K. (2001) 'Obstacles to the Professionalisation of Residential Child Care Work', in *Irish Journal of Applied Social Studies*, vol. 2(3), Article 6: 73-87 online @ <http://arrow.dit.ie/ijass/vol2/iss3/6> [Accessed June 12th 2012]
- Wincup, E. (2001) 'Feminist research with women awaiting trial: the effects on participants in the qualitative research process', in Gilbert, K. (Ed) *The emotional nature of Qualitative research*, Boca Raton FL: CRC Press, LRC
- Witte, S. and Haas, C. (2005) 'Research in Activity: An Analysis of Speed Bumps as Meditational Means', in *Written Communication*, 22: 27-165
- Wolfe, R. (1992) 'Data management', in Alkin, M. (Ed) *Encyclopaedia of educational Research*, (6th Edn) New York: Macmillan: 293-299

- Working in a multi-disciplinary setting in Northern Ireland: Curriculum Guidance for Diploma in Social Work Programmes (2000) online@ http://www.niscc.info/content/uploads/downloads/publications/Working_multi_disc_setting.pdf [Accessed 24th April 2011]
- Wosket, V. (1999) *The Therapeutic Use of Self; Counselling Practice and Supervision*, London: Routledge
- Woulfe, J. (2008) 'HSE bill of €3m for three troubled teenagers', in the Irish *Examiner*, 31st October 2008, Cork: Examiner Office
- Yamagata-Lynch, L. (2007) 'Confronting analytical dilemmas for understanding complex human interactions in design-based research from a Cultural-Historical Activity Theory (CHAT) framework', *Journal of the Learning Sciences*, 16(4): 451-484
- Yamagata-Lynch, L. and Haudenschild, M. (2009) 'Using activity systems analysis to identify inner contradictions in teacher professional development', in *Teaching and Teacher Education*, 25(3): 507-517
- Yamazumi, K. Engestrom, Y. and Daniels, H. (Eds) (2005) *New Learning Challenges: Beyond the Industrial Age System of School and Work*, Kansai: University Press
- Yin, R. (2009) (4th Edn) *Case Study Research: design and methods*, Los Angeles: Sage Publication
- Yip, K. (2006) 'Self-reflection in reflective practice: A note of caution', in *British Journal of Social Work*, 36(5): 777-788
- Young, I. M. (1990). *Justice and the politics of difference*. Princeton, NJ: Princeton University Press
- Youngballymun (2010) More than the sum of its parts: An evaluation of Ballymun Network for Assisting Children and Young People (2005-2010), Dublin
- Zeichner, K. (1993) 'Action research: personal renewal and social reconstruction', in *Educational Action Research*, 1(2): 199-219

APPENDICES

APPENDIX: 1



BIO-DATA FORM

Name		
Role		
Age		
Length of Service		
Location		
Do you work	Fulltime	Part-time

APPENDIX: 2



Questions

- 1) Do you think you need ongoing training?
- 2) What training do you get in your profession?
- 3) Are you asked to suggest training that you need?
- 4) Do you or your team engage in reflective practice?
- 5) Is your training competency based?
- 6) Do you have professional supervision? How often?
- 7) How would you rate your supervision?
- 8) What elements of training do you think are important?
- 9) Is your training beneficial and effective to your profession?
- 10) Do you think there are adequate resources provided for training?

Thank you very much for your time and for taking part in the research

APPENDIX: 3



January 3rd, 2011

Dear -----,

I am a PhD student and I am required to conduct a piece of research into a relevant topic which will form the basis of my PhD thesis. My research topic focuses on CPD training for frontline professionals who work as social care practitioners.

The Research

Irish society has changed considerably in the past decade. There are many social and economic problems that impact on several vulnerable people thus requiring them to seek professional help. Professionals working with these people need good quality training to enhance their development and enable them to work competently to the best of their ability. This research explores this hypothesis. Toward this end, I would like to interview at least 15 participants.

I am writing now to ask if you would please circulate a letter of invitation to participate in this research to all staff working under your supervision. (For your information I enclose a list of indicative questions to be posed to participants – not for circulation at this time). I will call to follow up on this request at the end of next week but if you would like to contact me for further information in the meantime my contact details are below.

It is important to note that this research is strictly confidential. The privacy and well being of all participants will be of the utmost importance and names and locations of participants will not be used. Research data will be locked in a secure cabinet at the Institute of Technology, Sligo. Participants will have an opportunity to view word notes of the interviews and can withdraw at any time from the research. Research data will be destroyed after a period of time.

You are welcome to contact me at 087 6804167 or email at either:

maureenohara2002@hotmail.com or S00015603@mail.itsligo.ie

Yours faithfully

Maureen O'Hara

APPENDIX: 4



Questions

- 11) What are the main challenges in your work?
- 12) Do you think you need ongoing training?
- 13) What training do you get in your profession?
- 14) Are you asked to suggest training that you need?
- 15) Do you or your team engage in reflective practice?
- 16) Is your training competency based? Purpose?
- 17) Do you have professional supervision? How often?
- 18) How would you rate your supervision?
- 19) What elements of training do you think are important?
- 20) Is your training beneficial and effective to your profession?
- 21) Do you think there are adequate resources provided for training?
- 22) What if any changes would you like to see in your training?

APPENDIX: 5



CONSENT FORM

I _____ consent to participate in research conducted by Ms. Maureen O’Hara at------. I understand Ms. O’Hara is a postgraduate student at the Institute of Technology, Sligo and that the research is being conducted as part of her PhD thesis. I have read the accompanying details of the research and have received a full explanation of the nature of the process from the researcher. My consent is fully informed and given freely. I am aware that no individual will be identifiable within the documented research and all information given will be treated as confidential. I am aware that I may withdraw from the research process at any time without negative consequences. I have been informed that the research is to be published in a bound thesis but that no individual will be identifiable within the thesis.

Signed: _____

Date: _____

APPENDIX: 6a



08 March 2011

Dear _____,

Thank you very much for doing the interview and for allowing me the time to interview the staff at the residential child care centre yesterday. I really do appreciate all your help and kindness, please pass on my thanks to all your staff.

Kindest regards

Maureen O'Hara

S00015603@mail.itsligo.ie

APPENDIX: 6b



08 March 2011

Dear _____,

Thank you very much for doing the interview and for allowing me the time to interview the staff at the residential child care centre yesterday. I really do appreciate all your help and kindness, please pass on my thanks to all your staff.

Kindest regards

Maureen O'Hara

APPENDIX 7: FINDINGS FROM THE INTERVIEWS TRANSCRIPTS



1.0 Interview Findings

Included in these findings are eleven interviews with social care practitioners²³ and three interviews with social care managers.²⁴ All practitioners are female; there is one male and two female Managers'. Interviews took place in three different centres. The section begins by documenting the findings from the 12 sub-questions under the three core research questions. Sub-question one under core research question one asked:

1.1.1: What are the main challenges in your work?

Practitioner 1 is a female aged 35 with 12 years work experience, she said *“the main challenges are always dealing with challenging behaviour; we don’t get paid through the night, going out after kids; the bosses tell us to send texts to their phones but they won’t see that message until they turn on their phone in the morning, but it means they are covered in case of possible litigation. There are big changes since I first joined, the work is much tougher now, it’s influenced by drugs/alcohol”*.

Practitioner 2 is a female aged 32 with nine years experience, she said *“challenges include dealing with challenging behaviour and she sees gaps in TCI training where it is not addressing restorative aspect. She took it upon herself to do a course where these gaps will be addressed. The course is in her own time and she is paying for it all herself”*.

Practitioner 3 is a female aged 34 with 9 years experience; she claimed that *“it was a big challenge trying to de-escalate young people who present with challenging behaviour.*

Another challenge was the paper trail involved when a young person stays out at night or absconds from the centre, significant event reports need to be done as well as phone and email contact with all the relevant parties”.

Practitioner 4 is a female aged 27 with five years experience, she said it was a challenge *“Trying to get young people to engage in the programme set out for them and said while TCI is no good, it does not equip you to deal with stuff that crops up on a daily basis in a centre”.*

Practitioner 5 is a female aged 38 with 10 years experience; she said *“Dealing with challenging behaviour and aggressive young people was her main challenge as well as dealing with children/young people absconding from the centre”.*

Manager1 a female aged 42 with 18 years experience she said *“with a lack of staff and resources, my biggest challenge is balancing the needs of young people, staff and paperwork; providing good quality supervision”.*

Practitioner 6 is a female aged 27 with four years experience, she said *“my challenge is why they put children in wrong placements; also the challenging behaviour of young people here in the centre”.*

Manager2 a female manager aged 32 with 11 years experience, she said *“a challenge is managing staff, managing the centre with little resources and relying on agency staff due to shortages; and giving good quality care to young people”.*

Manager3 is a male manager aged 45 with 23 years experience, he said *“it’s challenging giving staff the tools, when you don’t have them, so that all staff can work together towards the one goal; developing the services; getting key-working staff to do individual pieces of work which can be shared with all staff members where they can learn from each other”.*

Practitioner 7 is a female aged 28 with four years experience, she said *“it’s a challenge dealing with young people who self-harm and have anger management issues; we had no training in it apart from what we did in college”.*

Practitioner 8 is a female aged 46 with 17 years experience, she said *“the challenge is managing difficult behaviour and containing it while on your 25 hour shift; there is a lack of resources – proper placements for difficult children; absenteeism and/or absconding is another big challenge for us; getting a phone*

call in the middle of the freezing night and going out to get them; being able to deal with them when you collect them as well as the big challenge of all that paper trail afterwards and indeed in this job as a whole”.

Practitioner 9 is a female aged 39 with 13 years experience, she said *“a challenge is getting children in care to change how they see themselves, their only aim is to get the dole; drugs and alcohol is another challenge, they threaten violence, we don’t know what they have taken, and it’s scary”.*

Practitioner 10 is a female aged 26 with four years experience, she said *“the challenge is getting up at night between 12 midnight and 7am and having to be up the next day; dealing with young people, and that’s them all who are on drugs”.*

Practitioner 11 a female aged 50 with 12.5 years experience said *“ the challenge is balancing family life with working long hours; keeping up with legislation; the changing norms of young people in care, suicide, self-harm now and challenging behaviour”.*

Practitioner 12 is a female practitioner aged 33 with 12 years experience, she said *“It is challenging in residential child care having to deal with severe behaviours resulting from drug and alcohol abuse, head shops a contributing factor; shifts at 25 hours are too long, it’s difficult trying to manage family and work”.*

Practitioner 13 is a practitioner aged 62 with 15 years experience, she said *“it’s a challenge trying to meet the physical, psychological and emotional needs of some of the young people who are in care; in my 15 years here I think young people are too old when we get them to do anything with them”*

Practitioner 14 is a practitioner aged 34 with 10 years experience, she said *“The most challenging thing is the non-involvement of staff in making decisions: management don’t involve staff here and they should”.*

Practitioner 15 is a female practitioner aged 58 with 10 years experience, she said *“the biggest challenge is keeping young people safe at the centre; they are always absconding; also young people now are on drugs and have no value on life, they are very violent and would think nothing of kicking you or stabbing you”.*

In summary, nine interview participants: practitioner 1, practitioner 2, practitioner 3, practitioner 5, practitioner 6, practitioner 8, practitioner 9, practitioner 10 and practitioner 11 said the main challenge was dealing with challenging behaviour in young people. Practitioner 4 found it challenging getting young people to engage in the programme of care that is in place for them. Practitioner 7 found it

challenging dealing with young people who self harm as she got no training for this apart from what she learned in college. Practitioner 12 found it challenging when working in residential care and trying to deal with aggressive behaviours of Young people as a result of drug abuse.

Practitioner 13 said that after 15 years in the job she finds it challenging working with children that are too old when placed in care and said it would be better if they were placed when younger. Practitioner 14 said the management do not communicate their decisions with the staff in the residential child care centre. Practitioner 15 said her biggest challenge was keeping young people safe in the centre because they kept absconding. The three manager's found it challenging trying to balance the needs of young people and staff as well as managing their centres and coping with the vast amounts of paper work. Manager3 invoked Engeström's (2006) thinking when he mentioned "*it's challenging giving staff the tools so that all staff can work together towards the one goal*".

Sub-question two under core research question one asked:

1.1.2: Do you think you need ongoing training?

All eighteen participants answered yes this question.

Practitioner 1 said: "*yes, we need training to work in the community, it's now gone from just working the child; it's the whole family now. Really we are family support workers now but without the title except we don't get the pay that family support workers get. All the official family support workers have been removed off the panels in this HSE area, but why wouldn't they when we are doing the work for much less pay?*"

Practitioner 2 said: "*Yes, we need training but with maybe new ideas in TCI also any training needs to be specific to young people and the work here*".

Practitioner 3 said: "*yes because it keeps you up to date with changes*".

Practitioner 4 said: "*yes but it should relevant and should be tailored to residential care*".

Manager1 said: "*Relevant training is needed for management, not the stuff for the staff*".

Practitioner 5 said: "*yes we need it; the TCI refresher can be good*"

Manager2 said: "*yes, but I need management training in how to manage staff – supervision, post crisis response and resources. I go to the same TCI as staff here,*

if they are not happy with me, they won't discuss it there, a different forum is needed for them to say how they feel about me”. Manager3 like practitioner 1 said: *“yes ongoing training is needed because of developing outreach – working in the community with families, preventing children coming into care and respite services as well as many changes in relation to residential Care”*.

Practitioner 6 said: *“yes there are so many things changing so we need to be informed, we need ongoing training for that reason”*.

Practitioner 7 said: *“Yes ongoing training would be good. I'd like to get First Aid training but the only training that I've had in four years is a refresher in TCI”*.

Practitioner 8 said: *“training is ok but it doesn't make the job easier, you still have to think here on your feet as the crisis unfolds, no training helps you with that; a lot of the time you're glad to be leaving at 1pm and nothing serious has happened, you go by what you did before in a situation, your experience”*.

Practitioner 9 said: *“ yeah but not rubbish training, TCI is grand but people are bored with it; shifts are too long, people are too tired then to attend training after shifts as we have to; then there is the TCI exams which makes us look silly in comparison to other professionals, yet we work at the frontline”*.

Practitioner 10 said: *“yes, but the only ongoing training we have had in 2 years is the refresher TCI, we've had nothing else”*.

Practitioner 11 said *“yes, it's needed because the more knowledge you have on legislation for dealing with courts and the JLO the better you can challenge respectfully; guards and social care workers should do training together”*.

Practitioner 12 said: *“yes as it keeps you on top of any new therapies although the only one we are told about is TCI”*

Practitioner 13 asserted that: *“after 15 years experience, no training has really prepared me for the traumatic work with young people, but at present all the talk here is about computers and I don't know a thing about them. There was none of them in my time but I hear at all the team meetings how this and that have to be on the computer. I haven't a clue how to turn one on so I'd need training in that, that's if it would be possible to train me. Ah it would of course. Well I hope so because it seems to be an area that is constantly changing and developing.*

Practitioner 14 claimed: *“yes and what's offered is good”*

Practitioner 15 said: *“yes, but there should be new types of training to keep up with all the changes in residential care”*.

In summary, there were varied replies to this question. Practitioner 1 said practitioners need training now because they are effectively family support workers who are not paid at that rate; however, they do work with families as well as the child in care. Practitioner 2 and SC4 said they need training but it needs to be relevant and specific to working with young people who are in residential care. Manager’s 1 and 2 said they need training in management because as it is the only training they are getting is the same as the practitioner’s. Manager3 said he needs training in how to do outreach work in the community. Practitioner 3 and 6 said training was needed to keep them up to date on changes in legislation and to do with young people.

Practitioner 7 said she would like to have done First Aid training but in the last four years, the only training she has had is in TCI. Practitioner 8 said training is ok but it does not make the job easier, she is glad when its 1pm – time for her to go and if nothing serious has happened on her shift. Practitioner 9 said she needed training but not rubbish training, she said people are bored with TCI training whereby staff have to attend this after working long shift. It is not helped by having to do exams which she said *“other professionals at the frontline don’t have to do”*. Practitioner 10 said training was needed but the only training she had in the last two years was one refresher TCI training. Practitioner 11 said training is needed whereby staff learn about legislation which can help them to liaise with the JLO and the courts. Practitioners 12, 14 and 15 all agreed that ongoing training was essential to their professions. They said they need to be focused and kept up to date with new changes and developments.

Sub-question three under core question one asked:

1.1.3: What training do you get in your profession?

Practitioner1 said: *“TCI is the main one”*.

Practitioner 2 said: *“TCI and Fire Safety are the two mandatory ones, all others scaled back due to funds; we pay for any other training and are supported by the manager”*.

Practitioner 3 said: *“I got TCI, Anger management, and Fire training”*.

Practitioner 4 said: *“TCI is the most, then Fire training and others, like Children’s First but have not had any of them in ages”*.

Practitioner 5 said: *“TCI and Fire training are the main one we do”*.

Manager1 said *“the standard, TCI and Fire etc but I feel that quality and standards are questionable. The kind of training that we get is of very poor quality, it’s not good quality, very poor; relevance is sometimes questionable... say going to anger management training, that is not relevant to us. We are not going to be dealing with a member of the public who has an anger management issue, yet we are lumped in with the ones who it is relevant for; the same with manual handling, it’s mandatory...what manual handling would we be doing in our work?”*

Practitioner 6 said: *“TCI is the only training I’ve had in 4 years, I didn’t even have Fire training; there is other training on offer. There is training in Dublin, but I’d have to pay for it myself and take time off work. I can’t do that”*.

Manager2 said: *“TCI refresher and Fire training is the only training because of the budget”*.

Manager3 said: *“Corporate training and other general training that comes up, like TCI”*.

Practitioner 7 said: *“TCI refresher, ASIST suicide training and Parenting Plus training, which I got time off for but had to pay for the two days myself, it teaches parents how to manage teenagers”*.

Practitioner 8 said: *“TCI is the main one we get regularly, then other bits of one’s”*.

Practitioner 9 said: *“The only training I’ve had is TCI. Kids come in at 2am, full of drugs, I’m exhausted, they could kill us, we are constantly traumatised, what about our rights, all you ever hear about is Children’s rights. Management says there is no budget to look at such things for us; the abuse we have to put up with from kids at night on drugs is shocking, the big bosses get their text, they don’t put up with it.”*

Practitioner 10 said: *“TCI is all we get, every 6 months, that the only thing we have”*.

Practitioner 11 said: *“we get loads of if, I’m just finished strengthening families. We do children and parents separate but they should be brought together ; also risk management and assessment, we did that as well; Care Planning training,*

First Aid, Children First – we are very pro-active at training here. Our social care leader pushes for training and gets people to come in here to give us training. Also we did drug and alcohol training too.

Practitioner's 12, 13 and 14 said: *“TCI, computer training, Children First, and Fire training”*

Practitioner 15 gets *“Children First, First Aid and Fire training. I didn't do the TCI but hear them talk about it”*.

In summary, all 15 practitioners and the three managers mentioned that TCI and Fire training was the mandatory training given. However, for many practitioners the TCI refresher was the only training they had had. For example, practitioner 9 said that kids come in at 2am full of drink/drugs, staff don't know what they have consumed and don't know what to do with them as they have not had any specific training in this area. Practitioner 4 said that while she gets TCI and Fire training mostly, she also had Children's First training but did not have it in ages". Practitioner 7 said that as well as TCI, ASIST training and Fire training, she did and paid herself for Parenting Plus training and did it in her own time, like practitioner 2 above who said she is paying for a course about the restorative part of TCI herself. SP11 said she did parenting plus training and she also had TCI, Fire training and Children First like the others above. SP10 summed it up by saying *“TCI is all we get every six months, that's it”*.

The final sub-question under core research question one asks:

1.1.4: Are you asked to suggest training that you need?

Thirteen participants answered yes to this question.

Practitioner 1 said: *“Yes we are asked to suggest training but in these times we know we won't get it”*.

Practitioner 2 said: *“Yes but no funds so we get in professionals free to give talks – ASIST and safe talk training given free here in the house. National Youth Council, there is two day training, its 70 euro's, I go and come back and tell the others – here at a team meeting; Child and adolescent mental health services (CAMHS) service psychologist comes in here to give us a talk”*.

Practitioner 3 said: *“Yes, but I didn't suggest any”*.

Practitioner 4 said: *“Yes Report writing and RAISE training, I suggested but didn’t get it”*.

Practitioner 5 said: *“yes but it’s not provided because of budget restraints. I asked for key working skills training”*.

Manager1 said: *“yes, but I don’t suggest any as what I’d like is not offered here, I’d have to travel and I won’t do that”*.

Practitioner 6 said: *“yes, I asked to do disability training as I work with children with disabilities in Dublin as well as the work I do here in residential care but I didn’t get it”*.

Manager2 said: *“No, I’m not asked but it’s a wish list: First Aid, drugs/alcohol abuse, self harm training, working with families are all needed, we have no training and a skeletal staff team as well”*.

Manager3 said: *“we haven’t had training needs analysis for years, we’ve been looking at it but we can suggest lots but there is no funding for it; the local manager sends in a list and we also source our own training”*.

Practitioner 7 said: *“yeah, we could add to what was on the notice board being offered, I requested the psychologist who is going to come to our staff team meeting to talk to us about kids who self harm”*.

Practitioner 8 said: *“ongoing training in TCI is provided but there must be something else out there that could be incorporated into it; it would be great to have something different to it”*.

Practitioner 9 said: *“yes but they don’t listen, I suggested flats out in the garden to prepare young people for independent living when they are ready to leave here”*.

Practitioner 10 said: *“yes, I suggested the suicide ASIST training but have got nothing, we don’t even have any in-house training”*.

Practitioner 11 said: *“yes, we suggested children and mental health Services (CAMHS) to come in to talk to us because we had a child with X²⁵. The psychiatrist has been here twice to talk to the team”*.

Practitioner 12 said; *“yes, when we changed from being solely short term residential care to doing respite, we were asked to suggest training however any training in the line of working with families that we suggested, we did not get”*

Practitioner 13 said: *“Yes, the HSE asks what training you’d want, I suggested computers as I know nothing about them but I got no training”*.

Practitioner 14 said: *“Yes, we are asked, I think we need to be trained in the day to day issues, drugs/alcohol etc. Fire training and all that is ok but it’s the work with the young people that we need the training in. Last year we started doing respite for the first time and asked for training but got none”*.

Practitioner 15 said: *“Yes, at some stage we were asked and I suggest drug/alcohol training, we got it a few weeks after that, I don’t know if it was already in the pipe line”*.

In summary, only practitioner 7 and practitioner 11 who both work in the same centre on the same team were given the training that they suggest. This training was given free during team meetings at the centre. Practitioner 7 said they have a

notice board showing upcoming training and/or they can suggest new ones themselves. She suggested getting in a psychologist from the local hospital to come into one of their team meetings. She did this because she was key-working a child who was self-harming and wanted to know how to address the situation.

Similarly practitioner 11 was key-working a child with a disorder and she suggested getting the psychiatrist from the local hospital to come into the team meeting to explain how to deal with this situation; he has come twice since.

25. To preserve this child's anonymity the particular disorder will not be disclosed

Practitioners 12, 13, 14 and 15 said they were asked but any training they suggested was not given except practitioner 15 asked for drugs/alcohol training and it was provided but she said it may already have been in the pipe line.

Practitioner 3 and manager1 said they were asked but neither of them suggested any training as they knew they would not get what they'd like. One manager, manager2 said she is not asked but she still writes a 'wish list' which she submits to her manager asking for training for her and her staff. Practitioner 2 works in the same centre as practitioner 7 and practitioner 11, she and they got the ASIST training which was given to them for free in their centre, whereas the other two centres have applied for but have not got the ASIST training. While they recognise that there are no funds, they have sourced free training from professionals

The fifth sub-question was asked from core research question two:

1.1.5: Do you or your team engage in reflective practice of your work?

Practitioner 1 said: *"I don't do it myself but reflective practice is done at team meeting and amongst each other"*

Practitioner 2 said: *"Yes I do it personally, but it's not common practice; it's a new phenomena"*.

Practitioner 3 said: *“YES, at handover and supervision, it’s helpful but no need for us to be over analysing things either”*

Practitioner 4 said: *“Yes it’s done in supervision and at hand over, I don’t engage personally in it”*.

Practitioner 5 said: *“No, and I need to because I don’t get supervision”*

Manager1 said: *“Yes I do reflective practice both for me and for the staff; I think we learn from our mistakes”*.

Practitioner 6 said: *“I do it every day as part of the team; I think it’s better to integrate it as a team, than on my own”*.

Manager2 said: *“It’s done a bit at staff team meeting only; it’s not done enough though”*.

Manager3 said: *“We’re looking at it; it’s part of the post crisis response stuff; we don’t do it enough, we should be doing it more, we are supposed to be reflective practitioners but we don’t do enough, we do it at team meetings but should do more at handover’s”*.

Practitioner 7 said: *“At supervision and during team meetings we reflect on our practice, but not me personally”*.

Practitioner 8 said: *“We do it on an ongoing informal basis; when you do your shift it takes ages for it to leave your system; I think reflective practice is better done as part of a team”*.

Practitioner 9 said: *“Yes the staff here bounce things off each other but I get mad at trainings when you hear other people saying do this and try such, I just know the kind of kids we have and what they are saying would not work with these kids, that’s why training needs to be specific to residential care”*.

Practitioner 10 said: *“Yes at team meetings and at handovers but it’s all very informal as we all talk to each other and know from time to time what’s going on”*.

Practitioner 11 said: *“Yes, it comes out naturally but we are trying to do more of it as a team at team meetings. We do evidence based practice – looking at the process, the beginning, the middle and the end”*.

Practitioner 12 said: *“No, not since I came from Dublin to this job, I did a bit in Dublin but there was no time for it”*.

Practitioner 13 said: *“Only at supervision, I’d be going over what I did with the supervisor”*

Practitioner 14 said: *“We do it at team meetings and at handovers; I do it an odd time myself”*

Practitioner 15 said: *“At weekly team meetings, at hand-over’s, sure every day we are reflecting here on what we do all the time”*

In summary, nine participants, seven practitioners and two managers said they do reflective practice as part of a team: Practitioner 1; practitioner 6; practitioner 7; practitioner 8; practitioner 9; practitioner 10; practitioner 11 and manager2 and manager3. Personal reflection was done by practitioner 2 and manager1, only. All the others said the reflection is always informal and done as part of handover’s, team meetings and at supervision. Manager3 said while he does it as part of a team, they don’t do it enough and they are now looking at it as part of the “post crisis response stuff”. Practitioner 5 said she does not do it but would need to as she does not get any supervision. Practitioner 12 said she does not have any time to do it. Practitioner 13, 14 and 15 said they do it at weekly team meetings and when they have supervision.

Sub-question two under core research question one asked:

1.1.6: Is your training competency based?

Practitioner 1 said: “No, not competency based”.

Practitioner 2 said: *“No, its skilled based, we are lacking in that and a code of practice like UK, etc”*.

Practitioner 3 said: “No”.

Practitioner 4 said: “No”.

Practitioner 5 said: “No”.

Manager1 said: “No”.

Practitioner 6 said: “No”.

Manager2 said: “No, our training is more practical based”.

Manager3 said: “No”.

Practitioner 7 said: “No”.

Practitioner 8 said: “No”.

Practitioner 9 said: “I think it is but I’m not sure”.

Practitioner 10 said: “No”.

Practitioner 11 said *“ No, not here but I do it through another course that I’m doing; I had 3 months to work through a portfolio; competencies are good, we should have a code of practice as well”*.

Practitioner 12 said: “no”

Practitioner 13 said: “no”

Practitioner 14 said: “No”

Practitioner 15 said: “No”

In summary, all 15 practitioners and three manager’s answered no to this question. Practitioner 2 said her training is more skilled based; manager2 said the training was more practical based”.

Sub-question three under core research question two asked:

1.1.7: Do you have professional supervision? How often?

Practitioner 1 said: “*Yes supervision is here if you need it*”.

Practitioner 2 said: “*Yes, every 6 wks I have it*”.

Practitioner 3 said: “*Yes, I get it about every 6 weeks*”.

Practitioner 4 said: “*Yes, I think about every 6 weeks I have it*”.

Practitioner 5 said: “*It’s provided here internally for some people every 6 /8 weeks; I don’t have professional supervision and would prefer external supervision*”.

Manager1 said: “*Yes, I have it monthly*”.

Practitioner 6 said: “*I have it about every two months*”.

Manager2 said: “*Yes, I have it monthly*”.

Manager3 said: “*I have it once a month*”.

Practitioner 7 said: “*It’s once every 6 wks at the moment*”.

Practitioner 8 said: “*Every 6-8 weeks I have it*”.

Practitioner 9 said: “*I have it every 4-6 weeks*”.

Practitioner 10 said: “*I’ve it monthly*”.

Practitioner 11 said: “*I’ve it every 6 months*”.

Practitioner 12 said: “*In my other job in Dublin, I had it every 6 weeks, I fell pregnant straight away in this job so haven’t had it yet*”

Practitioner 13 said: “*I have it ever 6-8 weeks*”.

Practitioner 14 said: “*We have it 12-18 weeks, should be done more but other things overtake it*”.

Practitioner 15 said: “*I have it every 10-12 weeks depending on how busy it is*”.

In summary fourteen practitioners said they have supervision, only one, practitioner 5, said she does not have supervision even though it is provided in the centre where she works. She said she *“would prefer to have external supervision”*. Practitioners said they have supervision between six and 12 weeks with practitioner 14 saying it should be done more regularly but other things take over. The three manager’s have supervision every month, while most Practitioners have supervision every 6-8 weeks.

Sub-question four under core research question two asked:

1.1.8: How would you rate your supervision?

Practitioner 1 said: *“I find supervision good, good too for reflective practice but still it would be better if it was coming from outside the unit”*.

Practitioner 2 said: *“It’s quite good, for the reflective piece”*.

Practitioner 3 said: *“It’s productive but there should be an outside supervisor, so as not to be overloading my team leader here with stuff”*.

Practitioner 4 said: *“Its good but an external supervisor would be better”*.

Practitioner 5 said: *“There is no time for reflection and it’s not a good idea that my colleague who works with me supervises me”*.

Manager1 said: *“Its demanding, a lot of pressure; it’s adequate re case management but not for reflective practice; it’s not supportive if I have a problem. Also I should not have to take my own notes. External supervision should be built in, it’s not, I’ve asked but management won’t get it for me”*.

Practitioner 6 said: *“I only had one supervision session which I found useful”*.

Manager2 said: *“It’s practical, the manager is supportive but there is no time for reflective practice. Time is taken up with from one to the next crisis in residential care. The manager I have also has to look after X²⁶ other centres as well. External supervision would be good”*.

Manager3 said: *“Yeah, we discuss things, what happened since the last meeting. It’s not reflective practice as such; as soon as some issue arises I contact the manager to get advice immediately anyway”*.

Practitioner 7 said: *“It’s ok, I talk about issues that come up, about my outreach work”*.

Practitioner 8 said *“I don’t find it helpful at all, it should be with someone different, sure we are talking about the same thing every day to my supervisor so what would be different in supervision?”*

Practitioner 9 said: *“Its grand but the HSE should have a policy of moving staff about from job to job for 6 weeks, that would keep people motivated and update their skills; staff in residential care have no chance of promotion”*

Practitioner 10 said: *“It’s good for if there was an incident; we had an incident last year, I had to go to Occupational Therapy, we had to do restraint, the one and only time I did it, it was for the safety of the child but it took me ages to get over it”.*

Practitioner 11 said: *“It’s grand; the key thing is to prepare for it”.*

Practitioner 12 said: *“No complaints about it then when I had it”*

Practitioner 13 said: *“Good, it gives me a chance to develop and ask questions”*

Practitioner 14 said: *“It’s only ok because it’s done by staff within the centre, it should be done by external staff”.*

26. To preserve the anonymity of the manager, the number of Centres will not be disclosed

Practitioner 15 said: *“It’s ok when I have it”*

In summary, the participants were not enthusiastic about their professional supervision. Two said it was good: Practitioner 1, practitioner 2 said it was good, practitioner 11 said it was grand but you needed to prepare for it. Practitioner 1, practitioner 3, practitioner 4, practitioner 5, practitioner 8 as well as manager1 and manager2 said there should be an external examiner doing the supervision.

Practitioner 5 said there is no time for reflection and it’s not a good idea that my colleague supervises me. Manager1 said she has to take the notes, she also said there is no time for reflection. Similarly, manager2 said the supervision time is taken up by going over the crises that happened in residential care with no time for reflection. This was also echoed by manager3.

Sub-question one under core research question three asked:

1.1.9: What elements of training do you think are important?

Practitioner 1 said, *“TCI theory but not the physical restraint part also drugs/alcohol training is important. We need communication training in self-harm and there is no support/backing for staff/security at night in this demanding and challenging job”*.

Practitioner 2 said: *“Behaviour management and building relationships which is not done here is important. Communication training is needed – non verbal – when the child first meets you. Behaviour management training is done here under TCI but it would be nice to have something different than TCI”*.

Practitioner 3 said: *“Ground work training is needed, dealing with self harm and communication training in how to deal with conflict is also needed”*.

Practitioner 4 said: *“The opportunity to meet other professionals would be important; we only meet others at TCI”*.

Practitioner 5 said: *“Skills based training is needed for help young people through difficult times; good effective communication training is needed to build relationships with young people; also training to work with families of young people is needed”*.

Manager1 said: *“What would be important would be that space be provided for the team to be away from the centre so they can reflect on their work. Also we should be meeting people from other centres; I feel alone and isolated here, being the only manager in this area; communication too is an important element for all social care professionals”*.

Practitioner 6 said: *“All elements are needed especially communication, I think”*.

Manager2 said: *“TCI theory is ok as it’s what we need to know about building relationships with young people, but we need ongoing training and different training to TCI, which could show us how to communicate better with the young people”*.

Manager3 said: *“Keeping people up to date as things happen and change and training in appropriate interventions for young people; having a variety of tools in the box to help young people”*.

Practitioner 7 said: *“Along with TCI we need other training like communication around managing challenging behaviour for young people and self harm stuff, training, a form of communicating geared to helping the young people”*.

Practitioner 8 said: *“It is important to be going over anger management, managing difficult behaviour. Also we should be going back over Children first and the standards and regulations, but we don’t, they are in the files in the office but we don’t take them out”*.

Practitioner 9 said: *“We have no training only TCI; young ones who are a danger to themselves should be locked up, it’s for their own safety. There can be many staff looking after say, a particular child in Residential care, yet she can abscond, she is free to go, the system is not working, it only takes a few minutes to lock a kid up for her own and for the safety of the staff”*.

Practitioner 10 said: *“Everyone in residential child care should be doing training on a continuous basis but we are not doing it”*.

Practitioner 11 said: *“Health and safety, care planning and being aware of legislation would be the most important for me”*.

Practitioner 12 said: *“TCI techniques are good but not the restraint part of it, I’d never use it”*.

Practitioner 13 said: *“Psychology training would be good but we never get it, then First Aid is good so you know what to do if there is an accident, proper communication would be good too, but we don’t get it and they say TCI is good but I didn’t do it”*.

Practitioner 14 said: *“Training that deals with day to day issues; TCI is a measure but something: communication, needs to be added to it to make it more effective”*.

Practitioner 15 said: *“I could not answer that question as nothing comes to mind”*.

In summary, there were varied replies to this question; however communication skills training came out clearly. Three participants: Practitioner 1; practitioner 3 and practitioner 7 said it would be important that they got communication training in how to deal with children who were self-harming; they said they had asked but had not been given this training. Practitioner 1, practitioner 7 and manager2 all said that while TCI was ok, other training was needed to build relationship and address behavioural difficulties of young people. Manager1 said, *“What would be important would be that space be provided for the team to be away from the centre so they can reflect on their work. Also we should be meeting people from other centres; I feel alone and isolated here, being the only manager in this area; communication too is an important element for all social care professionals”*.

Practitioner 9 claimed that she has no training at all only TCI which does not equip them to deal with the challenging problems that are presented in the centre. She suggested that young children who are a danger to themselves and to staff should be locked up for everyone's safety. Practitioner 2 said, *Communication training is needed – non verbal – when the child first meets you*. Practitioner 12 said she would not use the restraint part of it, only the techniques. Practitioner 14 said something new needed to be added to it to make it more effective. PL9 could not recall any important element of her training.

Sub-question two under core research question three asked:

1.1.10: Is your training beneficial and effective to your profession?

Practitioner 1 said: *“Some is effective and beneficial but something other than TCI is needed, like I think the guards have pressure point training”*.

Practitioner 2 said: *“ For me it's ok, but we need to branch out more- some of the girls went off and did Parenting Plus, you need to update your skills by yourself anymore, no funding for training but better if all staff have the same training”*.

Practitioner 3 said: *“It's ok but it should be more specific to working in residential child care”*.

Practitioner 4 said: *“At times it's like its keeping the trainers in a job, that's because it's not at all relevant”*.

Practitioner 5 said: *“TCI is basic, we need more relevant and effective training ; something other than TCI is needed, maybe counselling, we are brining ourselves to this job and need to know how to communicate our thoughts and feelings”*.

Manager1 said: *“It's not effective, wasting time taking 2-3 days doing TCI, it could all be done in one day”*.

Practitioner 6 said: *“The behaviour part of TCI is but restraint is a last resort”*.

Manager2 said: *“It's very underfunded; we've had no training in two years, none at all”*.

Manager3 said: *“Yes, the team have been very resourceful in sourcing beneficial and effective training; resourcing ideas that will help them by getting information on them”*.

Practitioner 7 said: *“Some of it is, TCI theory but not the restraint, it’s not for use in mainstream residential child care. There is a lot of time taken up with it and it’s not used, there should be something like it without the physical side to it”*.

Practitioner 8 said: *“Some is beneficial, more is a waste of time but what can you say when you are told that you have to go it”*.

Practitioner 9 said: *“TCI is ok but boring, I think they invented it when there was no drugs or alcohol; all the young people think everyone is on drugs, it’s going to get worse”*.

Practitioner 10 said: *“It’s not effective or beneficial at the moment as we are not getting any; we have X²⁷ children here who are self harming and have suicide tendencies, and are taking drugs, yet we have no training whatsoever in how to deal with any of these things”*.

Practitioner 11 said: *“No it is not beneficial or effective: training should be a priority, if there was more training there would be less crisis”*.

Practitioner 12 said: *“Yes, I can only speak of Dublin when I was there. I was introduced to Marta Mao, a communication/video type of training which was good”*.

Practitioner 13 said: *“Yes it’s better than when I started 15 years ago there was no training at all for years”*.

Practitioner 14 said: *“some is ok like TCI and Fire training but what do we need to know about say domestic violence or others that we have been at in the past are not at all relevant”*.

Practitioner 15 said: *“Only sometimes. I don’t believe in TCI, we never use the restraint part of it here. The restraint is no good. How could we possibly be thinking of restraining the big fellas that we are caring for? Also by restraining young people I believe that you break your relationship with them”*.

In summary, practitioner 1 said some training was effective and beneficial but other training than TCI was needed. Practitioner 5 said TCI was basic and something like counselling was needed in this demanding job. Manager1 said it

was a waste of resources having some training taking three days to do when it could all be done in one day.

Practitioner 6 said TCI theory was effective and beneficial but the restraint was a last resort. Practitioner 7 echoed this by saying TCI was not at all suitable for mainstream residential child care.

27. Numbers of children /young people will not be disclosed to protect the anonymity of the centre and the practitioner

Practitioner 9 said TCI was ok but she thinks it was invented before young people started taking drugs/alcohol. Manager2 said her or her team has had no training at all in the last two years due to budget cuts.

Manager3 said he and his team have been resourceful sourcing their own ‘free’ training. Practitioner 10 said no its not effective of beneficial because at present they are getting no training despite having asked for it as they have X number of children who are both self-harming as well as abusing drugs. Practitioner 4 said it’s not effective or beneficial because the training is not relevant, she claimed “*at times it feels like its keeping the trainers in a job*”.

Practitioner 11 said it was neither beneficial nor effective and said if training was a priority it could help to eliminate a lot of crisis at work. Practitioner 12 said she did no new training in her present post but was introduced to Metre Mao when she worked in Dublin before re-locating to this centre. Practitioner 13 said the training is better now as it was non-existent when she started 15 years ago. Practitioner 14 said some of it is ok like Fire training and TCI but questioned the likes of Domestic Violence training that she has been sent to as regards its relevance to her work in as a practitioner in a centre. Practitioner 15 said it’s only beneficial and effective sometimes as she does not believe in TCI and she questioned the point of doing the restraint training when it is not practiced in the centre where she works.

The third sub-question under core research question three asked:

1. 1.11: Do you think there are adequate resources provided for training?

Practitioner 1 said: *“It’s as adequate as can be with budget; training is provided outside the centre but you need to fund it yourself and it needs to be relevant”*.

Practitioner 2 said: *“No, our training officer wasn’t replaced – he used to send out brochures detailing training, that’s all gone now and we source our own training. For example the Strengthening Families training is free but we have to pay back the course by giving training free to other groups once we are trained. Also the management are only interested in training that has an emphasis on young people.”*

Practitioner 3 said: *“No it’s not adequate because we are not getting relevant training; all we have is TCI which is boring”*.

Practitioner 4 said: *“No, there is too much time and money put into TCI and we don’t use the restraint”*.

Practitioner 5 said: *“No resources could be spent more effectively on training specific to residential care; we have no support, no appreciation of our work; our only support is Occupational therapy; we need proper supervision and reflective practice; we support each other as a team but that’s it”*.

Manager1 said: *“I don’t know about budgets but the quality of training is very poor and the training is not relevant; we should be trained in therapeutic care.”*

Practitioner 6 said: *“No, training is very limited for fulltime staff. Funds are also affecting say; I know it’s hard to get psychologists in to assess children”*.

Manager2 said: *“There are no resources, we even tried locally to get services to come in for a team meeting session but they are constrained and couldn’t do it. All the staff need refreshers by now but have had none”*.

Manager3 said: *“No, we could do with more team based training; here we have strength based assessment through TCI”*.

Practitioner 7 said: *“No, not in the recession, we are doing our best by getting people to come in here to talk to us, for free”*.

Practitioner 8 said: *“No, not in today’s climate; I know there are things in Dublin and the like but I couldn’t be taking time off or going to them”*.

Practitioner 9 said: *“No, the HSE don’t listen to their staff, they provide the training before they ask the staff; we need a member of staff to take on what training is needed, it has to be what is needed here, not what HSE propose”*.

Practitioner 10 said: *“No, we don’t even get in-house training, the only mandatory training is TCI; it’s nice to go out to it and meet people from other centres, it’s the only chance we have to meet them; you don’t even get to meet all the staff here, with how shifts are arranged; it would be good say once a week if all members of the team involved in the programme of care met up, even just for an hour; even a team meeting to explain family support. We work a lot with families now but have had no training; we should be networking; we are supposed to be part of a multi-disciplinary team. In high profile cases on TV you hear about social workers and their burn out but you never hear of social care staff and their burn out. Social care staff have no support, no backing from unions or anyone”*.

Practitioner 11 said: *“No, a lot of the time it’s about using resources better. It should not be an issue because it’s mainly a safety factor as well. All the training we get is the mandatory TCI; everything else that we had was sourced by ourselves here in the centre, from the services where possible”*.

Practitioner 12 said: *“No, not with recent budgetary constraints and the state of the healthcare in general in Ireland”*.

Practitioner 13 said: *“No, there are no resources now and the way the country is going”*.

Practitioner 14 said: *“If the training is pertinent to our area of work we usually get to go to it.”*

Practitioner 15 said: *“No, there is not. The HSE is under stress, there is no money, and they have no money for any training. I believe a lot of money goes into TCI and that’s it”*.

In summary, it is clear from the replies to this question that there is no training provided to Practitioner staff apart from the mandatory TCI refresher although manager2 said *“all the staff need refreshers but have not had any”*. Practitioner 1 said the training is as adequate as can be within budget constraints. Practitioner 2 said it’s not adequate, she mentioned they had a training officer who has not been replaced; while they did the Strengthening Families training which was free, now they pay back by training other groups for free. Practitioner 3 said it’s not adequate as the only training they get is TCI which she said *“was boring”*.

Practitioner 4 also said it's not adequate and because too much time and money is spent TCI but the restraint part is not being used. Practitioner 5 said resources could be spent better mentioning that Practitioners do not have any support only Occupational Therapy, there is no appreciation of their work, they don't have proper supervision or time for reflective practice. The only support they have is each other as a team. Manager1 said while she does not know about budgets but the quality of the training provided is of poor quality. Manager3 said we could do with more team based training.

Practitioner 6 said training is very limited. Practitioner 7 said resources are not adequate and she commented on how they are doing their best to get professionals to come in to talk to them for free. Practitioner 8 said resources are not adequate and said there may be training if she was prepared to travel, say to Dublin for it. Practitioner 10 said no, we don't even have in-house training. She also said they don't get to meet all the staff on their team and they never net-work with teams from other centres despite as she said, *"it's supposed to be a multi-disciplinary service"*. And while on TV they constantly talk about social work burn out, they never mention practitioner burnout. Practitioner 11 said no there are no resources with TCI being the only mandatory refresher and after that they try to source their own in-house training. Practitioner's 12, 13, and 15 said there was no money now in the HSE for training or resources. Practitioner 9 summed it up by drawing attention to the need for Engeström's activity theory by saying *"No, it is not adequate, the HSE don't listen to their staff, they provide the training before they ask the staff; we need a member of staff to take on what training is needed, it has to be what is needed here, not what HSE propose"*.

The final sub-question on core research question three asks:

1.1.2: What if any changes would you like to see in your training?

Practitioner 1 said: *"I want to see the change where practitioners like doctors and all other professionals are paid while on call"*.

Practitioner 2 said: *"I'd like to see thinking outside the box, staff being encouraged and supported to do training. I've been battling for years to get management to get another model other than or as well as TCI but no, it's still"*

only TCI. Also we are not supported to do research, I keep an eye on Scotland, myself; HIQUA are more about improving approaches without training; training is a personal and not a service goal but if we source it, the manager is very supportive of getting it for us”.

Practitioner 3 said: “We need relevant training along with TCI so that we could pass on skills to the young people”.

Practitioner 4 said: “There should be no exams in TCI and training should not be done during the summer months; also relevant training to deal with challenging behaviour should be provided”.

Practitioner 5 said: “Our training is not relevant, it’s for nurses and the likes and we are put in with them. Burnout is high in this job, we have children for 24/7; changes should include our need to be motivated; we need some kind of counselling training or something where we could off load stuff”.

Manager1 said: “TCI restraint is not practiced; managers should not have to travel to other city centre’s like Dublin for management training. There should be time for the team to train together with cover provided; there should be no exams at training; training should not be on during the summer; training is needed to address trauma in children and self awareness training for staff”.

Practitioner 6 said: “Training should be more available and you should be paid to do it, not having to take time out and pay for it yourself; training should be on First Aid, self harm and alcohol/drugs awareness training, what is needed here”.

Manager2 said: “There should be a budget for training, up until 2 years ago we were fine, a lot of money spent in getting everyone to have the BA in social care degree but since then nothing; we need to have relevant training, not taking days at court room skills and legislation which is for social workers and not practitioners”.

Manager3 said: “Changes I’d like would be more team based training, great merits in everyone learning the same thing at the same time; I’d like all the team to be learning lots of skills so they could have them for helping the young people;

the positive of not having no training days out or no funds is that the team themselves have had to become more resourceful and get different people to come in here to give talks”.

Practitioner 7 said: *“We need another package of training – keep the TCI therapeutic part but get rid of the physical restraint”.*

Practitioner 8 said: *“We need very specific training for managing difficult behaviour, what we get is too general”.*

Practitioner 9 said: *“ TCI needs to be revamped and the whole team released for a whole day to do the training together; training given to residential child care needs to be devised by staff who work in residential care, TCI is so boring”*

Practitioner 10 said: *“There should be more training other than TCI – basic stuff like Fire training or how to deal properly with kids who are self harming. Kids coming into care have changed, it’s all abusive stuff now resulting from abuse of alcohol and drugs, we are not prepared for how to deal with this; our work is changing from simple life story work to kids who go out at night and don’t return for days on end, we have no means of locking them up, all we have is basic TCI stuff that we do here every day but when you go to TCI they have buzz words to describe what we do”.*

Practitioner 11 said: *“no changes but there should be always be potential to develop people and for the team to develop”.*

Practitioner 12 said: *“There should be consistent training for all staff so that everyone is trained at the same time in whatever it is, this means everyone knows what to do exactly in a situation instead of conflicting views”.*

Practitioner 13 said: *“There should be more opportunities to link families to the child in care; we should be working holistically with the whole family, not just the child”.*

Practitioner 14 said: *“I’d like to see training that is more practical and issues based and relevant to us in residential care”.*

Practitioner 15 said: *“Yes, the changes that I’d like to see is that the training should not be given to us by people who have never worked in this job. They haven’t a clue how it is or how it works. When we leave that training and come here, we still have to deal the frustrating situations that we still need help with but are not getting from them. It’s useless. I suggest that if one of them trainers or some trainer were to come in here and be here when the trouble arises with the young person and let them observe it”*. She continued:

“Then they could be in a position to say look: I think you should try this instead of that, say a psychotherapist. As it is they are there putting stuff up that’s of no relevance to us. When you ask them a question, they don’t have the answer. As workers we may not be aware of what we are doing wrong, of how we are acting, if it’s the proper thing to be doing or saying in different situations. Also I’m in this job as I said for 10 years and I find that in this job you get so jaded and burnt out by all that you see and hear. You will know by now that a doctor gets paid for on call. We are on call in this job all the time. Many nights are spent in the barracks or up in the hospital emergency department but we don’t get the on call pay like the doctors or others who do it. We are in here for 50 hours on our two shifts but we only get paid for 36, isn’t that some disgrace? We have absolutely no support. Social care workers don’t fight, they are all bet down. It’s a job you can only do for a short time. I think I’m at the end of mine”.

In summary, practitioner 1 said the changes she want is that practitioners like other professionals should be paid at night while on call. Practitioner 2 said she has been battling for year but has not been listened to whereby she wants to change the TCI model. She says research is not encouraged by management and HIQUA is all about approving approaches without training. Practitioner 3 wants other relevant training as well as TCI which would enable her to pass on skills to young people. Practitioner 4 called for no exams in TCI, no training during the summer months and more training to deal with challenging behaviour. Practitioner 5 said the training for practitioners is not relevant, is more for nurses; staff need motivational training owing to being in the company of young people on a 24/7 basis on shift.

Practitioner 6 said relevant training in drugs/alcohol/self-harm was needed. Practitioner 7 said the therapeutic part of TCI could be kept but another package was needed to compliment it. Practitioner 8 said all that was given was too

general and relevant training is needed for working in residential child care. Practitioner 9 said TCI needs to be revamped and the whole team need to train together and training given should be devised by staff who have worked in residential child care. Practitioner 10 said more training other than TCI was needed to deal with the children coming into care now who have changed due to abuse of alcohol/drugs.

Practitioner 12 called for a more consistent training of staff in RCC so that there would not be conflicting views on how to manage situations. Practitioner 13 said Practitioner training should involve an holistic approach whereby the family of the child is also involved in the training, not just the child. Practitioner 14 would like practical relevant training focused on working in residential child care. Practitioner 15 said that training for RCC should be given by people who have trained and worked in the area. She said practitioner 's are effectively on call, they work 50 hours over two shifts but are only paid for 36, they are not paid for during the night despite spending many nights up, some either in the Garda station or in the A&E Department.

Manager1 also said TCI restraint is not practiced, there should be no exams and training should not be held during the summer. Also she said she should not have to travel to larger cities i.e. Dublin for her management training. Manager2 said there should be relevant training other than taking days out here and there for say court room skills and legislation which is for social workers and not practitioner 's. Manager3 said changes should include team based training and commented that it is best if the whole team trains together.

FINDINGS SUMMARY

The main challenges reported was the need to address challenging aggressive behaviour of children/young people and the need to address the lack of staff, of resources and relevant CPD training, which appeared to be causing stress for these professionals. Other challenges included need for proper communication skills training to work with vulnerable complex children/young people, due to the nature of the client group changing. Staff claimed they are not asked for their views or listened to by senior management, their voice is not being heard;

Accountability/the paper trail is posing challenges for staff. They all said they needed ongoing CPD training however all that was offered, although not that regularly was mandatory training; they need to have a competency framework. While most professionals were asked to suggest training, none of them got what they had requested unless management had already intended to put on what they happened to request. While some practitioners and managers were aware of and said they tried to engage in reflective practice, they also found many faults with it. All professionals had structured, set professional supervision, however, many did not approve of it, citing it should not be done by colleagues and some called for external supervision. Most participants said their training was only partially beneficial and effective, albeit the little amount which was offered. After mandatory training, communication training was cited as being the most important element of CPD training. Participants wanted consistent, relevant CPD training that is planned in collaboration with their management.

PEER REVIEWED PUBLICATIONS

Year	Title	Author
2012	<p>‘A Care Practitioner’s perspective on the need for reflective practice in the work of Prison Officers, Social Care Practitioners and Gardaí in the Republic of Ireland’, in <i>Reflective Practice Journal: International and Multidisciplinary Perspectives</i>, vol. 13. No.1. Pp. 39-53. Available online@</p> <p>http://www.tandfonline.com/doi/pdf/10.1080/14623943.2011.616886</p>	O’Hara, M
2011a	<p>Title: Reflective practice: a case for inclusion for frontline professionals in Ireland.</p> <p>Reference: <i>Irish Social Worker</i>, Spring 2011, pp.17-27.</p> <p>Format: article;</p> <p>Topics: child abuse; police; reflective practice; social care staff; social work; social work education; staff development; training; Ireland;</p> <p>http://www.scie-socialcareonline.org.uk/searchp.asp?query=author=%22O'HARA%20Maureen%22</p>	O’Hara, M.
2011	<p>‘Female police officers in Ireland: challenges experienced in balancing domestic care responsibilities with work commitments and their implications for career advancement’, in <i>Irish Journal of Public Policy</i>, vol. 3, Issue 2, November 2011</p> <p>http://publish.ucc.ie/ijpp/2011/02/OHara/03/en</p>	O’Hara, M
2011b	<p>‘Reflective Practice: A Case for Inclusion for Frontline Professionals in Ireland’, in <i>The Research West Review</i>, (RWR) Vol. 1. No. 2. Article 2. May 1st, 2011. Available online@</p> <p>http://greenlinkwest.webs.com/RWR%20M%20O%20HARA.pdf</p>	O’Hara, M.
2011	<p>‘Gender and development: voices of female police officers in Ireland On work challenges and commitments, domestic care responsibilities, and implications for career advancement’, in <i>Journal of Research Peace Gender Development</i>, 1(5): 173-180. Available online@</p> <p>http://interesjournals.org/JRPGD/pdf/2011/June/O%E2%80%99Hara.pdf</p>	O’Hara, M.
2010	<p>‘Comparing social care and custodial care’ in <i>Cúram</i>,</p>	O’Hara, M.

Year	Title	Author
	Summer 2010, vol. 42: 7-10. Available @ http://www.iascw.ie/PDF/proof4_Cúram%20issue%2042.pdf	
2010	‘Positive Highlights on Quality Daycare for Children: A North West of Ireland Study’, in <i>Child Care in Practice</i> , 16: (4): 359-375. Available @ http://dx.doi.org/10.1080/13575279.2010.498163	O’Hara, M.
2009	‘Exploring childcare: A north west of Ireland study’, in <i>Irish Journal of Applied Social Studies</i> , Vol. 10 (1): 49-65. Available @ http://arrow.dit.ie/ijass/	O’Hara, M.
2009	‘What is the significance of care work for prison officers? Comparing Social care and custodial care’, in <i>Journal of Social Criminology</i> , (JSC) vol. 1(1): 90-110. Available @ http://socialcriminology.webs.com/The%20JSC%201%202009%201.1.pdf	O’Hara, M.

Power point presentations

O’Hara, M. (2008) ‘Simplicity Parenting’ , Oral Power-point Presentation presented at La

Leche, League of Ireland Annual Conference, Saturday 8th March 2010: The West County Hotel, Ennis, Co. Clare.

<http://www.lalecheleagueireland.com/images/La%20Leche%20League%2008.pdf>

O’Hara, M. (2008) ‘What are the Positives and Negatives of Full Day Care?’ Poster

Presentation, presented at *presented at the Sociology Association Ireland (SAI) 35th Annual Conference*, 9-11th May 2008 at NUI Galway.