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Care and the Standards of Proficiency for Social Care Workers

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Abstract

This paper examines the *Standards of Proficiency for Social Care Workers* (Social Care Workers Registration Board (SCWRB), 2017b) in light of the scholarship of care. It does so by setting out some key strands of care scholarship and their significance for social care, followed by a critical assessment of care and its relational and emotional dimensions in the Standards of Proficiency (SoP) (SCWRB, 2017b). Given the centrality of care in the title Social Care Worker and the prevalence of the term in legislation and policy, the word is often ill-defined or not defined at all. Discussion of care within social care literature is remarkable by its absence. This is unfortunate for both service users and the emerging profession. This paper argues that placing care more centrally to social care can provide a key counterweight to the increasing processes of managerialisation ascendant in the social professions. An examination of care in the SoP with reference to two core dimensions - professional relationships and emotional labour - highlight some of the complexities and contradictions of care. The paper concludes that a technical rational understanding of care prevails within the SoP, while its relational and emotional dimensions of practice are underdeveloped or absent. It proposes that care scholarship provides a fertile opportunity to augment these threshold standards with a more critical and relationally informed understanding of care in teaching, practice and research.

Keywords: Care, care ethics, relationship-based practice, emotional labour.

Introduction

This paper examines the *Standards of Proficiency for Social Care Workers* (SCWRB, 2017b) in the light of scholarship of care. It does so by setting out some key strands of care scholarship and their significance for social care followed by a critical assessment of 'care' in the SoP. Given the centrality of care in the title 'Social Care Work' and the prevalence of the term in legislation and policy, the word is often ill-defined or not defined at all. This paper argues that attention to the complexity and paramount significance of care can provide a key counterweight to increasing managerialisation, so pervasive in the social professions. Banks (2004, p.35) identifies "the calling to care" as a key attribute of the contemporary social professions, while the sector has long called for recognition and respect for social care workers and which professionalisation contributes to (Byrne, 2016; Farrelly & O'Doherty, 2005; Williams & Lalor, 2001). For the purpose of registration, the Social Care Workers Registration Board (SCWRB) define social care as a relationship-based practice through which a planned and purposeful provision of care, protection, psychosocial support and advocacy is provided, in partnership with marginalised individuals and groups using a social justice and human rights frame (SCWRB, 2017b). The standards of proficiency (SoP) set down 80 proficiencies deemed essential in order to enter the register (SCWRB 2017a). The proficiencies are categorised within five domains (i) Professional Autonomy and Accountability; (ii) Communication,

Collaborative Practice and Teamworking; (iii) Safety and Quality; (iv)Professional Development and (v) Professional Knowledge and Skills.

The setting up of the Social Care Registration Board by CORU in 2015, the publication of the *Standards of Proficiency for Social Care Workers* (SCWRB, 2017b), the *Criteria for Education and Training Programmes* (SCWRB 2017a) and the *Code of Professional Conduct and Ethics for Social Care Workers* (SCWRB, 2019) exemplify key processes in professionalisation. Inspection of services is another dimension exemplified by the work of the Health, Information and Quality Authority (HIQA). Regimes of inspection and regulation play an increasing role in defining the parameters of care within the discipline, setting out how care is to be understood and practiced, highlighting some dimensions over others. As the structuring and professionalising of social care proceeds apace, this is an opportune time to examine the complexities and contradictions of care and how these are elaborated, or not, in the *Standards of Proficiency for Social Care Workers* (SoP).

The Current Context

Care is currently configured at the intersection of gender, race and class, resulting in significant inequalities for those who require care and support, for those providing it and in the relationship between both. Women are the majority of carers, both informally and in paid employment (National Women's Council of Ireland, 2020; Central Statistics Office, 2020a, Table 5.15). They comprise 79.9 percent of those working in human, health and social work activities (CSO, 2020a; Figure 5.18) and spend double the amount of time men do on caring, and more than twice as much time on housework. (Russell et al., 2019). Migrant workers undertaking care work with older people in private homes and in residential care settings experience multiple forms of discrimination based on immigration status and ethnicity (MRCI 2012, 2015; IHREC, 2018). Despite the innately complex and demanding nature of care, most care workers earn just over the minimum wage on zero hours' contracts (Pembroke, 2017), while the means-tested Carers Allowance is minimal (€219-€257 per week depending on age and means). Where professional qualifications are required (e.g. social care work), terms and conditions of employment vary greatly between those working in the shrinking public sector and those employed in an increasingly marketized sector (see www.impact.ie and www.glassdoor.ie). The weak to non-existent care infrastructure in Ireland means a significant penalty for those who care in the public and/or private sphere (CSO, 2020a; Russell et al., 2019). In 2019, the unemployment rate among women whose youngest child was between 4 and 5 years of age was 66.8 percent (CSO, 2020a Table 5.10). The affective inequalities evident during Covid-19 highlight underlying tensions regarding the central role of care in society and the unwillingness of the state to recognise the inevitable interdependency of all citizens or to strengthen institutional supports in the affective sphere. This neglect of the affective sphere of life is mirrored in the experiences of social care workers (Keogh & Byrne, 2016). How care is configured within the standards is therefore of enormous significance. While the gendering of care is a key issue for equality across a range of contexts in the private and public spheres, the regulatory framework provided by the SoP also provides a political space for articulating core dimensions of care as a professional practice, thus enhancing the visibility of care in the title of the emerging profession and challenging its invisibility in the political sphere. The extent to which this is achieved is the focus of the following discussion.

Feminist Care Scholarship

Care is one of those words that is widely used but rarely defined. As a result, care is both ambiguous and contested, with Daly and Lewis (2000, p.284) suggesting the word is used in such diverse ways that it is in danger of losing its core meaning. Moss and Brannen (2003, p. 4) remind us that the conceptualisation of care is a historical process: ideas about what care may mean in a given context (e.g. care of children) are subject to changing policies and practices, inscribed by the norms and cultures of particular groups, places and historical times. Policies and practices that excluded and segregated large sections of the Irish population in the guise of 'care' for much the twentieth century (O'Sullivan & O'Donnell, 2012; O'Sullivan, 2009), are familiar to all. Duffy (2005) suggests that one of the tasks of care scholarship is to move beyond common sense understandings of care to develop sound conceptual and theoretical frameworks. The remainder of the paper examines the relevance of selected strands of care scholarship for social care and provides a critical analysis of care within the Standards of Proficiency. Two dimensions of care are examined in greater depth - its relational and emotional components. The following section outlines feminist care scholarship as it is here that a significant tranche of theoretical and empirical research has been developed. The following themes are examined: care as labour and a disposition, circles of care, care as a set of social relations and care ethics.

Care as labour and a disposition

Since the 1970s, feminist scholarship has sought to make the work aspect of care visible, and to understand the processes and structures through which care is mainly undertaken by women (Finch & Grove, 1983; Graham, 1991; Harrington-Meyer, 2000; Moss & Brannen, 2003; Ungerson, 2000). This perspective sees care as a form of labour, tending to the needs of another, time consuming and in many cases physically demanding. It highlights issues of workload, financial reward and opportunity, physical stress, burnout and the costs of care (Himmelweit, 1999). For mental or physical work to be considered care, it must benefit and not harm the recipient. The link between competency and work is particularly crucial in the field of professional care, such as social care. Care is also understood as a feeling or emotion involving a disposition towards others, a concern for the well-being of others: a dependent child or parent who needs support, a lover, spouse, sibling or close friend. But care as a disposition is also expressed as a concern for the wellbeing of strangers and those, such as neighbours, who are generally less well known (Lynch, Baker & Lyons, 2009; Rummery & Fine, 2012). Empathy and the recognition that the condition of another is important and involves both an interest in their life and a degree of responsibility for their well-being is fundamental to what we consider to be care (Kittay, 1999; Lynch et al. 2009; Rummery & Fine, 2012; Slote, 2007). Indicating the way that much of the subsequent care theory developed, an important distinction was made by Finch and Groves (1983) between caring 'about' and caring 'for' someone. The former denotes the disposition towards the dependent, while the latter is concerned with the physical and mental work of caregiving (Rummery & Fine, 2012). There is overwhelming empirical evidence that care workers are motivated by the emotional aspects of their labour (O' Connor 2019). Service users also want to be cared 'for'/supported by someone who cares 'about' them (BASW, 2019; Buckley et al., 2008; Roeden et al., 2011). The extent to which the standards acknowledge and respond to the demands of such relationships and associated emotion management is addressed later.

Understanding care as a social relationship also enables us to distinguish between care relationship that are intimate, familial and enduring, and those that are occupational or professional, limited in time and focused primarily or exclusively on mental and physical well-

being (Rummery & Fine, 2012). Formal and paid care work typically requires recognised levels of training, education, and in many cases professional levels of knowledge. Even so, the emotional satisfaction gained from care work in both spheres is often used as a counterpoint to demands for adequate pay and conditions (Hochschild, 1983). The care relationship is a complex and often difficult relationship involving power and dependency. Disability activists provided a trenchant critique of care scholarship in the early 1990s for its occlusion of the relations of power between care provider and care recipient (Barnes, 2006; Morris, 2001; Oliver, 1996). Morris (1991) argued that the ideology and the practice of caring led to the perception of disabled people as powerless. The contribution of concepts such as 'choice' and 'control' to care scholarship have provided fertile opportunities for interdisciplinary scholarship and policy changes (Barnes, 2011; Kroger, 2009; Rummery, 2011; Watson et al., 2004)

Circles of care

Alongside scholarship that established care as both valuable work requiring an 'other-centred' disposition, care scholars have employed the concept of 'circles of caring' to highlight the differing degrees of independence, emotional attachment and mutuality of care relations (Lynch, 2007; Bubeck, 1995). The work of Baker, Lynch and Lyons, among others at University College Dublin, Ireland, has contributed much to our understanding of care and their thinking is summarised below (Lynch, 2007; Lynch, Baker & Lyons, 2009). Care is conceptualised as occurring within three concentric circles; primary care, secondary care and tertiary care. Primary care or love relations are characterised by high interdependency and high levels of attachment with associated intimacy and responsibility over time. These may be obligations inherited from families or chosen relations we form with friends or partners. Even if little love labour is invested in the sphere of love relations by parties to this intimate world, relationships retain a high level of care significance (Lynch et al., 2009). Secondary care relations also involve responsibilities and attachment, but they have less moral obligations, a greater degree of choice and contingency and are context specific - they can and do change when the context changes. Secondary care relations may be informally experienced in neighbourhoods, communities and workplaces. They also form a significant dimension of professional practice in social care and other social professions. Such care relations are shaped by codes of professional conduct and ethics and reflect a lower order affective engagement in terms of time, responsibility, commitment and emotional engagement (Lynch et al., 2009). Tertiary or solidary care relations involve largely unknown others, for whom people have care responsibilities, through statutory obligations at national or international levels, or when people care politically or economically through volunteering or activism. Solidarity is a macro-level expression of collective caring, a politicised form of love; it can be and is expressed through publicly supported health, education and welfare programmes, and while this solidarity may be conditional at times, the core principles underpinning it, is concern for the welfare of others (Lynch et al., 2020).

Lynch et al., (2009) acknowledge that abuse and neglect can replace love labouring in primary care relations, not only denying someone the benefits of love labour, but damaging them through abuse and/or neglect. Equally in secondary care relations, other-centred care labouring may or may not take place; professional care practices can be patronising, neglectful, inattentive or abusive. At the level of the nation state, opportunities to express solidarity through forms of taxation and social expenditure can serve to undermine or enhance the care capacities of institutions, such as early childcare settings, nursing homes, hospitals, schools and family support systems. Lynch (2007) suggests there is nothing inevitable in affective relations; discourse, policy and resourcing can enhance individual and organisational care

practices whether in public or in the private realm. Studies of countries operating public polices involving the equalisation of wealth and income show that people are healthier and have higher levels of well-being in more equal and solidarity-led societies (Dorling, 2014; Pickett & Wilkinson, 2018; Wilkinson & Pickett, 2009).

Care as a set of structural relations

In addition to the above foci, feminist inspired scholarship draws attention to the salience of care and love as "goods of public significance" and identified the importance of caring as a human capability meeting a basic human need (Nussbaum, 1995, 2001). The work of Lynch (2007; 2010; 2020) and the work of Lynch, Baker and Lyons (2009) highlights the importance of attending to the social relations of care in the pursuit of a socially just society. Their work frames care as a primary social good which is a significant source of inequality, evident in contexts where people are deprived of the love, care and solidarity (LCS) they need to survive and develop as human beings and/or when they are abused, violated or neglected affectively. Care is also a source of inequality when it is unevenly divided, between women and men particularly, but also between social classes and ethnic/racial groups and when those doing love and care work are not recognised economically, politically and/or socially for that work (Lynch, 2010, p.31). While the nature of affective relations, especially in terms of love and care, is a micro and highly interpersonal matter, to define affective relations in micro-level terms alone is to miss the central role of wider social relations in determining the capacity of people to care. For example, the state and the European Union enact laws regulating political, economic and cultural relations that impact on caring. Affective equality is therefore both an interpersonal and a structural matter (Lynch Baker & Lyons, 2009).

Tronto and Fisher (1990) and later Tronto (1994) described care as a process involving four "intertwining" phases with associated moral values. "Caring about" involves attentiveness to the needs of others and can be an attribute of an individual, an organisation or a state. At this first phase, someone or some group notices unmet caring needs. Once needs are identified, "taking care of" involves someone or some group taking responsibility to ensure these needs are met. The third phase, "caregiving", refers to the 'hands-on' daily tasks of care, which must be undertaken competently. This involves training, education and is the part of the process most heavily regulated. The fourth phase, "care-receiving", emphasises that care happens within the context of a two-way relationship rather than as a one-way dispersal of services, and recognises the voice of the service user and inequalities of power in care relationships, which must be attended to. This important phase recognises that when previous caring needs have been met, new needs undoubtedly arise (Tronto, 2017). In 2013, Tronto added a fifth phase, "caring with" which highlights that "when a group of people (e.g. a family or a population) can rely upon an ongoing cycle of care to continue to meet their caring needs, these patterns once established and reliable, produce the virtues of trust and solidarity" (Tronto, 2017, p.32). Understanding care in this way provides a valuable structure for understanding the social relations of care and the responsibilities of all parties to the process.

Care ethics

The final strand of care scholarship examined here is called care ethics. Ethics of care provides a framework for developing a model of professionalism which values care in a way that is absent from the managerial approach to professional knowledge and practice. Meagher and Parton (2004) argue that unless care is relocated at the centre of debates, policies, and practices, what makes social work (and social care more generally) distinctive will be lost.

Care ethics argues that "particularity, relationship, interdependence, and emotion are at the heart of moral life" (Campbell, 2015, p.37). Adherents to an ethic of care argue that empathy, compassion, and feeling with others may often be better guides to appropriate actions than abstract rules and dispassionate rational calculations. Emotion is given a *positive* role in the job of determining what we ought to do. It is argued that "knowing what to do in a particular situation requires empathetic projection into another's life" (Campbell, 2015, p.41). Collins (2018, p.5) suggests an ethics of care approach can provide a "correcting influence" to an excessive emphasis on "justice-based approaches", which have tended to dominate contemporary policy-making, and can result in a lack of attention in practice, to an individual's interpersonal, practical and emotional needs (Lloyd, 2006; Holland, 2010). Tronto's (1994) seminal work on care ethics is a central plank of this strand of scholarship associated with the moral qualities of attentiveness, responsibility, competence, responsiveness and solidarity (outlined above).

Justice-based approaches focus on questions of fairness, objectivity, equality, and individual rights through the impartial application of universal principles. In relation to social care, justice-based approaches motivate the drive for legislation and codes of conduct that provide clear rules and regulations to govern practice (Campbell, 2015, p.36) and are crucial in maintaining minimum standards of care. Campbell argues, not that principles and guidelines in social care should be abandoned, but that appropriate practice requires practitioners to pay attention to the particularity of each moral situation, on the basis that morality cannot be confined to considerations of rights and rules alone, but needs to also take account of human relationships and context (Campbell, 2015, p.40). Care ethics opens up the idea that services have an important ethical dimension, involving practitioners in a process of ongoing and often complex decision making about what is the 'right thing' to do, and can be at odds with technical and managerial approaches and the importance attached to instrumental values and universal rules (Moss & Brannen, 2003, p.9).

The contribution of an ethic of care to the social professions is evident in a wide range of literature (Banks, 2011; Barnes et al., 2016; Collins, 2018; Fenton, 2015; Holland, 2010; Meagher & Parton, 2004; Orme, 2002; Steckley & Smith, 2011). In a critical assessment of care ethics, Collins (2018) argues that the ethic of care perspective reflects the value placed by service users on the expression of genuine human concern and caring; its emphasis on unique relationships with particular people, sharing common and mutual human experiences, is central to the practice of the social professions.

Applying Theories of Care in the Social Professions

The care scholarship outlined above has long been applied and critiqued in professional contexts such as nursing (Smith, 1992; Watson, 2008; Woods, 2011); teaching (Kostogris, 2012; Langford, 2019; te Riele et al., 2017) and social work (Banks, 2012; Collins, 2018; Llyod, 2006; Meagher & Parton, 2004; Orme, 2002). There is also a rich scholarship in children's social care in the United Kingdom (Cameron, Connelly & Jackson, 2015; Emond, 2016; Pithouse & Rees, 2011; Steckley & Smith, 2011). What then is its contribution to the discipline of social care?

Firstly, care scholarship challenges the notion that care is a natural attribute of women and instead argues that care comprises skills and dispositions not specific to one gender. Recognising care as a skill and teaching these is an important part of valuing care in social care education. It highlights the important distinction between 'caring for' and 'caring about', the

practical, mental, cognitive and emotional dimensions of care. It confirms the importance of emotions in care, as a source of satisfaction, motivation and stress, while also highlighting this invisible work among professionals in the field. Secondly, thinking about care as a set of social relations can shift thinking from a micro-level focus to thinking about care as a structural set of relations where the role of the state, and the social divisions of class, ethnicity, ability, age, as well as gender, shape the experience of people who need support as well as the power and authority of the social care worker. Thirdly, thinking about care as a set of concentric circles with varying degrees of intensity and obligation provides a valuable tool for teaching about care and giving students the language to distinguish different types of care and the connections between them. Finally, care ethics reminds us that no context-free list of advice exists on how to care. In order to provide care, one must identify the particular needs of concrete individuals, so context and human relationships are central to practice (Campbell, 2015, p.39). Care scholarship therefore has enormous significance for social care. The next section will examine how the understanding of care outlined here is framed in the *Standards of Proficiency for Social Care Workers* (SCWRB, 2017b).

Care in the Standards of Proficiency

There are fourteen references to care in the standards, articulated in four of the five domains of proficiency (SCWRB, 2017b). These references are mainly contained in terms such as "social care settings", "social care process", "social care needs", "social care contexts". They do not explicate the meaning of care; instead the reader must draw inferences from the contexts in which the term is used. Domain 1: Professional Autonomy and Accountability contains three references to care, requiring graduates to "respect and uphold the rights, dignity and autonomy of service users in the diagnostic, therapeutic and social care process" (SoP 1.3), "to exercise a professional duty of care" and "to maintain professional boundaries in a range of social care settings" (SoP 1.6 and SoP 1.21 respectively) (SCWRB, 2017b, p. 4). The approach to care here reflects a recognition that it is not the responsibility of the relatively powerless to assert their rights, rather the onus is on the relatively powerful to behave in ways that acknowledge and respect these rights. Standards and professional guidelines restrict the type of interactions that can occur between social care workers and service users, typically motivated by a need to protect the latter from potential harm because of the power imbalances inherent in the relationship (Alexander & Charles, 2009; Fewster, 2004). The importance of rights, boundaries and duties in social care is highlighted, but there is little to communicate the language of care in a professional context, such as commitment, loyalty, relationships, proximity, emotional attunement and tacit understanding, so evident in the literature on the social professions (Banks, 2004; Barnes, 2006, 2012; Campbell, 2015; Coady, 2014; Smith, 2009; Smith, Doran & Fulcher 2013).

Domain 2 Communication Collaborative Practice and Teamworking has four generic references to care. The SoP require graduates "to recognise service users as active participants in their health and social care context" (SoP 2.3), "support them to communicate their choices, concerns and social care needs" (SoP 2.2), "communicate considered and informed opinions to carers" (SoP 2.9), "engage in collaborative practice involving service users and carers (where appropriate) in planning care, with an awareness of power and authority in relationships with service users" (SoP 2.12) (SCWRB, 2017b, p.6). Social care policy has more recently recognised the importance of service user involvement, partnership, participation, rights, and empowerment (HIQA, 2019) and these are very well reflected in the above standards. They reflect elements of the modernisation agenda in social care where values of collaboration,

partnership and service user voice are at least formally important. The value of the service users voice is recognised in care ethics scholarship, as is the critical role of carers in being responsive to care needs (Tronto, 1994; 2013). The influence of concepts such as 'choice', 'active participation', 'collaboration' and the call to be aware of one's 'power and authority' in professional care practice echoes the critique of disability theorists.

There are four standards referring to care in Domain 3: Safety and Quality. Two refer to social care and two refer to care/carer. Specifically, the standards require graduates to be able "to gather appropriate information relevant to a person's health and social care needs" (SoP 3.1), "prioritize their safety and that of carers" (SoP 3.7), "comply with regulations and access recommendations of inquiries relevant to social care" (SoP 3.13), and "work with colleagues to resolve gaps in care needs" (SoP 3.15) (SCWRB, 2017b, p.7) These standards reflect the emphasis on assessment, prioritising safety and compliance, learning from past mistakes and resolving care gaps collaboratively. While this domain is about assessment, intervention and evaluation (see McGarr & Fingleton in this volume), the risk averse focus of the standards misses the opportunity to reflect on care as a complex process (for example, the work of Tronto, 1994 & 2013) on the phases of care and the associated moral values of attentiveness, responsibility, competence, responsiveness and solidary, in assessing quality care standards.

There are three references to care in Domain 5 Professional Skills and Knowledge, requiring graduates "to recognise the historical, organisational and structural context that shapes social care provision" (SoP 5.14), the importance of "advocacy and system-level change to improve access to care particularly for marginalised groups" (SoP 5.15) and the "development of selfcare and self-awareness for effective professional practice" (SoP 5.19) (SCWRB, 2017b, p. 9-10). In drawing attention to the importance of a structural analysis of social care and advocating to challenge inequalities in access to care, these domain standards are among the more radical of the proficiencies. These standards confirm the far-reaching implications of framing social care practice in the context of social justice and human rights, allowing for a more political understanding of care. References to self-care and self-awareness *implicitly* acknowledge the emotional demands of practice. In terms of professional skills and knowledge however, care as an interpersonal relationship involving *both* individual and structural power dynamics must be acknowledged. Understanding the impact of the structural divisions of gender, social class, age, disability and ethnicity on professional practice are not referenced as critical proficiencies in this domain. Given the centrality of gender to care, and the intersectional inequalities arising in care work, proficiency in this field appears salient. Rummery and Fine (2012) remind us that care is simultaneously emotion and labour and relationship, and that this is the case for professional and informal carers, as well as for those receiving care. Some proficiency in understanding this level of complexity in care should feature in the domain of professional skills and knowledge.

This overview highlights the tensions between a conceptualisation of social care concerned with boundaries, duties, safety, rights, protection, regulations, and a more emancipatory project of collaboration, choice, voice, advocacy, responsiveness and trust. What is lost here is an articulation of care as a process with a range of different phases, or on the importance of attending to particularity, context and empathic projection in deciding what is the best approach. Neither is there a requirement to understand the social relations and social divisions of care. However, the standards acknowledge the importance of professional relationships as the bedrock of social care practice. This is examined in the next section.

The Relational Dimensions of Care

The Social Care Workers Registration Board (2019) provides a clear and substantive definition of social care driven by its chief characteristic; it is a relationship-based practice. All elements of engagement are based on the formation of trusting and purposeful relationships between the social care worker and the service user. The standards contain five references to relationships across two domains. Domain 2: Communication, Collaboration and Teamworking requires social care practitioners 'to build and maintain professional relationships with colleagues as independent practitioners and collaboratively as team members' (SoP 2.13) "…based on mutual respect and trust" (SoP 2.15). The second reference in this domain is to power and authority in relationships between social care workers and service users (SoP 2.12) (SCWRB, 2017b, p.6). In Domain 5: Professional Knowledge and Skills, two standards refer to relationships with service users, requiring "an understanding of the role of relationships as a tool in the delivery of social care" (SoP 5.8) and of "relationship dynamics between social care workers and services users, specifically transference and countertransference" (SoP 5.9) (SCWRB, 2017b, p. 9).

Professional relationships with colleagues

The two standards that refer to relationships with colleagues reflect the importance of collaborative working in social care, building and maintaining professionally respectful and trusting relationships is an essential bedrock of practice (McGuinness, 1993; Lalor & Share, 2013; Mulkeen, 2019; Thislewaite & Nesbet, 2007). This is a considerable challenge given the findings of inquiries into the protection of children and reports of failings across a diverse range of social care settings (Government of Ireland, 2009; HSE, 2010, 2016; Irish Human Rights Commission, 2010; Keenan, 2017). Inadequate communication across disciplines features strongly in child protection inquiry reports in the Irish and UK contexts (Buckley & O'Nolan, 2013; HSE, 2010, 2016; Munro, 2011; Shannon & Gibbons, 2012). The response to these findings has given rise to a range of innovative practices to address these gaps in communication and place the service user at the centre of deliberations; one example is the Meitheál model of family support operated by the Child and Family Agency, Tusla (Cassidy, Devaney & McGregor, 2016). The emphasis here on the ability to build and maintain professionally respectful relationships with colleagues is apposite given the requirement to work in partnership within multi-disciplinary teams to meet service user needs and plan care.

Professional relationships with service users

The standards require graduates to understand the role and purpose of building and maintaining relationships as a tool in the delivery of social care (SoP 5.8) and have a critical understanding of the dynamics of professional relationships with service users (SoP 5.9) (SCWRB, 2017b, p. 9). They also require awareness of the concepts of power and authority in relationships with service users (SoP 2.12) (SCWRB, 2017b, p. 6). These three standards represent the total references to relationships between social care workers and service users.

Children's residential care is the oldest form of social care in Ireland (Government of Ireland, 1970) and it is in this sector that literature on the role of relationships as central to care work is best developed (Emond, 2014, 2016; Emond, Steckley & Roesch-March, 2016; Smith, Fulcher & Doran, 2013; Steckley 2020; Ward, 2014). As social care evolved, a persistent theme in research and practice is that purposeful, trustworthy, competent and responsive relationships are central to the practice of social care (Brown et al., 2018; Cahill, Holt & Kirwan 2016; Ellem 2019; Smey-Carston & Jones 2016; Winter 2009; among others). Smith (2009, p.122) reminds us that the caring relationship is responsive to the needs of the other so care workers

need to know these and respond to them with appropriate professional rigour. People with lived experience of intellectual disability for example want the 'professional relationship' to include warmth, empathy, care and authenticity, where practitioners can skilfully and ethically bring themselves into the relationship (Roeden et al., 2011; BASW, 2019).

The concept of relationship-based practice (RBP) in social work has at its core the centrality of relationships and reciprocity in professional helping relationships (Ruch, 2005; Ruch, Turney & Ward, 2018). RBP is a relevant model of practice for social care practice also because it understands that people are not simply rational beings but have affective, conscious and unconscious dimensions that enrich but simultaneously complicate human relationships (Wilson et al., 2008). RBP places equal importance on the unique and complex nature of professionals and the rational and emotional dimensions of their behaviours as well as those of the people they seek to help (Ingram & Smith, 2018, p.7). It also moves the concept of relationship beyond the individual to incorporate an awareness of contextual factors such as power, professional role, poverty, social exclusion and political ideology. Writing about the challenges of relationship-based practice in the current context of managerialism and service cutbacks, Hingley-Jones and Ruch (2016, p.237) note that in a financially austere climate professionally informed practice can shrink in response to what might be referred to as "relational austerity"; authoritarian rather than authoritative and combative rather than compassionate – an unintended consequence of the ideological context of neoliberalism. Yet from the perspective of service users, Buckley et al. (2008, p.67) comment on the importance of positive and respectful relationships with parents and families in ensuring the safety and wellbeing of children. Trust, friendliness, empathy, open-mindedness, being believed and understood and being encouraged, were qualities that contributed to positive and respectful relationships according to parents and families. They also reported contexts where interactions were undermined by what service users perceived as bossiness, intrusiveness, indifference, unreliability and lack of respect (ibid). Thus, the complex and demanding nature of RBP is an important challenge to managerial approaches now ascendant in Irish social care.

Professional care relationships in the SoP

Standard 2.12 requires an awareness of the concepts of power and authority in relationships with service users (SCWRB, 2017b, p.6). Care is typically analysed dyadically as a relationship between non-equals - between those who 'need' care and those who 'provide' care. At the heart of care relations is the issue of power, or control as it is often expressed, illuminating how care carries risks as well as possibilities. In their analysis of power in care relations, Moss and Brannen (2003, p.12) draw attention to how policy initiatives in the field of social care regularly state an intention to empower services users, for example with an emphasis on service user participation, children's rights etc. They suggest this represents a view of power as the attribute of persons, notably bureaucrats and professionals who provide services, and that empowerment is about redistributing power to service users (ibid). Adhering to a principle such as participation and empowerment, without attending to all the complexities associated with the process, is often inadequate (Buckley et al., 2008). The rhetoric of empowerment which focuses on individuals also ignores the social and relational nature of power (Moss & Brannen, 2003). Power is also exerted is through the discourse of professionals and experts which are highly influential in turning subjective perspectives into objective truths and determining some things as self-evident and realistic while others are dubious and impractical (ibid). Smith (2009, p. xiv) suggests for example that it can become very difficult to question child protection discourses in a climate where '*protecting children*' is such a political hot potato. Power is also manifest in the care field when care relations seek to smother difference by trying to make the 'other' into the same (Moss & Brannen 2003). Tronto (1994) argues that responsiveness is a

key moral value in care; finding a relation to the other based on responsibility and a recognition of difference, a different way of understanding the other rather than putting ourselves in their shoes, is essential to care. Moss and Brannen (2003, p.15) suggest that power cannot be ignored in relationships of care, it can be made visible to make possible its recognition, and resistance. As this discussion highlights, attentiveness to power is not just an issue of interpersonal relationships.

Standard 5.8 sets out the role and purpose of building and maintaining relationships as a tool in the delivery of social care (SCWRB, 2017b, p.9)**.** Framing the role and purpose of relationships in this way emphasises an instrumental approach- relationships as a means necessary to 'deliver' social care. Cameron (2013) notes that professional relationships have both an instrumental function; for example, to understand the problem and how to change it, and an expressive function. Cameron (2013, p.8) refers to the expressive function as an ethical encounter, because of the primacy given to relations in the 'here and now' and not to what might be achieved at some future point in time. The author notes that the idea of relationships as non- instrumental ethical encounters focusing on respecting dignity and making connections is a considerable challenge in an era of instrumental practice (Cameron, 2013). Professional relationships are by their very nature two-way, so it must therefore be presumed that social care workers experience reciprocity in relationships (Alexander & Charles, 2009). Fewster (2001) reminds us that in a relational practice, the worker remains attentive to the mutuality of relationship, recognizing that both parties to the relationship create and are influenced by it. The rather instrumental slant of this standard misses the point of an expressive function to relationships, and the reality of mutuality and reciprocity at the heart of purposeful care relationships.

Standard 5.9 recognises that relationships are a dynamic process which include transference and countertransference (SCWRB, 2017b, p.9). Recognising that relationships are a dynamic process suggests that each relationship with a service user changes over time and both parties influence the kind of relationship that develops, negotiating how to proceed. The social care worker must pay attention to both their own and the service-user's emotional states in this dynamic. However, care is also political and the structural divisions of social class, gender, ability, race, age etc. influence professional relationships. For example, the complex gender differentiated investment in mothering and fathering, and the gendered nature of professional responses to child neglect and abuse, male violence and female perpetrated sexual abuse within families (as exemplified in the *Report of the Roscommon Child Care Case*) have been the subject of discussion elsewhere (Mulkeen 2016). The focus on one specific articulation of the dynamics of professional relationships in SoP 5.9 misses the opportunity to highlight the importance of other dynamics in shaping such relationships.

In summary, given the definition of social care as a relationship-based practice, it receives scant attention in the standards. In comparison, proficiencies in relation to safety and the management of risk are set out in considerable detail in six standards listed together in Domain 3 (SoP 3.7; 3.10; 3.11; 3.12; 3.13; 3.14) (SCWRB, 2017b, p. 7), while requirements around confidentiality are comprehensively addressed within five standards in Domain 1(SoP 1.10;1.11; 1.12;1.13; 1.14) (SCWRB, 2017b, p.4). This highlights the focused and detailed approach to proficiencies on responsibilities related to risk and regulation while the approach to relationships is more limited and diffuse, dissipating their complexity and centrality in the definition of social care articulated by the Social Care Workers Registration Board itself. Framed in this way the SoP suggest that proficiencies in managing risk and data are more important than proficiencies in building and sustaining professional relationships, working

with the dynamics of power or advocating for change. What is even more surprising is the lack of attention to emotional labour in the standards.

The Emotional Labour of Professional Care Work

Emotions are intrinsic to social care work where practitioners often engage with people at points of crisis or need. The emotions of both practitioners and the people they interact with are central to the lived experience of practice (O'Connor, 2019). Research demonstrates the salience of emotions in professional decision making (Ingram, 2013; Morrison, 2007; Munro, 2011; O'Connor, 2019). Hennessey (2011) ranks emotions as an equal partner alongside theory and skill, and service users place a high value on empathy, genuineness and warmth. Yet, emotions receive little space in the SoP.

Hochschild (1983, p.7) developed the concept of "emotional labour" to refer to the management of emotions in work contexts; "the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place". Organisational and socially constructed "feeling rules" (ibid, p.57) establish norms, that is the expectations regarding the "handling of other people's feelings and our own". Dependent on the feeling's rules, workers may engage in "surface acting" or "deep acting" in the management of their own emotions and the emotions of other people. In "surface acting" the person feigns sincerity when communicating appropriate feelings; in other words, pretending to feel what is expected. In suppressing real emotions and displaying emotions that are not really felt to conform to rules, surface acting can lead over time to emotional numbing (Jirek, 2015). In "deep acting", Hochschild (1983, p. 90) argues that "a fundamental change takes place in that by pretending deeply, [we can] alter [our]self". This process describes an individual's response to emotional dissonance. In response to managing the difference between how they feel and what they are feigning they pull the two closer together either by changing what they feel (deep acting) or by changing what they feign (surface acting) (Hochschild 1983). From this perspective Winter et al. (2018, p.7) suggest there is a difference between "seeming to become more patient and caring" and "becoming more patient and caring". Social care work, like social work, entails the management of both public and private emotions, as the development of effective relationships with individuals, families or groups requires deep emotional engagement in order to win people's trust and cooperation (Morrison, 2007; Ruch et al., 2018). Social care work can be regarded as having a substantial personal emotional cost, especially when the feeling rules are at odds with personal values and beliefs (Leeson, 2010; Syed, 2008; Zapf & Holz, 2006) or where there is little/no support or recognition of the work being done or the energy expended (Smith, 1992). In such instances, workers either become exhausted, experiencing burnout (Kim & Stoner, 2008), or they feel they must distance themselves from the emotional impact of their work, thereby becoming blasé, remote or disengaged (Mann, 2004).

Research on caring occupations such as nursing, shows how changes in the structure, practice and professional norms guiding these fields have the potential to increase or diminish workers' positive experience of caregiving (Hunter & Deery, 2005; Huynh et al., 2008). In a study of nursing homes, Lopez (2006, p.137) argues that employers can self-consciously create conditions that 'encourage relationship building and emotional honesty' in the workplace. What he calls "organized emotional care" is an approach in which, rather than prescribing expectations for workers' interactions with others, employers instead aim to create opportunities for caring relationships to emerge on their own. Hanlon and Fabianowska (2014) set out the centrality of emotional labour in social care by arguing that the nurturing goals of

social care differ from the instrumental objectives of many other occupations using emotional labour. They suggest that professional practice calls for controlled emotional involvement and professional distance, so workers are expected to be authentically caring and empathetic or to embody it through deep acting whilst also maintaining professional distance and managing this contradiction in their performance (Hanlon & Fabianowska, 2014, p. 55). Such complexity in professional practice must be addressed in the standards.

Emotions in the Standards of Proficiency

There is no explicit recognition of emotional labour in the SoP. They do however, set out requirements around empathy, self-awareness and self-care. Standard 23 in Domain 1 (SCWRB, 2017b, p.5) requires graduates to be able to see the world as others see it; practice in a non-judgemental manner, understand another's feelings and be able to communicate that understanding (SoP 1:23). These are key dimensions of empathy. Here also is the sole reference to feelings in the SoP. The ability to empathize with others is considered a necessary 'rule of engagement', a critical skill in the caring professions (Gerdes, Leitz & Segal, 2011; Phan et al., 2009). The standards also reflect the importance of self-awareness (SoP 5.13) and the practitioners' responsibility to manage their workload, their health and wellbeing, and the care of oneself (SoP 1.18; 1.20 and 5.19) alongside their responsibility to access supervision (SoP 4.5) (SCWRB, 2017b, p.4-9). Together these suggest an implicit awareness of the emotionally demanding nature of social care practice.

Nevertheless, there is a significant disjuncture between the evidence provided in the literature (Morrison, 2007; Sudbury, 2002; Taylor, 2011; Winter et al., 2018, among others) about the influence of emotions on relationship-based practice at all stages (engagement, assessment, planning, intervention and evaluation) and the lack of attention to emotions in the standards. Morrison (2007) reminds us that assessment cannot be effective unless there has first been attention to a process of engagement and rapport building with the service user. Given that emotions are often generated around power and status interactions (Kemper, 2000) and the presence of anxiety (Morrison, 1997; Barlow & Hall, 2007), she suggests social workers need to pay particular attention to both their own and their user's emotional states. The same can be said for social care workers. Morrison (2007, p. 254) reminds us that

> the degree to which vulnerable service users have suffered multiple experiences of dysregulated emotions, inconsistent care and unpredictable danger, in response to which they have developed 'emotional antennae' which are highly attuned to the emotional demeanour of those on whom they may have to depend, must not be forgotten.

The absence of attention to emotions in the standards may indicate a preference for education that prioritises the cognitive (knowing and thinking) over the affective (emotional) domain. In her analysis of child protection failures in the UK, Munro (2011, p.37) highlights the importance of practitioners being able to read and understand their own emotional responses, and to use this self-awareness as a basis for understanding others. Munro highlights the extent to which conscious and unconscious processes may be evident and communicated non-verbally in the face, eyes, tone of voice and body language of service users and practitioners. In a discussion of "feeling rules" in child and family social work, Winter et al. (2018) suggest that the expression of strong feelings may not sit easily with normative assumptions regarding the exercise of professional boundaries. There is a separation between the 'doing'—that is the expectation that close, meaningful relationships will be formed—and the 'feeling'—the expectation that social workers will manage their feelings in such a way as to maintain

neutrality and rational objectivity (O'Leary et al., 2012, cited in Winter et al., 2018, p.9). This contradiction is present in social care practice also. While not all the relational and emotional dimensions of care can be articulated as proficiencies, social care workers, like many care professionals, are motivated by the emotional aspects of their labour. Rummery and Fine (2012) remind us that the emotional and ethical side of caring cannot be easily professionalised; genuine emotional caring 'about' cannot be bought or forced, as it has a large voluntary dimension. Barnes (2006) argues that when divorced from the caring 'about', it is very easy for the labour of caring 'for' to become mechanistic at best and abusive at worst. These tensions are critical but neglected in the standards.

Conclusion

This article has introduced a range of relevant care scholarships and demonstrated the salience of such scholarship for social care education and practice. It provides a critique of care as articulated in the standards and an analysis of its relational and emotional dimensions. The paper highlights that care as a personal or professional practice, is simultaneously labour, emotion and relationship, shaped by the dynamics of power and inequality. Two critical issues are at stake. Firstly, in order to provide care, one must identify the particular needs of concrete individuals, so context and human relationships remain central to practice as does emotion management. In its relative neglect of the relational dimension of care and the more serious neglect of the emotional labour of care, the standards reveal a highly technical-rational approach to care. In addition, there is little of the language of care; interdependence, solidarity, loyalty, reciprocity, altruism, friendship, and love in the standards or how these can be developed as components of professional practice. Secondly, given that social care and opportunities to access care are marked by intersectional divisions of gender, ethnicity, social class, age and disability (among others), the SoP miss the opportunity to draw attention to the contradictions and inequalities in the lived experience of many social care workers and service users. Standards play an important role in drawing attention to these complex challenges. Given the shortcomings outlined in this paper care scholarship provides a fertile opportunity to augment threshold standards with a critical and relationally informed understanding of care in teaching, practice and research.

About the Author

Dr Majella Mulkeen is a lecturer in the Institute of Technology Sligo where she teaches on the social care programme, with expertise in equality, diversity and social justice. Her research interests are in the fields of gender, equality and markets in social care and more recently in affective inequalities in social care. She has published in these areas in the core social care textbook Applied Social Studies (2013), in the journal *Administration* (2016) and in the *Irish Journal of Applied Social Studies* (2012). She completed her doctoral studies on affective relations in residential social care practice, examining the perspectives of social care practitioners.

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