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Articles

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CLINICAL SOCIAL WORK

by **International Scientific Group of Applied Preventive Medicine I - GAP Vienna, Austria**

This journal brings authentic experiences of social workers, doctors and teachers working for the Internatioanl Scientific Group of Applied Preventive Medicine - GAP Vienna in Austria, where they have been preparing students for the social practise over a number of years. Our goal is to create an appropriate studying programme for social workers. A programme which would help them to fully develop their knowledge, skills and qualification as the quality level in social work studying programmes is increasing along with the growing demand for social workers.

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EVIDENCE-BASED PRACTICE IN SOCIAL WORK EDUCATION

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Abstract

This paper contains a review of the current literature around the dissemination of evidence-based practice (EBP), current social work models for dissemination of EBP, interviews with experts in the field, and a synthesis of this combined knowledge into recommendations for future dissemination of research and EBP efforts..

INTRODUCTION

An evidence-based practice occurred in the time of medicine and health-care service as an option of incorporating recent advances in research into professional decision making (Ramsey et al., 1991; Sackett et al., 1991) and has over the last 15 years developed rapidly across most areas of health care. An evidence-based practice is considered any practice that has been established as effective through scientific research according to a set of explicit criteria (Drake et al, 2001). Robert Wood Johnson Foundation consensus panel concluded in 1998 that research findings identify six evidence-based treatment practices for the treatment of persons with severe mental illness: assertive community treatment; supported employment; family psycho-education; skills training and illness self-management; and, integrated dual-disorder treatment. To be considered an evidence-based practice four selection criteria were used: the treatment practices had been standardized through manuals or guidelines; evaluated with controlled research designs; through the use of objective measures important outcomes were demonstrated; and, the research was conducted by different research teams (Torrey et al, 2001).

Accordingly, we can highlight that evidence-based practices or best-practices were identified for the diagnosis, treatment and other management of persons with severe illness through efficacy trials meeting these four crite-

ria. Initially evidence-based practice was defined as “the conscientious, explicit and judicious use of current evidence in making decisions about the care of individuals’ (Sheldon, 2002). Definition of Evidence-based behavioral practice from 1992 was following: “entails making decisions about how to promote health or provide care by integrating the best available evidence with practitioner expertise and other resources, and with the characteristics, state, needs, values and preferences of those who will be affected. This is done in a manner that is compatible with the environmental and organizational context. Evidence is comprised of research findings derived from the systematic collection of data through observation and experiment and the formulation of questions and testing of hypotheses” (www.ebbp.org). However, these definitions have thereafter been adapted in order to describe ‘a philosophy and process designed to forward effective use of professional judgement in integrating information regarding each client’s unique characteristics, circumstances, preferences and actions, and external research findings’ (Gambrill, 2006b). Thus, EBP is now mostly described as ‘the integration of best research evidence with clinical expertise and patient values’, a process that involves the following principles or steps (adapted from Sackett et al., 2000):

- Formulate focused and answerable clinical questions, based on service users’ needs.
- Search the literature for the best research-derived evidence in order to address the question previously framed.
- Critically appraise the identified evidence for va-

lidity and relevance.

- Integrate the selected evidence with clinical expertise and the service user's values and preferences, and apply the result to clinical practice and policy decisions.
- Evaluate effectiveness and efficiency through planned review against agreed success criteria (Greenhalgh et al., 2003) and seek ways to improve them in the future.

Accordingly, evidence-based practice is a decision-making process in which judgments are made on a case-by-case basis using best-evidence. In addition, evidence-based social work practice would incorporate the following characteristics.

A relationship in evidence-based practice is characterized by a sharing of information, observation and of decision-making. The practitioner/ social worker or other professional does not decide what is best for the client, but rather the practitioner provides and guides the client with up-to-date information about what the best-evidence is regarding the client's situation, what options are available, and likely outcomes. With this information communicated in culturally, nationally and linguistically appropriate approaches clients/ patients are supported to make decisions for themselves whenever and to the extent possible.

A critical, inquisitive attitude regarding the achievement of valued outcomes and undesigned negative outcomes rather than an unquestioning belief that only intended outcomes will be achieved and, therefore a failure to secure information about actual outcomes prior expectations to colour achievements.

A focus on fidelity in implementation of client chosen interventions rather than assuming that selected interventions will be provided as intended. Fidelity of implementation requires that the specific evidence-based practice be provided as it was tested when research supported its effectiveness. Too often serious distortion occurs during implementation. An aggressive pursuit of new information about outcomes rather than relying on static prior beliefs. This new information is derived from: researching what occurs, when interventions are implemented; and, new research findings promulgated by others. The ongoing knowledge revision based on this new information which in turn is communicated to clients. A relative weighing of information, placing information derived from scientific inquiry as more important than information based on intuition, authority or custom (Roberts, 2004).

Social work practitioners need to know what

has been identified as best-practices and they need to be prepared to be evidence-based practitioners. Social workers can benefit greatly from clear identification of interventions that work, through such efforts as seen in the systematic reviews conducted and disseminated through the Cochrane and Campbell Collaborations, as well as the work of the many evidence-based practice centers around the world. These collaborations and centers are using systematic reviews to identify effective interventions. What is learned through reviews needs to be effectively implemented and made available to the professionals. Dissemination and implementation of evidence-based practices present special challenges when the intended users are social work practitioners and their clients (Nutley, 2000a; Nutley, 2000b; Eisenstadt, 2000).

REVIEW AND EVIDENCE-BASED APPROACH

The first widespread push for EBP in social work came out of a series of studies that began to appear in the 1970s and called into question the effectiveness of existing social work interventions (Reid, 1994). The 1970s and 1980s witnessed a movement to develop evidence based models of practice in mental health and further the development of well researched psychosocial intervention models such as the behavioral, cognitive, interpersonal, and social approaches, as well as the biological and bio-psycho-social theories of mental illness (Bellamy, 2006). Evidence-based researchers in many disciplines pioneered models used in social work practice including: psychology, psychiatry, and social work. In the late 1980s and early 1990s substantial evidence regarding the treatment of common mental health disorders were high-lighted by the publication of the results of studies such as the National Institute of Mental Health Treatment of Depression Collaborative Research Program (Elkin et al., 1989). Over the past decade, the proportion and number of articles referring to EBP published in professional journals has risen in the disciplines focused on mental health services, health, and social welfare (Shlonsky, 2004). For a more detailed description of the history of the development and use of EBP in social work see Kirk and Reid (2002).

Today, New York State's Office of Mental Health, identified as a progressive program by NIMH, is promoting the use of the following EBP for adults with serious mental illnesses (Bellamy, 2006). These EBP interventions include: Assertive Community Treatment, supported employment, intensive case management, wellness self-management, family psy-

cho-education, integrated treatment for co-occurring substance abuse and mental health disorders, medication (and guidelines for practitioners to promote optimal prescribing practices), self-help and peer support services, and post-traumatic stress disorder (PTSD) treatment (New York State Office of Mental Health, 2001). The President's New Freedom Commission (2003) report identified the following additional EBPs for the treatment of mental health disorders: cognitive and interpersonal therapies for depression, preventive interventions for children at risk for serious emotional disturbances, treatment foster care, multi-systemic therapy (MST), parent-child interaction therapy, and collaborative treatment in primary care. The commission also recommended emerging best practices including: consumer operated services, jail diversion and community re-entry programs, school mental health services, trauma-specific intervention, wraparound services, multi-family group therapies, and systems of care for children with serious emotional disturbances and their families (New Freedom Commission, 2003).

TWO APPROACHES TO DISSEMINATION AND IMPLEMENTATION OF EVIDENCE-BASED PRACTICE

As published by Nutley and Davies, there have been used two major approaches to distribute and implement best-practices, namely macro and micro, or what I call top-down and bottom-up strategies. In top-down strategies findings are disseminated for use by front-line practitioners through agency directives, guidelines, manualized interventions, accreditation requirements, algorithms, toolkits and so forth. Top-down or macro strategies can serve to get the word out about what works or what is favored by those in authority, but such methods do not guarantee adoption of best-practices on the front lines. To increase the likelihood of adoption a bottom-up approach is needed. In contrast to the top-down approach, social work practitioners need to be prepared to engage in a process of critical decision-making with clients, about what this information means when joined with other evidence, professional values and ethics, and individualized intervention goals. A bottom-up approach recognizes the importance of engaging the practitioner and the client in a critical, decision-making process (Nutley, 2000b).

Sackett and others (2000) have noted there may be insurmountable barriers to implementing evidence-based practice guidelines in individual circumstances. For successful implementation a number

of components need to be in place. These include:

- Organizational culture, policies, procedures and processes must provide opportunities and incentives supporting evidence-based practice (e.g., financial incentives, funding, openness to change, workload adjustments, information technology supports, and legal protection).
- The organization's external environment must provide similar opportunities and incentives supporting evidence-based practice (e.g., national, regional and local authorities, funders and accrediting groups).
- Applied practice research and evaluation must provide scientific evidence about assessment, intervention and outcomes pertinent to the organization's practice domain.
- Systematic reviews which synthesize research findings must be conducted assessing the weight of the evidence generated by current research & evaluation studies.
- Prescriptive statements based on these syntheses must be developed and communicated in user-friendly forms (e.g., practice-guidelines, manuals, toolkits).
- Organizational procedures need to be put in place to assure fidelity of implementation of these prescriptions.
- Systematic, structured evaluation processes capable of providing timely feedback to various stakeholders as to the fidelity of implementation and outcomes must be designed and implemented as an ongoing process.
- The organization must have social workers available who are trained as evidence-based practitioners capable of functioning in evidence-based practice organizations (Sackett, 2000).

The wider field of social science knowledge utilization is just beginning to build a theoretical framework that explains why research evidence, such as the EBPs listed above, is or is not utilized in social work practice. While researchers have identified EBP health services, the implementation of these services into practice has been problematic. One of the greatest complaints has been backward of more than 20 years (in some European countries even more) between the identification and incorporation of EBP interventions into routine care (Balas, 2000; Bellamy, 2006). Furthermore, social work as a professional organization that introduces expertise and specialized knowledge, ethics and skills aimed at addressing difficult human problems, including different illnesses. However, many courses, experiences and training are

not supported by evidence as necessarily related to helping clients through the use of evidence (Dawes, 1994; Gambrill, 1999; 2000).

Very important consequence of increasing popularity of EBP among professionals has been its expansion from health care to other disciplines e.g. social work, historically particularly in English-speaking countries such as the UK, the US, Canada and Australia, where the new way is becoming increasingly influential (Gilgun 2005; Rosen 2002). Thus, in the UK the New Labour Government after its election in 1997 announced, in its White Paper Modernising Social Services, the objective that social services should base practice on research and other evidence of what works (Department of Health 1998), an aspiration that soon became one of the cornerstones of the government's modernisation agenda for social services (Bonner 2003). In fact, the need for underpinning practice with an evidence base has consistently been emphasised in subsequent White Papers in the area of social care (Department of Health 2001, 2006) and also in major policy documents published in Northern Ireland (Northern Ireland Social Care Council 2002), Scotland (Scottish Executive 2006) and Wales (Welsh Assembly Government 2007). Examples of the initiatives undertaken in order to bridge the gap between research and practice include the creation of the Centre for Evidence-Based Social Services, which operated between 1997 and 2004; the Social Care Institute for Excellence, established in 2001; the Scottish Institute for Excellence in Social Work Education, created in 2003 and which in 2007 changed its name to the Institute for Research and Innovation in Social Services; and the Social Services Improvement Agency, set up in 2006 to promote excellence within social services in Wales (Lishman, 2011).

Besides the Anglo-Saxon countries, other regions are also witnessing a growing development of EBP in the area of social care. For instance, SFI-Campbell (the Nordic Campbell Centre),¹ based in Denmark, has been producing and disseminating research-based knowledge – especially systematic reviews – in the Nordic countries since 2002, and the Institute for Evidence-Based Social Work Practice (IMS) was officially created in Sweden in October 2004. In the Netherlands, where outcome measurement and effectiveness in social services are increasingly demanded by governments and service users (Mullen, 2004), the Verwey-Jonker Institute has been promoting evaluative research into social issues over the last decade (Morago 2006; Lishman, 2011).

In this context, an evidence-based practice is also being incorporated as a component of professional com-

petence and responsibility of social work across different European, American and Australian countries. For instance, in the US the Educational Policy and Accreditation Standards expect social workers to employ evidence-based interventions as well as research findings in their professional practice, and in Australia social workers must demonstrate their ability to utilise research in practice (Australian Association of Social Workers 2008). In the UK, the critical evaluation and appropriate use of research findings has been formally recognised as a qualifying requirement in England and Wales (Training Organisation for the Personal Social Services 2002; Social Services Inspectorate for Wales 2004; General Social Care Council 2008) Northern Ireland (Northern Ireland Social Care Council 2003) and Scotland (Scottish Executive 2003). Therefore, social work education is now generally expected to provide students with appropriate knowledge and training in applying research evidence to practice.

Although EBP implementation is still emerging in social work education, an increasing number of authors have reported that the notion of EBP is gaining momentum across schools of social work, and they have also identified implementation issues and barriers as well as strategies to overcome them. In particular, the main themes arising from the literature in this area are:

1. Integration of EBP into the curriculum of social work education.
2. Readiness of social work academic staff for EBP implementation.
3. The role of agency-based practice learning in the EBP implementation process.
4. Relevance of EBP implementation for the social work profession ((Drake et al. 2007; Franklin 2007; Howard, McMillen, 2003; Howard, 2007; Howard et al. 2009; Jenson 2007; Mullen. 2005a; Mullen et al. 2005b; Mullen et al. 2007; Proctor 2007; Scheyett 2006; Shlonsky, 2007; Soydan 2007; Springer 2007; Thyer 2007; Weissman et al. 2006, Lishman, 2011).

The main purpose of this paper is to provide an overview of these themes and discuss them with reference to the literature selected, using the author's previous experience as a lecturer in social work at different important universities in US, Africa and Europe e.g. at the St. Elizabeth University of Public health and Social Work (SEU) as an exemplar. SEU has explicitly been promoting an EBP approach within social work programmes and, in general, the issues arising from the implementation of EBP in the curriculum are closely similar to those identified by the literature reviewed (Suvada, 2010).

INTEGRATION OF EVIDENCE-BASED PRACTICE INTO THE CURRICULUM OF SOCIAL WORK EDUCATION

For some authors (Howard et al., 2007), social work education has traditionally adopted a generalist practice perspective in which students are trained to work effectively at different levels and in a variety of settings and client's groups. Therefore, they are trim up with a broad, eclectic knowledge and skills base (e.g. interpersonal or 'use of self' skills and practical skills necessary to work effectively within organisational and interdisciplinary procedures (Jenson, 2007). Notwithstanding, this model has been criticised on many levels for several reasons, for example: for including officially approved theories and interventions of unproven efficacy instead of empirical evidence across specific fields of practice (Bledsoe et al., 2007; Mullen et al., 2007; Thyer, 2007).

In this context, Gambrill (2006c) claims that students risk becoming passive recipients of untested knowledge who uncritically receive it and inappropriately apply it to practice. Another objection to the generalist model is that, by assuming that social work's knowledge base is stable, it is ignoring the changing and somehow ambiguous nature of social work (Mullen et al., 2007). Therefore, a didactic approach would seem insufficient to prepare social work students in training for the requirements of modern practice. Instead, and given the increasing availability of good quality empirical research, a rigorous evidence-based approach to social work's knowledge base beyond lecture-based and opinion-based learning is regarded as the optimal tool for students to develop critical thinking skills and cope effectively with vast amounts of information, change and uncertainty (Franklin, 2007; Gambrill, 2006b; Shlonsky, 2007; Soydan, 2007; Howard et al., 2007).

As mentioned hereinbefore, it is a formal demand that social work trainee, and graduated practitioners generally need to establish an appropriate use of relevant findings from research studies. But there is a question to which EBP is being embedded within social work programmes is a different matter. In point of fact, to integrate a new subject into already dense curriculum like that one in most social work trainings is a great challenge for social work universities education worldwide (Howard et al. 2003, 2009). A short-term solution could be to try to include some teaching sessions and assessment tasks wherever there is some space for them and thus justify that accreditation requirements in relation to EBP teaching are met (Soydan, 2007). However, such a patchy, almost tokenistic,

presence of EBP in the curriculum is still far from the implementation levels that EBP promoters are advocating. For them, rather than a discrete subject, EBP is a coherent and systematic framework for critical inquiry that should, as implemented, for example, by the George Warren Brown School of Social Work at Washington University, inform the whole curriculum (Drake et al. 2007). Such an ambitious plan requires a strategic redevelopment of social work curricula with specific action on, at least, two areas: a teaching of EBP skills and a teaching of effective methods of intervention across the different subjects or modules of the curriculum (Springer 2007; Suvada, 2010).

EVIDENCE-BASED PROGRAMS AND ARGUMENTS FOR ITS USE IN DAILY PRACTICE

Despite the numerous barriers to which are facing social workers in the health services sector, we have a number of conclusive reasons to implement evidence into their practice with ill or another way affected clients. Practitioners have cited advantages of using EBPs such as: (1) conceptualizing, planning, and guiding treatment, (2) increasing knowledge and skills, (3) improving treatment outcomes for clients, (4) integrating and supplementing, not supplanting, clinical judgment and knowledge, (5) complying with current practice, values, and professional consensus, and (6) satisfying grant or managed care reimbursement requirements Overall, the basic tenet of EBPs is that clients should receive the benefit of the best technology that social work has to offer (Mullen, 2004; Lishman, 2011).

It is difficult to imagine the basis on which structured, fact-based and well informed decision making and planning referenced to the best available published research can be viewed as counter either to the provision of effective outcomes for service users or social work professional staff (Barratt, 2003). There are many questions as to what exactly should be addressed, disseminated and used as evidence to identify the best possible approach. Undoubtedly this argument will, and should, continue within the field. Though, if some fact upon what is a validated intervention can be secured, the question becomes one of dissemination and implementation (Suvada, 2010; Czarnecki, 2013).

THE TEACHING OF EFFECTIVE METHODS OF ASSESSMENT AND INTERVENTION

Besides training students to develop EBP skills, EBP implementation also requires that social work students are informed about the effectiveness of the methods of assessment and intervention that are taught across the different components of the social work curriculum. In particular, social work programmes should always include in the curriculum the teaching of those interventions with the strongest empirical support from research studies (Howard et al., 2009). In fact, in the last two decades a considerable amount of evidence has been generated in areas relevant for social work practice, such as mental health, learning and developmental problems, offending, poverty and social exclusion, work with children and families and the care of older people, to cite just a few examples (Weissman et al., 2006). Such a body of evidence constitutes a powerful tool to achieve an old professional aspiration – namely, to base social work practice on the best knowledge available in order to deliver effective interventions (Bledsoe et al., 2007; Mullen et al., 2007; Thyer, 2007). However, some authors claim that evidence of empirical support has been integrated into social work programmes only to a modest extent that interventions and approaches of dubious efficacy continue to be prevalent within such programmes. Furthermore, Lilienfeld et al. (2003) and Howard et al. (2009) use the term *pseudoscience* to refer to a body of social work approaches and strategies based on ‘fashion’ rather than on rigorous empirical evaluation. This situation is not likely to change unless social work academic staff effectively engaged with the EBP implementation process, which is the second of the themes identified by the literature reviewed in this chapter and which will be examined in the next section.

READINESS OF ACADEMIC STAFF FOR EVIDENCE-BASED SOCIAL WORK PRACTICE IMPLEMENTATION

In addition to the lack of space in already tight social work programmes, another potential challenge for EBP implementation identified in the literature is that all social work academic staff may have the readiness or skills for teaching EBP (Franklin 2007). Perhaps the discussion of this issue should be contextualised by looking at the debate that the expansion of EBP from medicine to social work has originated within the profession. As we all know, along with strong enthusiasm from some fields of the social work

profession, an EBP has also been received with considerable scepticism and a range of objections from other authors (Barratt 2003; Green 2006; Suvada 2010; Gambrill 2003, 2005, 2006a, 2006b, 2006c).

One of the main objections raised in discussion about EBP, is presents a deterministic version of rationality that ignores the complex processes of deliberation and choice that social workers must follow when making decisions (Webb 2001). Thus, concerns have been expressed that a narrow concept of evidence based on results from randomised controlled trials may be appropriate for medicine but not for such a complex and multifaceted field as social work (Green 2006; Parton 2000; Webb 2001), and that such a kind of evidence cannot meet ‘the sometimes contested and divergent knowledge brought into play in the many places and ways social work is practised’ (McDonald 2003). Sackett et al. (2000) describes EBP’s very nature: ‘a philosophy and process designed to forward effective use of professional judgement in integrating information regarding each client’s unique characteristics, circumstances, preferences and actions, and external research findings’. Consequently, Gambrill (2006b) argues, EBP is not presented as a substitute for professional competence: along with the best and most updated information from research studies and service users’ values and preferences, professional skills, empathy and the ability to build human relationships are essential assets of social workers’ practice. Equally, there seems to be wide acceptance that the sources of social care knowledge are diverse – for example, organisational knowledge, practitioner knowledge, user knowledge, research knowledge and policy community knowledge (Pawson et al. 2003). In relation to research evidence, the initial emphasis on results from randomised controlled trials has been gradually replaced by a broader, pluralistic approach that embraces contributions from different research designs as appropriate to the purpose of the enquiry (Braye, 2007; Lishman, 2000; Mullen, 2004; Rubin, 2005; Soydan, 2007; Taylor, 2007).

However, objections to EBP continue to be a significant feature of academic debates within social work schools (Rubin, 2007; Suvada 2010), which for some authors (Gilgun 2005; Howard et al., 2009; Magill, 2006; Springer, 2007; Thyer, 2007) suggests the existence of certain misconceptions about EBP as well as lack of information about how the notion of EBP in social work has evolved over the last years. This is a serious difficulty for EBP implementation that may require the creation of appropriate training, information sharing and discussion spaces for the professional development of academic staff (Franklin, 2007). From

our experience at SEU these kinds of initiatives have, in addition, a considerable potential for reinvigorating academic debates often stifled by increasing administrative and course management-related demands (Suvada, 2010; Czarnecki 2013). Yet, and despite its importance, promotion of EBP in the classroom as so far outlined is not sufficient for a fully effective implementation of EBP in social work education.

RELEVANCE OF EVIDENCE-BASED PRACTICE IMPLEMENTATION FOR THE SOCIAL WORK AS A PROFESSION

As indicated earlier, some of the strongest objections traditionally raised against EBP that it presents a deterministic version of rationality that ignores and replaces professional competence and is clearly insufficient to take into account the different sources of social work knowledge. The EBP extends the notion of reflective practice. What Franklin (2007) calls the 'resourced self' is precisely the essence of EBP implementation in social work education: to provide a systematic framework for critical inquiry that enables social work students to become resourced practitioners, able to make more informed and transparent decisions. MacDonald (1990), a pioneer of EBP in social work, has already argued that a more empirically based practice was required in order for social workers to take 'correct decisions' i.e. 'those for which appropriate information is sought from diverse sources, appropriately weighed against available knowledge, and whose outcomes are fed back into that knowledge base to inform future practice'.

A few studies have suggested that field instructors are far more influential than faculty instructors (Lager, 2004). If faculty members are teaching EBP in the classroom, without having buy-in from field educators, students are likely to follow the lead of their practice educator by downplaying the need for EBP, rather than adhering to the classroom instruction of faculty who may seem disconnected from the realities of the field. To counteract the apparent gap between research and practice, many have suggested students participate in integrative seminars and use tools such as field journals that are reviewed by both university and field instructors (Dettlaff, 2002). Field instructors, even highly experienced social workers, require additional training before they are ready to supervise students' field education. Recognizing this reality, most social work education programs provide ongoing training to their field educators (Miller, 2005; Suvada, 2010). These training activities may provide the opportunity to introduce EBP training to experienced

social workers who likely were not educated within this framework. These seminars and workshops may also be the best place to introduce new methods of assessing student competencies using EBP. Importantly, field education experts have begun to develop measures for evaluating student learning and performance of both explicit skills and "implicit" practice wisdom, and these measures could be adapted to include EBP competencies (Bogo et al., 2002, 2004; Czarnecki, 2013).

In fact, the literature provides a few examples of how interventions, some of them very popular but the efficacy of which has not been rigorously evaluated, may have harmful consequences for service users and the public in general. One example is 'Scared Straight' programmes, an approach that consists of inviting young people at risk of offending to visit a prison, where they have the opportunity to talk to adult inmates and know 'in situ' how life in prison is. The major assumption of this programme is that such a scary experience will deter the youngsters from future criminal behaviour. The model became popular in the US to the extent that it was adopted as public policy by several states. However, when nine different 'Scared Straight' interventions were evaluated, it was found that crime rates were significantly higher among participants in the programme in comparison with their control counterparts who had received no intervention (Petrosino, 2002). Therefore, social work students should be taught to avoid – or at least to be cautious about methods of assessment and intervention, the efficacy of which has not been rigorously evaluated.

This is particularly relevant to those areas of practice where social workers' activity is subject to intense scrutiny (e.g. child protection when it could be argued that, if after a professional intervention something goes wrong and the social worker and/or the agency are subject to inquiry, a decision strictly based on the integration of the different components of the EBP process is likely to be significantly more defensible than one based on wild information, opinions of colleagues or authorities). Thus, rather than as an instrument to undermine social workers' professional autonomy, EBP is presented as a vehicle for newly qualified social workers and practitioners in general, to make more informed, effective and ethical decisions, which, in turn, should reinvigorate social work's professional practice against increasing bureaucratic control and loss of professional autonomy (McDonald, 2003).

Indispensably because of the emergent spirit of EBP in social work education, the evidence of its impact in preparing students for professional practice

is limited on an excellent research opportunity for those interested in this area. It is probably too soon to provide any conclusive evidence of the effectiveness of an EBP approach in this field but when it is discussed advantages and disadvantages of EBP implementation in social work trainings, it would be advisable to clarify following: what are the outcomes on which the success of such study actually depend? While it seems reasonable to assume that teaching students about the level of effectiveness of major methods of assessment and intervention would result in more critical and informed professionals (the relevance of EBP becomes less clear when success is based on indicators such as achievement of funding targets, student numbers and student retention rates) (Czarnecki, 2013).

Full adoption and implementation of EBP in social workers remains elusive. The studies on the professional socialization of student social workers remains sparse, particularly in comparison to the socialization literatures for professions such as medicine or nursing (Suvada, 2010). The process by which social workers are socialized to value some knowledge innovations such as EBP and not others remains poorly understood. Interestingly, in one study encompassing four disciplines, social workers were unique among professionals for reporting that new knowledge and innovations were valuable to them, because they could use the information in encouragement of their client's needs, often invoking the word advocacy to describe their continuing education activities.

GENERAL REVIEW CONCLUSION AND RECOMMENDATIONS FOR PRACTICE

Several researchers have made general and wide recommendations for dissemination of evidence into the practice. First of all, it is essential to secure organizational and practitioner buy-in (Mullen, 2004). Before any real progress is made toward dissemination stakeholders and policymakers must both agree that EBP is valuable and important enough to valuation a commitment of time, space, staff, training, and other resources. Leadership is a crucial ingredient for change in this area (Barratt, 2003). Although the dissemination of EBPs must occur at all levels, important issues such as protecting practitioner time for research and training as well monitoring and following up on implementation activities must be guided by administrators and other persons or agencies with authority. Also, some authors have described the importance of establishing a network of local organizations and implementors so that they can pool resources such as training and research, become actively involved, and

develop broad community goals (Anderson, 1999; Howard, 1999). McKay and colleagues stress the importance of training and the establishment of an "engagement team" consisting of intake workers, clinical and administrative staff, and supervisors who oversee the implementation of interventions at each site (McKay, 2004). Commissions and practitioners cannot be realistically expected to "go it alone" on tight budgets, timelines, and a research base that is a moving target. A much more efficient approach seems to be one of networking and sharing with other social workers, community organizations, educational institutions, and other stakeholders. In essence, the research evidence on the use of EBPs has not been well developed. "Researchers have been relatively oblivious to the processes by which knowledge, once developed, might be effectively disseminated and used" (Kirk, 2002).

CONCLUSION

Evidence-based practice would allow social work students to become competent and highly resourced practitioners, more able to challenge ineffective practice and promote change within their organisations. However, EBP also involves dealing with the uncertainty derived from the existence of inconclusive or conflicting evidence, or just simply the lack of it, and this poses a major challenge to 'a society that is uncomfortable with change and uncertainty'. In fact, factors such as risk aversion and the reinforcement of the role of students as consumers of higher education services may result in standardised approaches to teaching that tend to make the learning experience as safe and satisfactory as possible but which might encourage students to become just passive customers instead of self-directed learners (Furedi, 2004). For example, university students are increasingly provided with user-friendly, digestible pieces of information as well as with prescriptive assessment guidance that, having the apparent advantage of minimising uncertainty and unnecessary effort, are hardly compatible with a genuine development of critical thinking skills and the very notion of the evidence-based practitioner (Suvada, 2010).

This is a challenge that like the others outlined in this paper, faces social work education in its efforts to implement EBP. As Austin and Claassen (2008) point out, EBP implementation is not a straightforward process but a complex one that requires considerable planning and resources.

However, in the literature reviewed, there is general agreement that, if social work education overcomes the difficulties involved in this process, it will

be able to make a significant contribution not only to the education of newly qualified social workers as resourced and critical practitioners but also to increasing the influence, credibility and autonomy of social work as a profession (Lishman, 2011).

To encourage practitioners to implement EBPs a unified approach that incorporates the best of all of the strategies outlined above and addresses the major barriers identified in this paper:

1. Increase EBP education (particularly at the master's level) as well as access to high quality continuing education based on EBPs.
2. Build partnerships toward sharing EBP resources, including technology, training, and technical assistance, between agencies and practitioners.
3. Facilitate buy-in and ownership of EBPs at all levels of stakeholders including practitioners, administrators, researchers, policy makers, and community members.
4. Translate research into user-friendly, digestible, and specific approaches, providing tools such as tool kits, guidelines, and technical support to both support and encourage the use of EBPs.
5. Improve the communication, feedback loop and relationship between researchers and practitioners.
6. Increase the number of EBPs available to the field.
7. Test the different types and mechanisms of dissemination, perhaps through analyses based on a taxonomic framework like the one proposed by Walter to organize future research efforts (Walter, 2003).

The most important factor in facilitating change toward the use of research in Professional practice is whether or not the profession wants to change (Bellamy, 2006). As the call for EBP in mental health services grows, social workers will benefit by being more research-minded and thereby improve services for their clients. The call for the use of research evidence in practice is not limited to a trend of policy, but is also aligned with the professional code of ethics (NASW, 1996) and meeting the expectations of an increasingly savvy consumer movement in mental health (Bellamy, 2006). Major national reports, which often shape federal and private funding streams, continually call for the use of research-supported interventions. However, policies that encourage, if not require, the use of EBPs cannot succeed without adequate training, resources, technical assistance and other infrastructure support necessary to deliver evidence based mental health interventions. Even if social workers endorse the value of EBP, practitioners and administrators may not have the knowledge or the resources to implement research based practices. The search for research evidence alone is difficult, and

the more complicated the decision the less available the evidence (Gray, 1997; Czarnecki, 2013). Additional demonstration projects, and research and policy efforts aimed at moving EBPs into community based organizations there-by building professional and organizational capacity are needed to address these and other barriers. Social workers are poised to move this work forward by transferring the increasingly broad and sophisticated body of research mindfully into the hands of the community agencies and practitioners.

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THE STRUCTURE OF THE SOCIAL WORK SUPERVISORS IN SLOVAKIA

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Key words:

supervision; social work; structure; probe

Abstract

Act No. 305/2005 on socio-legal protection of children and social care as amended entered Supervision in social work in Slovak legislative system. In this way acquires professionalization of the helping professions considerable edge over other countries in Central Europe. Continuously starts a discussion regarding importance of supervision as a method, which results in order to incorporate these issues into Act no. 448/2008 on social services and on amending and supplementing Act no. 455/1991 on Trade Licensing (Trade Licensing Act), as amended. Interested in supervision, as well as its performance, has increased in last five years. This initiated us to perform the first probing between supervisors in the field of social work in Slovakia. The article shows the part that analyses the structure of supervisors in Slovakia.

INTRODUCTION

Specific characteristics that social work supervisor who works in the helping professions should have are altruism, willingness to help, ability to cross-cultural work, flexibility in the methods and interventions, to be open to new knowledge and approaches, etc.

However, a good supervisor must be a good teacher and a good adviser in one. Supervisor respects his/her supervisees' personality, their progress as professionals, is sensitive to individual differences (race, ethnicity, gender, etc.). Supervisor's authority and competence is seen as a natural part of the supervisor's role. A good supervisor is pleased to be a part of the worker's professional growth. Supervisor has a sense of humour, which helps both – supervisor and supervisee, to get over a hard period during their co-operation and to gain good prospects for mutual co-operation.

Professional skills of the supervisor include extensive training and experience in working with the clients, these skills helped to the supervisor to gain a broader perspective on subject field. A good supervisor knows how to use a wide range of the supervisory interventions and can properly select the one that is the most suitable for his/her supervisees according to their learning needs, learning style and personal

characteristics. Supervisor continues to develop through continuous learning, self-evaluation, feedback from supervisees, clients, other supervisors and colleagues.

A good supervisor has the characteristics of a good teacher - can properly apply the teaching theory, appreciates the efforts of the supervisee to learn, but also is a good adviser - objectively evaluates the problematic situation, provides alternative perspectives and concepts of problem situations, directs the search for solutions and so on.

These facts ignited us to provide the first probe focused on a wide-ranging analysis of the structure and of encouraging the further research activities between Social work supervisors in Slovakia.

RESEARCH GOALS

The goal of the quantitative research was to capture the feedback from the supervisors who operate in Social work in Slovakia and to find out their gender, age, educational and professional structure, as well as to diagnose the fields and sectors in their professions.

RESEARCH METHODOLOGY

To collect empirical data, we used a questionnaire from our own provenance. When developing the questionnaire we used pre-research activities and consultation of renowned experts on a subject. Collection of empirical data in the representative survey was provided by electronic tool ProSurvey.

For statistical testing, we used the test of a 'good match' χ^2 . If the level of significance – p-value (Sig.) of the test used was less than 0.05, we accept an alternative hypothesis according to our data. The range of the deviation between the actual and expected frequency, as well as its direction points z-score (criterion z). As a significant difference we considered when the value of criterion z was greater than 1.96 or less than -1.96.

RESEARCH RESULTS

141 supervisors who work in the field of Social work and have appropriate education and experience entitling them to perform this work have participated in the research. Sample of 40.86% from the base file that we had identified participated in the research. We consider this proportion as representative- offering and effective probe into the phenomenon analysed by us and providing us sufficient feedback. The first demographic data observed and defined was the gender. In this case we also offered an option that the gender question doesn't need to be answered. In 9 cases this option was chosen (6.38%).

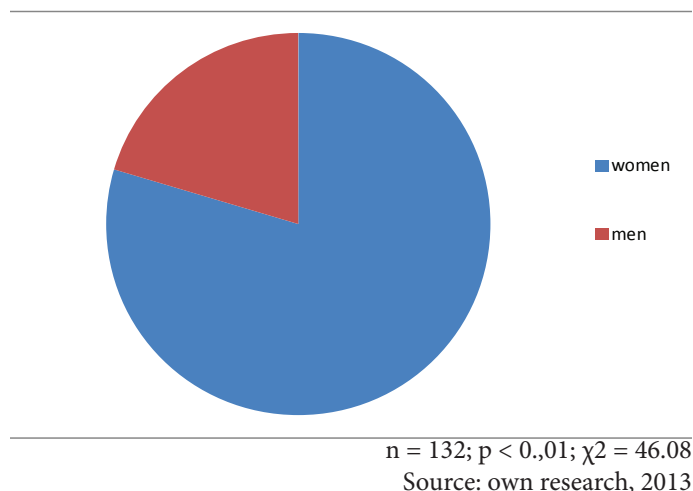
Table 1. Structure of supervisors in Social work in Slovakia by gender – the sample

Men	Women	No answer
19.15 %	74.47 %	6.38 %
$z = - 3.57$	$z = 10.36$	$z = - 6.78$

$n = 141$; $p < 0.01$; $\chi^2 = 110.8$
Source: own research, 2013

The results point at the statistically significant representation of women as supervisors in Social work profession. In our research we identified women in 105 (74.47%) cases, while men in 27 (19.15%) cases. To compare with the basic file we display graphically the gender distribution of the supervisors without the respondents who didn't respond to this question. 132 supervisors provided the information about their gender, 79.64% (105) were women and 20.45% (27) were men.

Figure 1. Graphical display of the structure in Social work supervisors in Slovakia by gender – the sample



When analysing the sample we were also interested in knowing in which region the supervisor works. According to the pre-research activities we decided to retain the possibility of the multiple responses. There is a possibility that several autonomous regions might represent one catchment area for the supervisor. N in this case doesn't indicate the number of the respondents but the number of their choices.

Looking at the result of the test criterion χ^2 we can conclude homogeneous distribution of catchment areas in Social work supervisors in Slovakia. The criterion z significantly pointed at the large deviation between actual and expected multiplicity in Banská Bystrica region, Košice region, Prešov region and Trenčín region. These differences are, of course the consequence of different geographical features, which in the context of supervisory activities reflect the need of its performance in such areas.

Table 2. Geographical distribution of catchment areas in Social work supervisors in Slovakia by regions - the sample

Region	%	z-score
Banská Bystrica	18,44	2,32
Bratislava	15,60	1,21
Košice	19,86	2,88
Nitra	13,48	0,38
Prešov	17,73	2,04
Trenčín	7,09	- 2,11
Trnava	10,64	- 0,72
Žilina	15,60	1,04

Another demographic characteristic we studied was the supervisors' age structure. Respondents were offered the option to insert themselves into age

range that differentiated for/to 10 years. In terms of age distribution, the Social work supervisors in Slovakia are not a homogeneous group. This situation is understandable, acceptable and even desirable. Looking at the results, we can see significant dominance in the age interval 31-40 years and 41-50 years. As we can see these are the professionals who are on the top of their worklife prime, the professionals that we can assume sufficient work experience, who can offer professional view to the third, disinterested party and who would lead to more effective Social work.

Table 3. Age structure in Social work supervisors in Slovakia - the sample

Age	%	z-score
20 - 30	5,67	- 4,25
31 - 40	41,13	6,27
41 - 50	35,46	4,58
51 - 60	15,60	- 1,30
61 and more	2,13	- 5,30

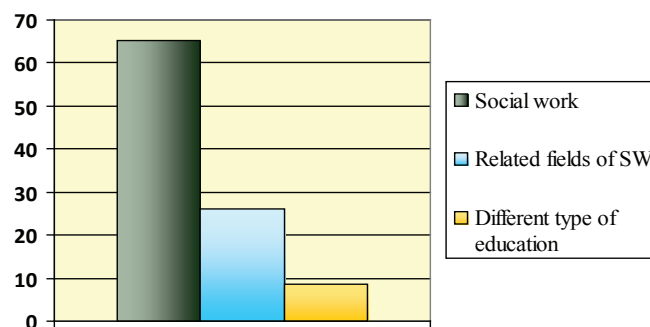
Education is an important condition to perform supervisory activities. Nowadays, the education condition is at least the second level of university degree - Master degree in a field of Social work or related field of study. It is an adjective 'related' that very often causes much embarrassment. Clearly defined by Act. 448/2008, what we presented in a basic file description. But it is only related to a social services supervision performance. Moreover, the act does not address other forms of education such as doctoral studies, rigorous continuation in the field of study, university extension study in related fields and others that often exceed the framework of the second level education. Another controversy raises the ability of social work (and hence supervision in social work) to maintain the purity of their own scientific and professional profiling. It is also important to ask whether such purity is desired and needed in today's holistic understanding of science.

For these reasons, we have decided to focus our attention even on this area. Educational profile was recorded using three categories:

1. Social work
2. Related field of Social work and
3. Different type of education

92 (65.25%) supervisors out of 141 had Social work university degree, 37 (26.24%) supervisors had related field of study, 12 (8.51%) supervisors had different type of education.

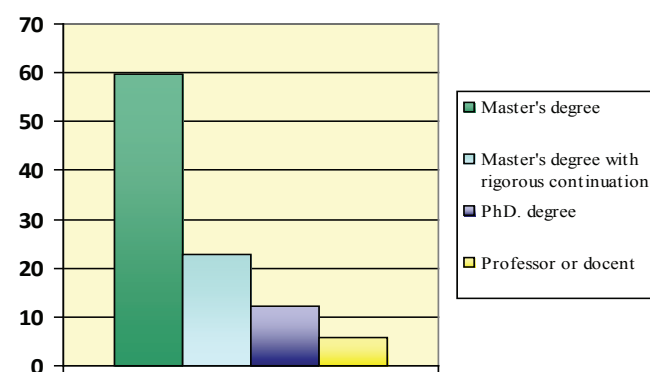
Figure 2. Educational profile of supervisors in social work in Slovakia - the sample



n = 141; p < 0.01; $\chi^2 = 71.26$
Source: own research, 2013

We followed educational profile of the supervisors from the point of the highest academic or scientific degree achieved. It is a very well-known fact that the supervisors are often professionals who enhance their professional competences during their whole career. This fact was confirmed.

Figure 3. Educational profile of supervisors in social work in Slovakia achieved by an academic degree - the sample



n = 141; p < 0.01; $\chi^2 = 98.21$
Source: own research, 2013

Over 40% of the supervisors who participated in our research achieved higher degree than the second level of the university degree. 59.57% (84) of the supervisors involved in our research achieved the second level of the university degree, 22.70% (32) achieved the second level of the university degree plus further, rigorous degree, the third level of the university degree was achieved by 12.06% (17) supervisors involved, scientific-pedagogical university teaching degree 5.67% (8).

As we have already mentioned earlier, own professional experience is extremely important for the supervisor's performance in social work. Therefore, this has become the subject of our interest. We are pleased to confirm that nowadays supervisors have sufficient experience to perform their profession. Only 7.8% (11) of the analysed sample supervisors

have professional experience in social work less than 6 years and more than 58.8% (83) have professional experience in a range of 11 years and more. Generally acceptable limit of the professional experience in a range of 6-10 years is fulfilled by statistically significant proportion of the supervisors – 33.3% (47).

Table 4. Range of the professional experience of the social work supervisors in Slovakia - the sample

Years	%	z-score
0 - 5	7,80	- 2,19
6 - 10	33,33	6,46
11 - 15	21,99	2,61
16 - 20	17,73	1,17
21 - 25	12,06	- 0,75
26 - 30	2,13	4,12
31 and more	4,96	- 3,16

n = 141; $p < 0.01$; $\chi^2 = 70.61$
Source: own research, 2013

In terms of professional experience analysis we were not satisfied just with a clear statement of its length. We were also interested which were the fields of performance do the professionals perform the most. There is a clear domination of the social services field.

As many as 47.52% (67) of the supervisors who participated in our research identified themselves in this context, Equally interesting finding is the relatively low level of the professionals who are active in the fields of management and governance of the social subjects – 2.84% (4).

Table 5. Fields of the social work supervisors' professional experience in Slovakia – the sample

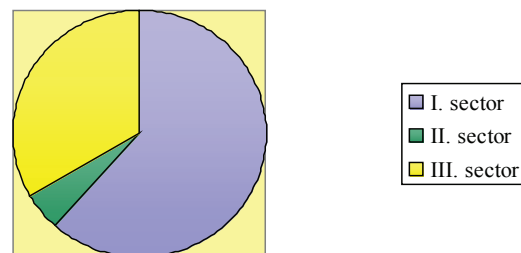
Fields	%	z-score
Education and research	9.92	- 2.14
Socio-legal protection	20.57	1.24
Social services	47.52	9.83
Street work and community social work	9.22	- 2.37
Management and governance of the social subjects	2.84	- 4.40
Others	9.92	- 2.14

n = 141; $p < 0.01$; $\chi^2 = 110.35$
Source: own research, 2013

Another studied entry in the context of the social work supervisors' characteristics concerns their professional orientation. We were interested in the

proportion of their identification in the sector allocation.

Figure 4. Sector allocation of the social work supervisors in Slovakia - The sample



n = 141; $p < 0.01$; $\chi^2 = 68.08$
Source: own research, 2013

Sector I. is characterized as a state and public sector, 61.70% (87) supervisors who participated in our research work here. This sector consists of the subjects that are connected to the state budget, these subjects are contributory organizations. 4.96% (7) supervisors work in sector II.. These are individuals or the organisations established for the purpose of income production. This sector is also called private sector or profitable business sector. Sector III. consists of the organisations that are not included in the sector I. and II. It is a non-government sector, non-profit sector. It is financially and organisationally independent from the state. 33.33% (47) of our respondents chose sector III. as a field of their occupation.

CONCLUSION

Structure of the respondents pointed out that the typical supervisor is a woman aged 31-40 years with the second level of the university degree and a field of study is a social work, she has been working for 6-10 years in this field. This simplified generalization is made only on the bases of the modus recorded in individual responses, of course. Research results of the wide analyses of the structure of social work supervisors in Slovakia pointed at a high level of feminization in this field. Proportional representation of women is almost 80%. We are pleased to find out that more than 40% of the supervisors have the second level of the university degree and more than 58% have professional experience for 11 years and more. Supervisors in social work in Slovakia are therefore qualified and professionally proficient group of experts.

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THE LEVEL OF PATIENT SATISFACTION WITH OUTPATIENT CHEMOTHERAPY ADMINISTRATION.

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Key words:

patient satisfaction; outpatient chemotherapy administration; telephonic services in Health facilities

Abstract

The authors deal with the statements of patients receiving outpatient chemotherapy administration. Through a questionnaire survey they look for the level of satisfaction of patients with approach of physician and nurses in health and nursing care, they pay attention to feelings related to the nursing care, outpatient care environment, waiting times and telephone services in health facilities. Patients are undergoing therapeutic process and therefore they expect a change for the better, so every positive stimulus associated with their treatment is very important.

INTRODUCTION

In our research, we focused on the patients themselves, their level of satisfaction with the provision of health and nursing care, to approach of medical staff, to the issue of information about their medical condition or to the ability of nurses and doctors to answer patients' questions. Waiting times, nursing care and other factors are just as important to patients as mere treatment and nursing care.

RESEARCH PROBLEM

To determine the level of satisfaction of patients receiving outpatient chemotherapy administration in OÚSA in Bratislava with the quality of health and nursing care.

OBJECTIVES OF THE SURVEY

- O1 - Find out whether health care employees on ambulances meet the requirements of professionalism and moral of health care professional.
O2 - Identify the level of patient satisfaction with outpatient spaces in which was administered, re-

- spectively is administered outpatient chemotherapy.
O3 - Find out the level of patient satisfaction with the level of telephone connection.
O4 - Find out the level of awareness of patients regarding their health.
O5 - Find out the level of patient satisfaction with the quality of nursing care at the clinic where chemotherapy is administered.

RESEARCH METHODS

As a basic survey method we chose a questionnaire of our own design, which we evaluated and showed our findings it in tables and graphically. The questionnaire was anonymous. It contained 15 closed-type questionnaire items and 1 item with free answers. The survey was conducted in the period from 25 April 2008 to 16 November 2009.

WORKING HYPOTHESES

- H1 – We assume that most patients are satisfied with management, organization and location of outpatient facilities in which patients received chemotherapy treatment.
H2 – We assume that medical and nursing care and

holistic approach of health professionals in relation to the patient is at the professional level.

H3 – We assume that most patients are satisfied with the level of information about their medical condition.

H4 – We assume that most patients are satisfied with the availability and quality of telephone connection.

CHARACTERISTICS OF SURVEY POPULATION

A core set of respondents were patients treated with the outpatient chemotherapy in OÚSA Bratislava in the total number of 250 patients. Age of the respondents was 29 - 65 years.

Table 16.

Sex	n	%
Male	80	32
Female	170	68
N	250	100

Table 17.

Residence	n	%
Urban	200	80
Rural	50	20
N	250	100

Table 18.

Status	n	%
Single	40	16
Married	150	60
Divorced	20	8
Widower	30	12
Companion	10	4
N	250	100

Table 19.

Highest completed education	n	%
Basic	20	8
Secondary	10	4
Secondary with GCE	140	56
College	80	32
N	250	100

ANALYSIS OF SURVEY RESULTS

H1 – We assume that most patients are satisfied with the organizational work placement and outpatient facilities

Table 1.

Are you satisfied with waiting time for treatment in the clinic?	n	%
Yes, it is reasonable	150	60,0%
I do not know, I do not care	20	8,0%
I do not like it, it is too long	80	32,0%
N	250	100%

Table 2.

How do you feel in the waiting room?	n	%
It is nice	160	64,0%
It is cramped and dark	90	36,0%
I do not know, I do not care	0	0,0%
Dingy and dirty	0	0,0%
N	250	100

Table 3.

Are you satisfied with ambulance office hours?	n	%
Yes	230	92,0%
No	0	0,0%
I do not know, I do not care	20	8,0%
N	250	100%

Table 4 .

How do you assess the organization of entry into the ambulance?	n	%
It is very well organized	40	16,0%
Passable	160	64,0%
It is very tedious	50	20,0%
Unsuitable	0	0,0%
N	250	100%

H2 – We assume that medical and nursing care and approach of health workers in relation to the patient is at a high professional level.

Table 5.

How do you rate the approach of nurse that brought you into ambulance?	n	%
Very good	200	80,0%
Good	50	20,0%
Passable	0	0,0%
Poor	0	0,0%
Do not know	0	0,0%
N	250	100%

Table 6.

Are you satisfied with practicing physician?	n	%
Yes	210	84,0%
I do not know	40	16,0%
I am not satisfied	0	0,0%
N	250	100%

Table 7.

How do you assess the willingness of nurses to address and answer your questions?	n	%
Very good	190	76,0%
Good	60	24,0%
Passable	0	0,0%
Poor	0	0,0%
I do not know, I did not have questions	0	0,0%
N	250	100%

Table 9.

What is your overall impression of the level of patient care?	n	%
Very good	140	56,0%
Good	70	28,0%
Passable	40	16,0%
Poor	0	0,0%
I do not know	0	0,0%
N	250	100%

Table 10.

Would you recommend our clinic chemotherapy, if necessary, to your friends?	n	%
Yes	210	84,0%
I do not know	40	16,0%
No	0	0,0%
N	250	100%

H3 – We assume that most patients are satisfied with the level of information about their medical condition.

Table 11.

Information from the doctor about your illness was?	n	%
Sufficient	190	76,0%
Can not judge	60	24,0%
Insufficient	0	0,0%
N	250	100%

Table 12.

Have you been informed about the way of administration of chemotherapy and its side effects?	N	%
Yes	220	88,0%
I do not know	30	12,0%
No	0	0,0%
N	250	100%

Table 13.

Do you understand all the information and instructions provided by your doctor?	n	%
Yes, I understand everything	190	76,0%
Yes, but I understood only certain information	60	24,0%
No, I do not understand everything	0	0,0%
N	250	100%

H4 – We assume that most patients are satisfied with the accessibility and the level of telephone connection

Table 14.

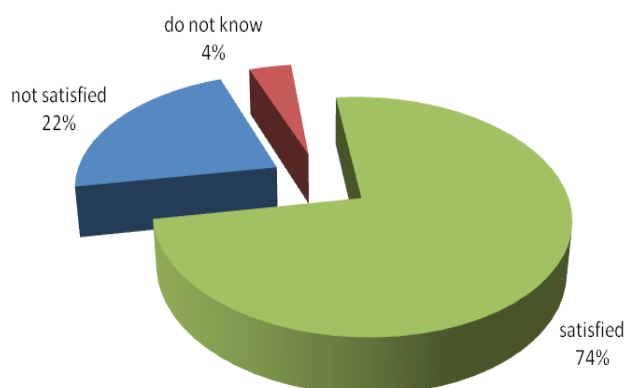
How do you rate telephone connection with ambulance?	n	%
Very good	170	68,0%
Good	60	24,0%
Passable	20	8,0%
Poor	0	0,0%
I do not know, I have not tried it	0	0,0%
N	250	100%

Table 15.

How do you rate willingness of a worker's who took your phone call?	n	%
Very good	180	72,0%
Good	60	24,0%
Passable	10	4,0%
Poor	0	0,0%
I do not know, I did not call	0	0,0%
N	250	100%

In working hypothesis H1 we assumed that a majority of respondents - patients will be satisfied with the organizational work and with location of out-patient facilities in which they administered chemotherapy. This working hypothesis was verified in items 3, 4, 5 and 6.

Figure 1.

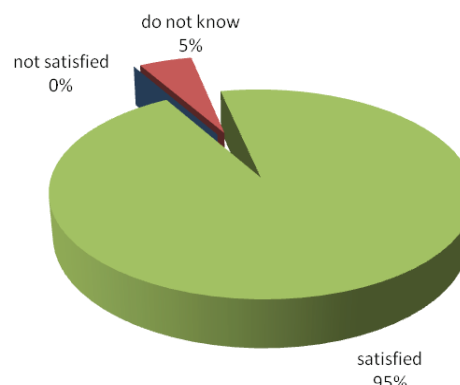


We found that 74% of respondents were satisfied with the organization of work, 22% expressed dissatisfaction - mainly with confined space prior to the administration of chemotherapy and 4% of respondents could not express.

On this basis, we can conclude that working hypothesis H1 is confirmed.

In the working hypothesis H2 we assumed that health care of workers to patients is at a high professional level. The working hypothesis was verified by items 7, 8, 12, 13 and 14.

Figure 2.

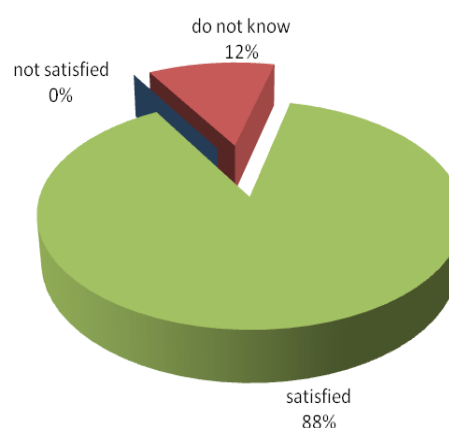


We found that 95% of respondents rated the medical and nursing care as very good and at a high professional level, 5% of respondents reported that medical and nursing care was at the professional level.

On this basis, we can conclude that working hypothesis H2 is confirmed.

In the working hypothesis H3 we assumed that patients are satisfied with the information provided on their health. The working hypothesis was verified items 9, 10 and 11.

Figure 3.

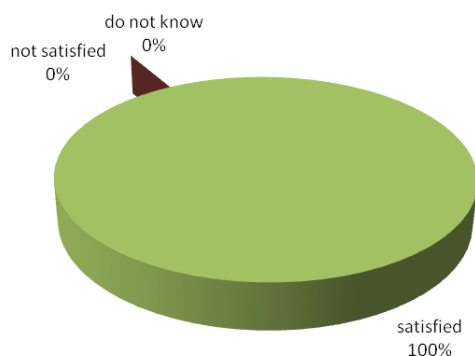


We found that 88% of respondents were satisfied with the level of provided information about their health and 12% of respondents were unable to comment on the issue.

On this basis, we can conclude that working hypothesis H3 is confirmed.

In the working hypothesis 4 we assumed that most patients will be satisfied with the possibilities and the level of dial-up connection. The working hypothesis was verified in items 1 and 2.

Figure 4.



We found that up to 100% of the respondents were satisfied with the level and options of telephone connection.

Based on our findings, we can conclude that working hypothesis H4 is confirmed.

RECOMMENDATIONS FOR PRACTICE

- Nurses and doctors should treat the patient, so that right from the first contact they should have confidence in them and should not feel that their multiple issues are “burden or time consuming”
- Nurses should be particularly attentive to nonverbal and verbal expressions in contact with patients
- Ensure that there are enough information brochures in the waiting room - as newsletters, journals about diseases, diet for patients that are an important source of information
- Provide information panel (wall) with information on the nearest store with assistive devices, wig studies and the like
- Nurses should pay attention to their behaviour and demeanour even in telephone contact with the patients and their family members
- Leading nurses and nurses should implement surveys to monitor levels of patient satisfaction with health and nursing care, draw conclusions, and thus constantly improve their nursing care and

clinical practice.

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RISK OF RECURRENCE IN PATIENTS WITH COMPLICATION OF HYPERTENSION AND CARDIOVASCULAR RISK OF THEIR RELATIVES

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Key words:

complications of hypertension; cardiovascular risk; home care nursing

Abstract

The aim of this study is to evaluate global risk of home care patients with manifest cardiovascular disease as well as to evaluate global risk of first-degree relatives of these patients to be able to start adequate education of every risk person in family.

Methods: Prospective analytic study used questionnaire method. Respondents were 100 patients with complication of hypertension in care of Home care agency SANAS Topolcany and other Home care agencies in Slovakia (group A) and 50 first-degree relatives of patients with complication of hypertension which are or which were in care of Home care agency SANAS Topolcany (group B).

INTRODUCTION

Nurses of home care agencies (HCA) are often meeting with patients with severe complication of hypertension, mostly cerebral stroke. These patients are immobile, completely dependent in activities of their lives. The reason of this situation is that hypertension is often untreated or treated without effect.

Every patient with evident cardiovascular disease (CVD) is in high risk of recurrence and that is why we must provide him as much informations as possible about his illness and risk factors, which are increasing his risk. Therefore it is very important to know about the presence and severity of known risk factors in families of patients with complication of hypertension.

The aim of this study is to evaluate global risk of home care patients with manifest CVD as well as to evaluate global risk of first-degree relatives of these patients to be able to start adequate education of every risk person in family. The questions are:

- Are patients with complication of hypertension and their first-degree relatives (son, daughter) endangered by risk factors of incorrect life-style?
- Are the patients with complication of hypertension endangered by the recurrence of complications?
- What is global cardiovascular risk in their first-

degree relatives?

METHODS

Research problem in this work was related to „risk population“. This population are:

1. Patients with underwent complication of hypertension (cerebral stroke, ischemic heart disease, atherosclerosis of lower extremities)
2. first-degree relatives of these patients.

To be able to evaluate global risk of patients recurrence and the global risk of CVD of their relatives we determined two hypothesis.

Hypothesis No. 1: We suppose that majority of patients with complication of hypertension is in high risk of recurrence of complication of hypertension.

Hypothesis No. 2: We suppose that majority of first-degree relatives in families of patients with complications of hypertension has mild or high added risk of cardiovascular disease.

Respondents were divided into two groups:

First group of respondents (group A) were 100 patients with complication of hypertension in care of Home care agency SANAS Topolcany and other Home care agencies in Slovakia. Second group of respondents (group B) were 50 first-degree relatives of patients with complica-

tion of hypertension which are or which were in care of Home care agency SANAS Topolcany. Entrance criteria were age 18 – 100 years. Collection of data was done in second half the year 2012.

Our study is prospective analytic study which used questionnaire method (questionnaire with 53 items about patients knowledge and life style) completed with clinical and biochemical record and with statistical evaluation. Clinical and biochemical record was fulfilled by nurse of HCA after return of questionnaire. This record provided information about weight, belt circumference, hips circumference, blood pressure, glycaemia and cholesterol level. All investigations were done by standards: Recommendations for regular practice (1) and Recommendations for optimal diagnosis and treatment of dislipoproteinaemia in adults (2). During identification of modifiable risk factors CVD we used Methodic manual for work in advisory centers of health (3) and Guidelines for management of arterial hypertension (4).

All data were analysed in program MS EXCEL 2010 using its statistic functions and calculations in contingent tables. Hypothesis were tested by Binomic test on the level of importance $p = 0.05$.

On the basis of identified fix and flexible risk factors we set cardiovascular risk (CVR). For determination of risk indexes in patients with complication of hypertension in HCA we used Setting of global risk of ischemic heart disease, which is shown in Methodic manual for work in advisory centers of health.(Table 1)

In the risk-relatives we used system for estimation of individual cardiovascular SCORE, which is possible to use in primary prevention in individuals without ischemic cardiac disease (Table 2). After setting the global risk, we recommended to the relatives

with mild or high added risk to visit the general practitioner.

Table 1. Grade of risk in accordance with number of risk factors

Grade of risk	
Low	History + 0 or 1 risk factor
Middle	History + 2 risk factors
High	History + 3 risk factors
Very high	History + 4 or more risk factors

Source: Avdicova, 2000

In the risk-relatives we used system for estimation of individual cardiovascular SCORE, which is possible to use in primary prevention in individuals without ischemic cardiac disease (Table 2). After setting the global risk, we recommended to the relatives with mild or high added risk to visit the general practitioner.

RESULTS

Distribution of patients and first-degree relatives by number of observed risk factors is shown in the Table 3 and Figure 1.

In this part of research we evaluated every respondent individually and we found out that only 1% of patients and only 1% of relatives has none observed modifiable risk factor. Presence of 5 or more risk factors was in 20% of patients and in 24% of relatives.

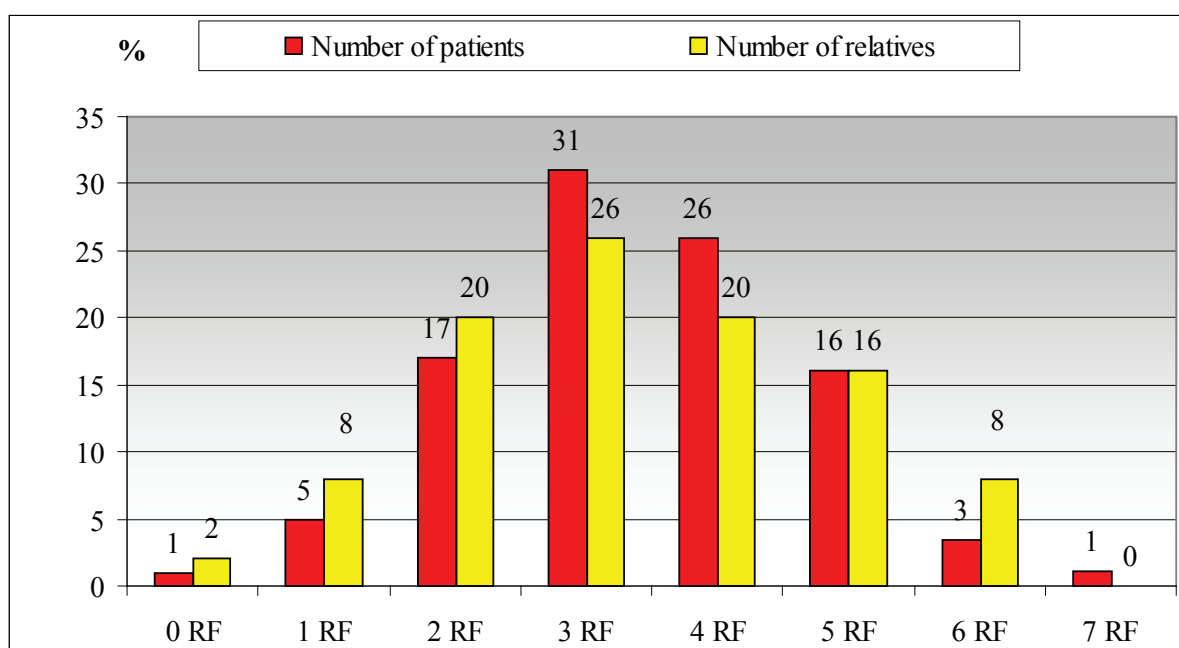
Table 2. Stratification of cardiovascular risk for determination of prognosis

Other risk factors and history of other diseases	BP normal 120-129/80-84	Higher normal BP 130-139/85-89	1. degree 140-159/ 90-99	2. degree 160-179/ 100-109	3. degree ≥180/≥110
No other risk factors	Average risk	Average risk	Low added risk	Mild added risk	High added risk
1 – 2 risk factors	Low added risk	Low added risk	Mild added risk	Mild added risk	High added risk
3 or more RE, or PCO or DM	Mild added risk	High added risk	High added risk	High added risk	High added risk
Affiliated clinical conditions	High added risk	High added risk	High added risk	High added risk	High added risk

Source: Snincak, 2005

Table 3. Distribution of patients and first-degree relatives by number of observed risk factors

Number of risk factors	Number of patients		Number of relatives	
	n	%	n	%
0	1	1	1	2
1 RF	5	5	4	8
2 RF	17	17	10	20
3 RF	31	31	13	26
4 RF	26	26	10	20
5 RF	16	16	8	16
6 RF	3	3	4	8
7 RF	1	1	0	0
Σ	100	100	50	100

Figure 1. Distribution of patients and first-degree relatives by number of observed risk factors

Hypothesis No. 1: We suppose that majority of patients with complication of hypertension in care of Home care agencies is in high risk of recurrency of complication of hypertension.

Risk of recurrency was evaluated by following items and subsequently we determined number of risk factors:

Positive history of cardiovascular disease.

Blood pressure \geq BP 140 / 90 mmHg = 1RF

BMI \geq 30 = 1 RF

Glycaemia \geq 5,6 = 1 RF

Cholesterol \geq 5 = 1RF

Smoking in last two years = 1RF

Physical activity: Frequency less than 3 times a week or low intensity = 1RF

Diet: if fatty meat, vegetable less then once a day, fruits

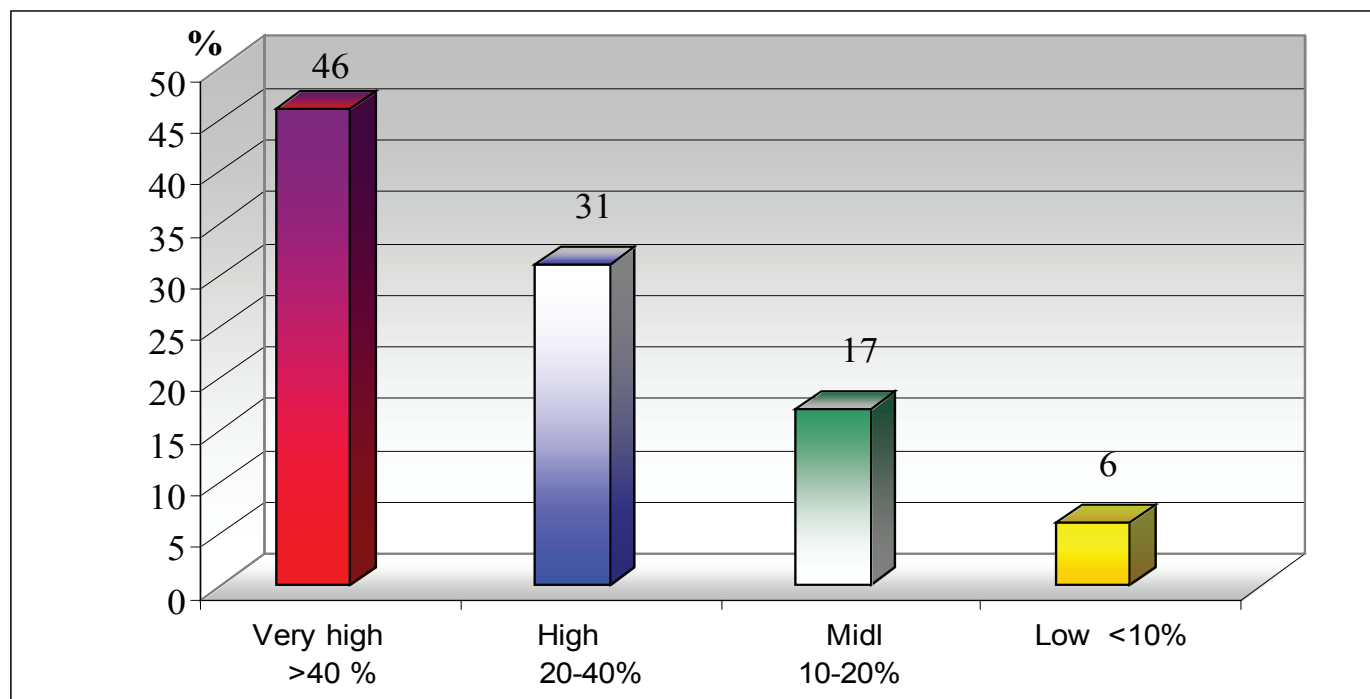
less than once a day, fatty milk or fatty yoghurts = 1 RF

According with the table demonstrating 10-years risk of cardiovascular disease we determine how grade of risk is present in particular patient (Table 4, Figure 2).

Patients with high or very high risk were placed to the group, where the high added risk is present (3 or more risk factors), patients with low and mild risk (2 and less risk factors) were placed to the group, where the high added risk is not present (Table 5).

Table 4. Classification of patients to the degrees of 10-years risk of recurrency by number of risk factors

Grade of risk	10- years risk CVD	Number of risk factors	Number of patients	%
Very high	>40%	>4	46	46
High	20-40%	3	31	31
Mild	10-20%	2	17	17
Low	<10%	0-1	6	6
Σ			100	100

Figure 2. Classification of patients to the degrees of 10-years risk of recurrency by number of risk factors

Patients with high or very high risk were placed to the group, where the high added risk is present (3 or more risk factors), patients with low and mild risk (2 and less risk factors) were placed to the group, where the high added risk is not present (Table 5).

Table 5. Ten years risk of recurrency in patients with complication of hypertension in Home care

	n	%
With high risk of recurrency	77	77
Without high risk of recurrency	23	23
Σ	100	100

Binomic test ($\alpha = 0,05$) was used: $Z_0 > Z(1-\alpha)$: $6,415854 > 1,644854$: $p < 0,05$. Difference is statistically significant.

Hypothesis No. 1 is confirmed: Majority of pa-

tients with complication of hypertension in care of Home care agencies is in high risk of recurrency of complication of hypertension.

Hypothesis No. 2: We suppose that majority of first-degree relatives in families of patients with complications of hypertension have mild or high added risk of cardiovascular disease.

Level of added risk of cardiovascular disease compare to average risk of population was determined by relation of blood pressure to number of risk factors.

BP

Normal (sBP 120-129 or dBP 80-84 mmHg)

Higher normal (sBP 130-139 or dBP 85-89 mmHg)

Hypertension 1. grade (sBP 140-159 or dBP 90-99 mmHg)

Hypertension 2. grade (sBP 160-179 or dBP 100-109 mmHg)

Hypertension 3. grade (sBP ≥ 180 or dBP ≥ 110 mmHg)

Risk factors:

The same classification as in Hypothesis 1.

The risk of first-grade relative was determined

by table of stratification for 10-years risk of cardiovascular disease (Table 6, Figure 3).

Table 6. Stratification of cardiovascular risk for prognosis in first-degree relatives

Grade of risk	Absolute 10- years risk of CVD	Number of risk factors	Number of patients	%
High	20-< 30%	5-< 8%	17	34
Mild	15-< 20%	4-< 5%	17	34
Low	<15%	< 4%	15	30
Average	0	0	1	2
Σ			50	100

Figure 3. Numbers of first-degree relatives in Home care agency group

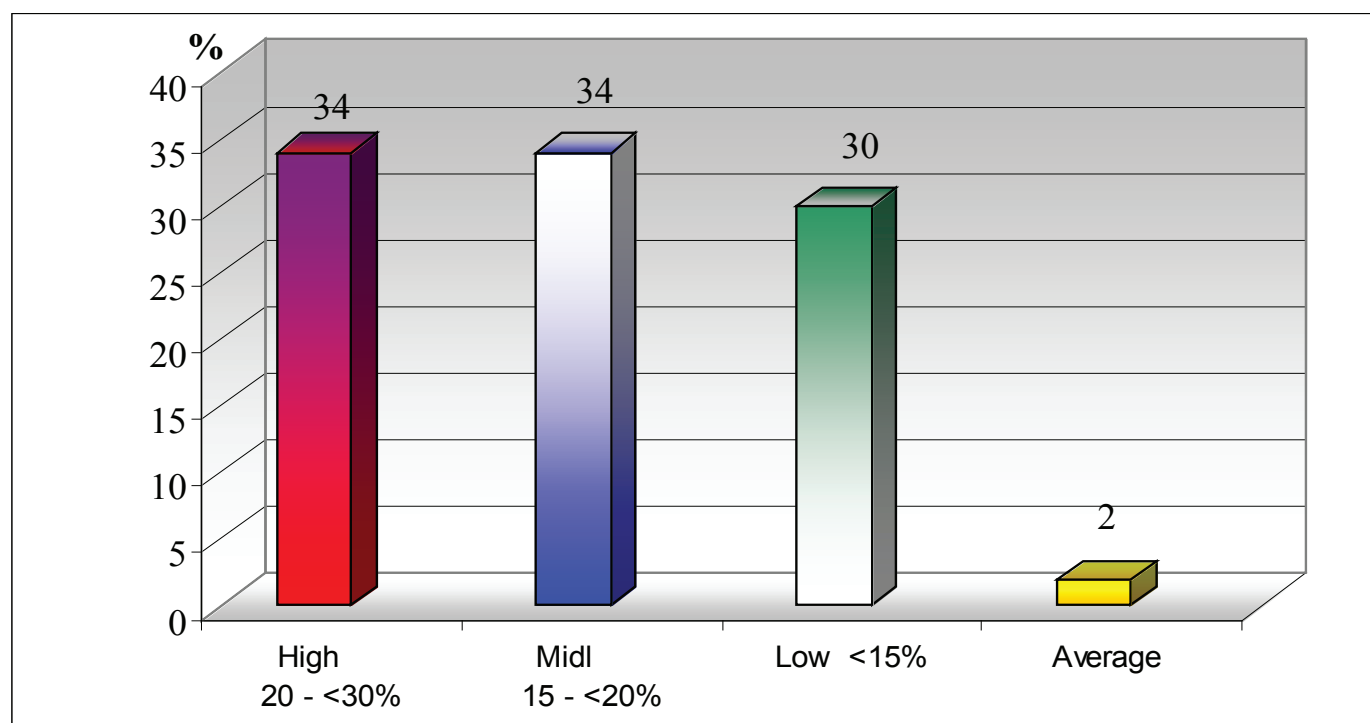


Table 7. Result of complete cardiovascular risk in first-degree relatives

	n	%
Presence of mild or high absolute 10-years risk of CVD	77	77
Non-presence of mild or high absolute 10-years risk of CVD	23	23
Σ	100	100

Binomic test ($\alpha = 0,05$) was used: $Z_0 > Z(1-\alpha)$: $2,72853 > 1,644854$: $p < 0,05$. Difference is statistically significant. Hypothesis No. 2 is confirmed: Ma-

jority of first-degree relatives in families of patients with complications of hypertension have mild or high added risk of cardiovascular disease.

DISCUSSION

For stratification of risk we used factors published in 2003 by European Society for Hypertension (5) such as BP, BMI, glycaemia, cholesterol, smoking, physical activity, DASH diet.

In the results of MONIKA project in 2002 it is quoted that 1 – 3 risk factors were detected in 85,3% respondents, but they observed only 4 modifiable risk factors (6). Raslova (7) declared that in popula-

tion of 40-years men and women 34% Slovak people had 3 and more risk factors of atherosclerosis, but they did not declared how many factors they observed. In our group of relatives there are as much as 70% respondents with more than 3 risk factors.

For setting the global risk of recurrency of Ischemic Heart Disease in the group of Home care patients we used the table, which is published in Methodist manual for work in advisory centers of health. But it is necessary to say that risk of every patient with manifest cardiovascular disease is high. It means that correction of every other risk factor in this group of patients is very important (3).

Using stratification of individual risk of recurrency of complication as well as setting of risk indexes in patients with complication we learned that 31% of patients had high risk and 46% of them had very high risk of recurrency of CVD within 10 years. It is more than 30% difference compare to the patients with manifest CVD without risk factors.

We could not find any other similar research in Slovakia concerning risk factors and risk indexes in patients with manifest CVD. Therefore we compare these results with our results from 2007 where they were different. In low grade of risk there is almost the same number of patients (6% versus 7%), in mild grade of risk we noticed increase (17% versus 10%), in high added risk is also increase (31% versus 17%) and in very high added risk with cumulation of more than 4 risk factors we noticed decrease (46% versus 64%).

In first-degree relatives we used for estimation of individual cardiovascular risk the SCORE system which is possible to use in primary prevention (8). Compare to 2007 we noticed increase in every grade of added risk compare to healthy population. Similar results are published in evaluation of prevention programmes in Slovakia. Using SCORE model it is: in 10-years risk ($\geq 5\%$) 30,1 % men and 6 % women in actual age 40 – 65 years (9).

In hypothesis No.1 we supposed that majority of patients with complication of hypertension in care of Home care agencies is in high risk of recurrency of complication of hypertension. In the group of patients of Home care 77% patients had high risk of recurrency. Our supposition was statistically confirmed. This high percentage of risk of recurrency is caused by high presence of modifiable risk factors. Therefore it is necessary to focus the secondary prevention to this specific group of patients. Practice shows that our country has big defect in care of the patients with complications of hypertension. Medicament treatment is stressed much more than education in spite of that researchs show that if education improves, self-

management of patients is improving, it leads to reduction of necessary antihypertension medicaments and risk of complications is decreasing (10). It is necessary to improve our education programmes and to engage home care nurses which have ideal possibilities to educate directly in microcommunity of patient, it means in families.

In hypothesis No. 2 we suppose that majority of first-degree relatives in families of patients with complications of hypertension has mild or high added risk of cardiovascular disease. In the group of relatives of Home care 68% of relatives had high added risk of cardiovascular disease. Our supposition was statistically confirmed. This result is even worse than published results in regular population. Therefore it is necessary to focused the primary prevention to this groups of population where risk of cardiovascular disease is genetically inherited and increased by life-style of family. One of the possibilities how to improve the care of these patients is to force the family doctors to take care of them. Unfortunately there is nonexistence of family doctors in this country.

CONCLUSION

Our work confirm our suggestions that majority of patients with complication of hypertension in care of Home care agencies is in high risk of recurrency of complication of hypertension. As it is result of lack of education of these patients, it is necessary to improve our education programmes and to engage home care nurses which have ideal possibilities to educate directly in families. Our work also confirm that majority of first-degree relatives in families of patients with complications of hypertension have mild or high added risk of cardiovascular disease. Therefore it is necessary to focused the primary prevention to this groups of population where risk of cardiovascular disease is genetically inherited and increased by life-style of family.

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TIME TREND IN TUMOR DISEASE INCIDENCE IN CHILDREN AND ADOLESCENTS IN THE CZECH REPUBLIC

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Key words:

incidence; childhood tumours; malignant neoplasm; oncology register

Abstract

The aim of the study: To describe the time trend of tumour disease incidence in children and adolescents (i.e., men and women between 0–19 years of age) in the Czech Republic over the past nineteen years of the period monitored.

Material and Methods: The available data from the National Oncology Register of the Czech Republic (NOR CR) which have been published or are freely available at the website of the Institute of Health Information and Statistics of the Czech Republic (ÚZIS) were used as the source data.

Results and conclusion: The data was obtained may serve as clearly laid out data for cross comparing tumour disease incidence in children and adolescents in the Czech Republic and other countries, as well as for efficient medical cost planning and predictive estimates of tumour disease among children and adolescents in years to come.

INTRODUCTION

The importance of malignant tumour epidemiology has been rising constantly due to an increasing number of malignant neoplasms in most of the developed countries in the world. The interest of both the professional and lay public may for the most part be explained by the growing incidence of tumour diseases, representing a significant social issue which brings serious social and economic consequences. The Czech Republic is no exception. Because the Czech Republic possesses a standard national oncology register (NOR CR) which has been systematically maintained since 1976, this article summarizes epidemiological data for malignant childhood tumours reported in the CR population over the past 19 years, i.e., from 1991 until present.

In spite of the rare occurrence of tumour diseases in children, they represent approximately only 1–3 % of the total number of tumours [1 – 3], holding second-highest position among causes of mortality in children up to 15 years of age.

Tumour diseases in children are serious both in terms of the difficulty of their detection (false differential diagnosis due to their infrequent occurrence), complicated development, aggressive treatment generating serious complications and the unfavourable prognosis compared to other childhood diseases. After traumas (accidents and injuries) they are the second most frequent cause of mortality in children. Paediatric oncology is not just the oncology of adults applied to children but an entirely independent follow-up field focused on specific issues. Paediatric oncology significantly differs from adult oncology in the occurrence of individual tumours and in terms of organ localisation. In children, most tumour diseases consist of hemoblastosis and hemoblastoma – tumours of the nervous tissue, mesenchymal cells and immature cells of embryonic leaf while 80% of the tumours in adults are represented by carcinomas [1 – 3].

MATERIAL AND METHODS

The available data from the National Oncology Register of the Czech Republic (NOR CR) which

have been published or are freely available at the website of the Institute of Health Information and Statistics of the Czech Republic (ÚZIS) were used as the source data.

The data on malignant tumour occurrence have high validity, since all the data are re-verified and their accuracy and completeness are checked. Data included in the National Oncology Register of the Czech Republic are also compared retrospectively with the death register. That is why the most up-to-date data is made available only after a delay of several years.

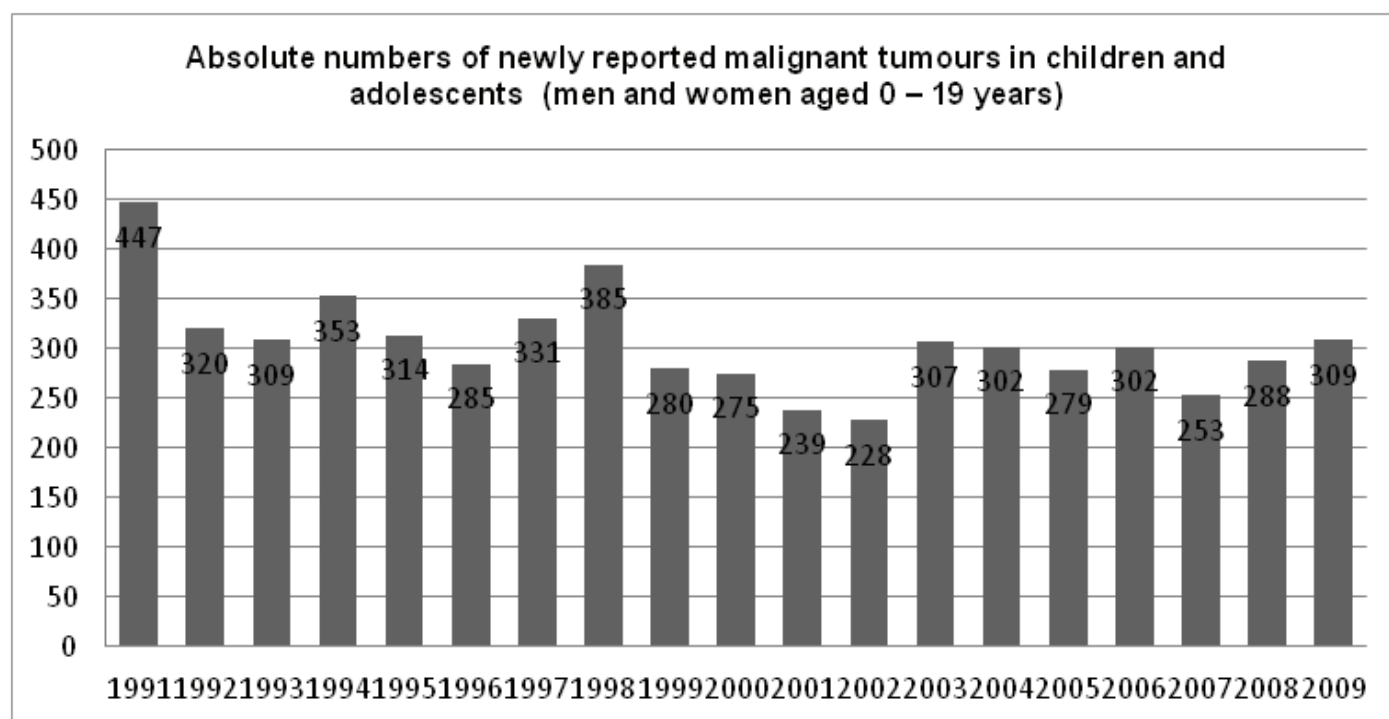
The results presented in this article come from data gathered and processed from 1991 to present [4-22]. Individual data on the incidence of the malignant tumour diseases reported were divided into four age groups (0 - 4 years, 5 - 9 years, 10 - 14 years and 15 - 19 years). The data obtained was used to prepare outputs in the form of tables and graphs expressing the temporal evolution of tumour incidence – the absolute numbers of newly reported diseases and the relative count recalculated per 100,000 men or women of the particular age group, i.e., the frequency of the newly originated diseases in the CR population in a

RESULTS

The values indicated in absolute numbers serve as basic indicators for tumour disease impact on the population. These absolute numbers indicate the number of newly reported tumour diseases during the monitored period in the population studied. In this case, the absolute numbers indicate how many new malignant neoplasm diagnoses were made under the MKN-10 (dg. C00 – D09) code in children and adolescents in the Czech Republic in the particular age group per year. These characteristics are particularly suitable for designating oncology care capacity demands; they are less suitable for comparing various populations or determining the time trend development.

Figure 1 and 2 depict the temporal trend in absolute numbers of malignant neoplasm and in situ neoplasm cases (dg. C00 – C96 and D00 – D09 according to MKN-10) in the set monitored. Both graphs allow the dynamics of tumour disease incidence in children and adolescents to be followed during individual years over the period monitored. Both figures show oscillation of the absolute numbers of newly reported

Figure 1. Absolute numbers of newly reported malignant tumours in children and adolescents (men and women 0 – 19 years)



particular calendar year in the period monitored. To depict the time trends better and to increase the layout clarity, bar graphs were selected to depict the absolute numbers of malignant neoplasm incidence (Figure 1 through 7) and line charts to depict the relative numbers of incidence in individual age groups (Figure 8 through 11).

neoplasms during individual years. In spite of the fact that a duty to fill in a report on neoplasms is a matter of law and the Neoplasm Report form must be submitted by the medical facility diagnosing the oncological disease, active collaboration by all medical facilities and their employees is of key importance for creating valid data. It is important that

maximum support for quality and the timely nature of the data entered in the national oncology register is provided for by employees of individual medical facilities, since reporting morale may influence the individual numbers of new disease cases, as well.

Figure 2 also shows that during the 1990s, higher numbers of malignant neoplasm were reported in men. After 2001, the absolute numbers of newly reported tumours for both sexes in the same year are balanced or slightly higher in men.

Figure 3 depicts the total absolute numbers of newly reported malignant tumours in by individual age groups in the set studied. The figure shows the highest numbers of newly determined tumours in children are in the adolescent age group between 15–19. This age group in the set also has a higher risk of tumour development than children younger than 15 years, based upon the prerequisite of longer carcinogenic exposure, cell aging and the related decrease in changes (decrease in telomerase, somatic mutations, etc.).

Figure 2. Absolute numbers of newly reported malignant tumours – by sex

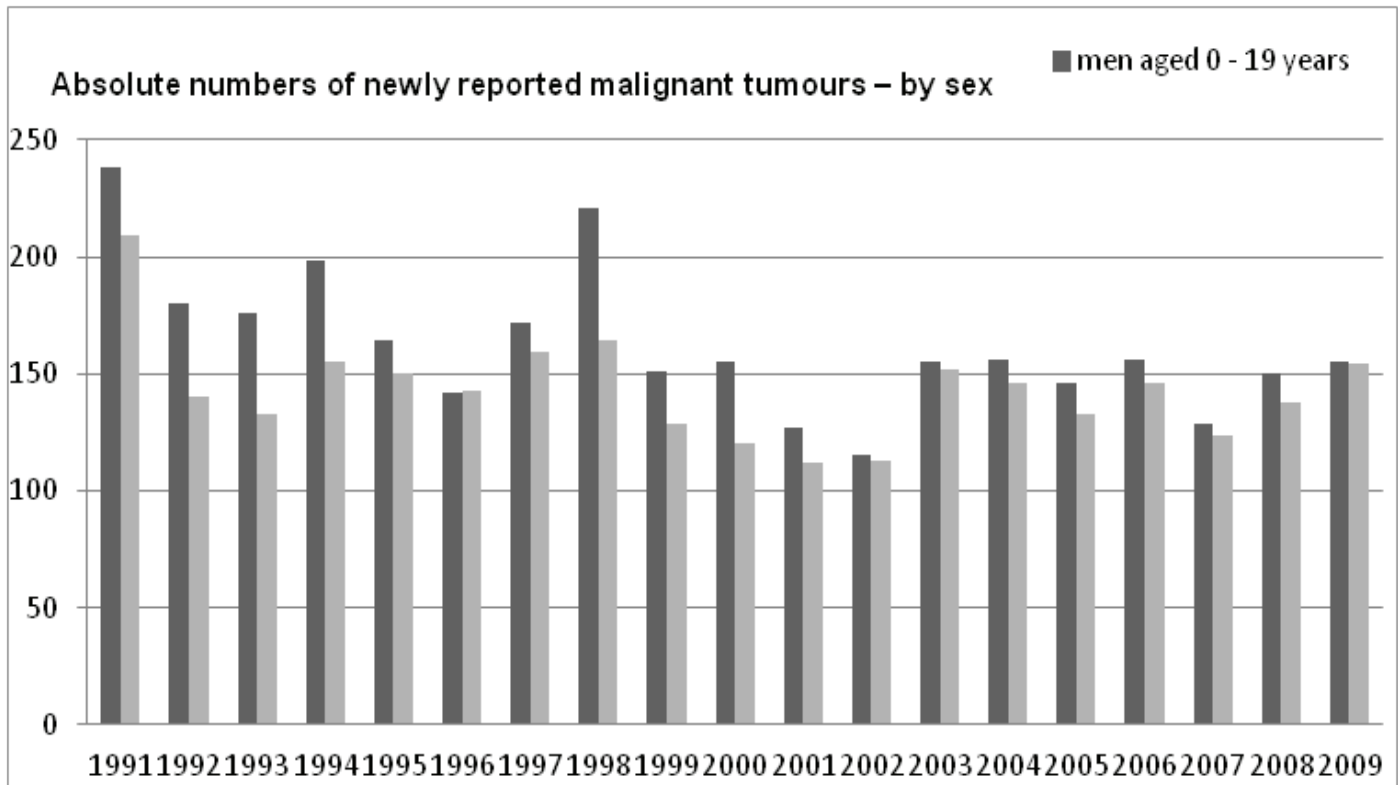


Figure 3. Absolute numbers of newly reported malignant tumours based on individual age groups

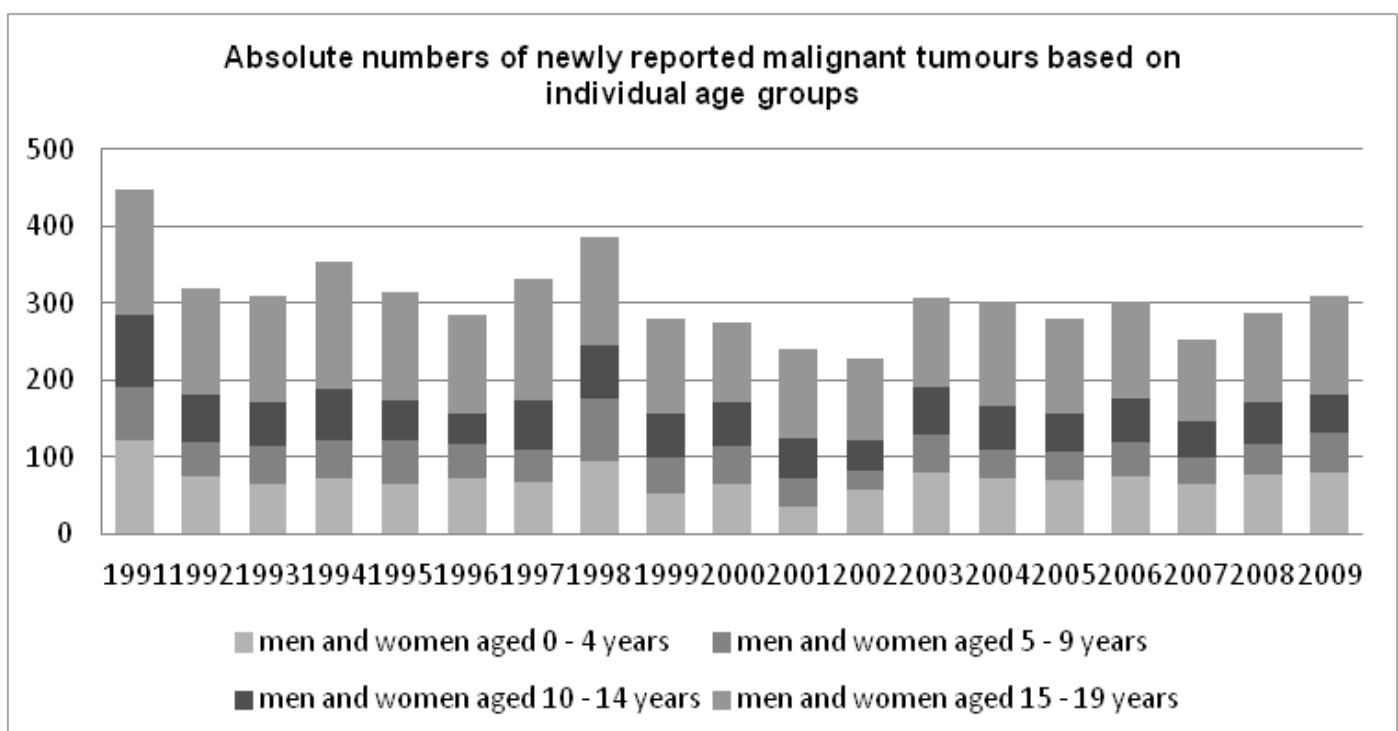


Figure 4. Absolute numbers of newly reported malignant tumours in the 0 – 4 age group

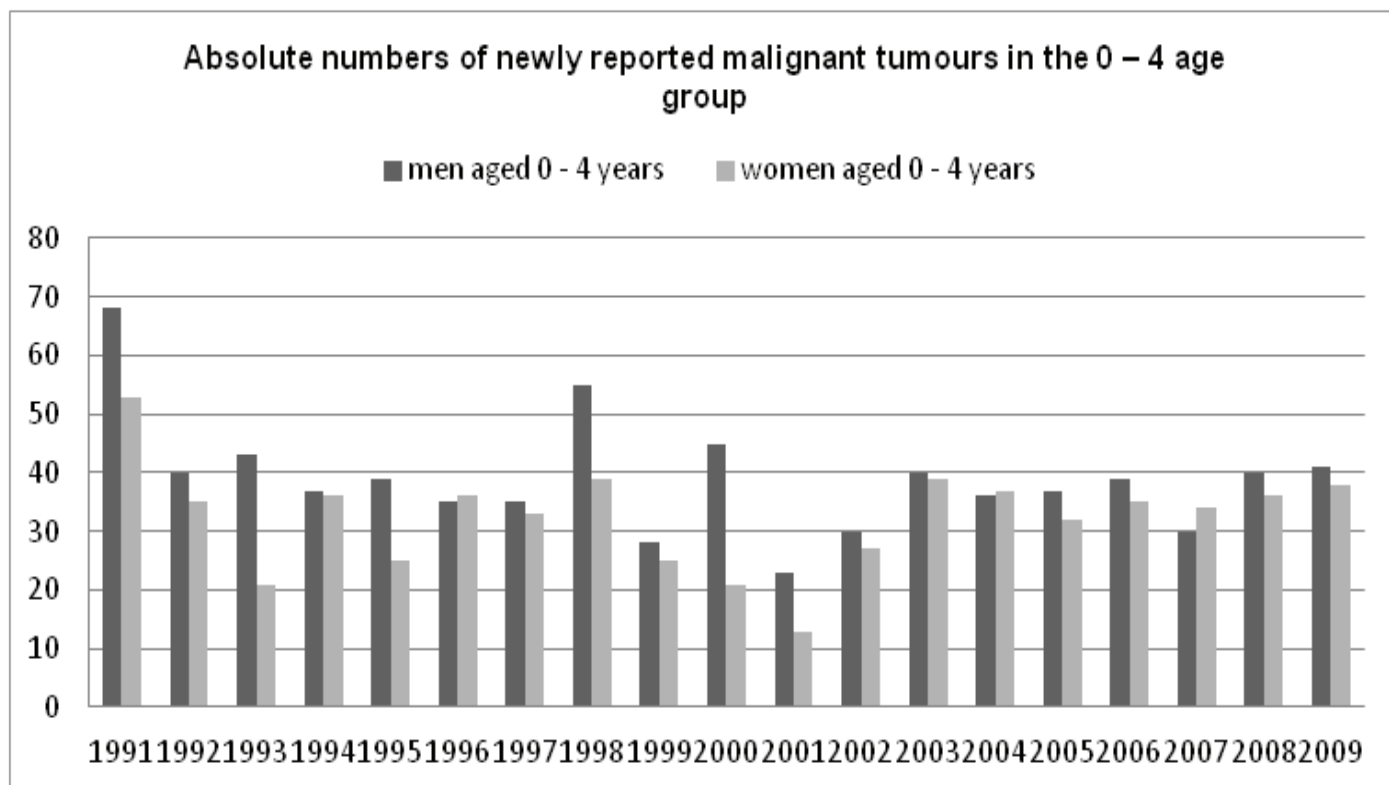


Figure 5. Absolute numbers of newly reported malignant tumours in the 5 – 9 age group

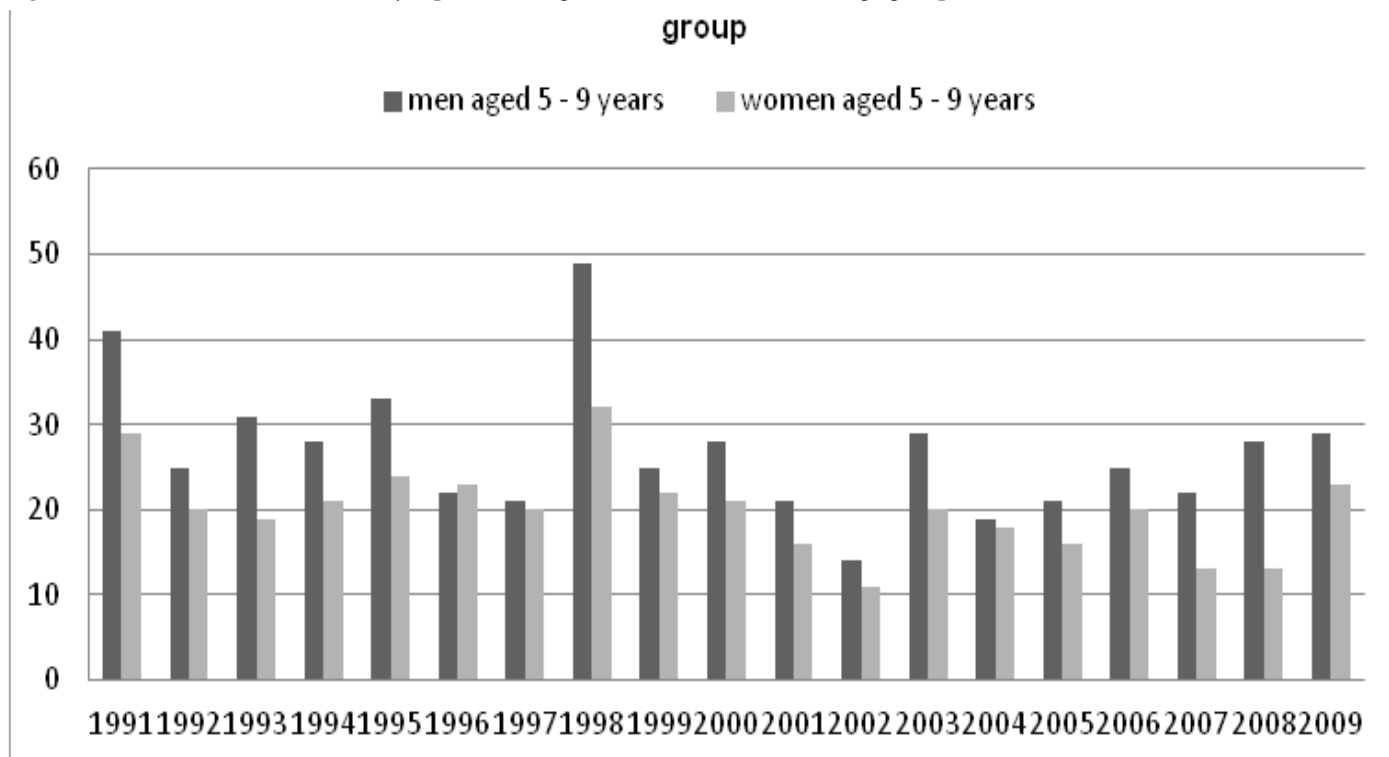


Figure 6. Absolute numbers of newly reported malignant tumours in the 10 – 14 age group

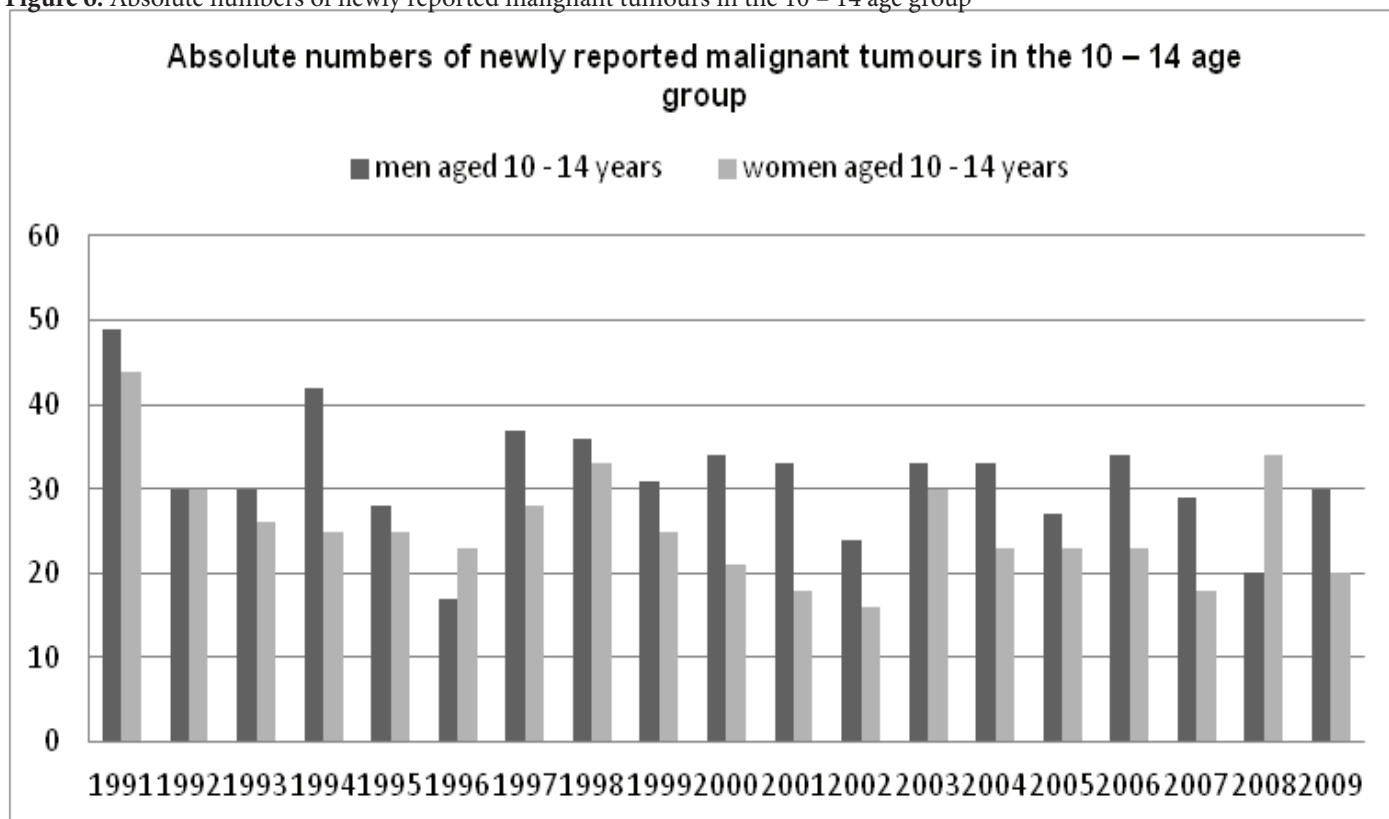


Figure 7. Absolute numbers of newly reported malignant tumours in the 15 – 19 age group

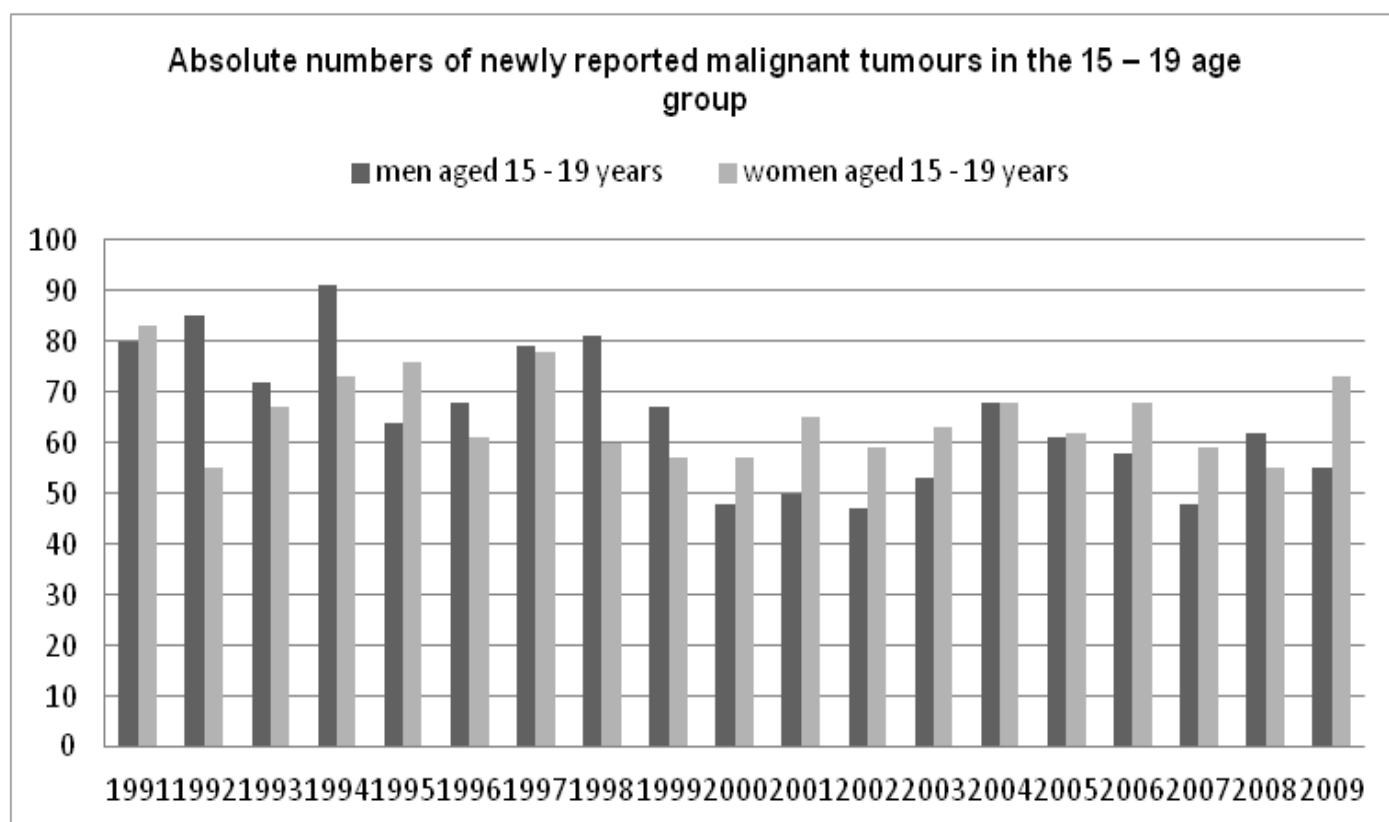


Figure 4 to 7 show that the higher absolute numbers of newly reported malignant tumours in the 0–14 age group concern boys in contrast to the 15–19 age group where, since 2000 (with the exception of 2004 and 2008) the higher number of newly reported malignant tumours concerns girls. Closer comparison of the absolute incidence of malignant neoplasm in individual diagnoses in the 15–19 age group shows the greatest differences between sexes (if we exclude malignant neoplasm of female genitalia (dg. C51 – C58) and malignant neoplasm of male genitalia (dg. C60 – C63)) found in the diagnosis of malignant neoplasm of the thyroid gland with internal secretion (dg. C73 – C75). The most frequently represented tumour diagnosis in this age group was malignant tumour of the thyroid gland (C73), particularly in girls and women. Malignant thyroid tumours are a disease with increasing incidence in childhood and adolescence. Thyroid gland tumours are more frequent in girls and young women; in children under 10 years of age the incidence is balanced for both sexes.

The group of four graphs indicated below (Figure 8 to 11) depicts the gross malignant tumour incidence in children and adolescents in the CR defined as a share in the number of newly discovered cases of the diseases in the particular population in the particular period of time and the number of individuals in the particular population in the particular period of time. These graphs depict the relative numbers of the newly reported malignant neoplasm and in situ neoplasm (dg. C00 – C96 and D00 – D09 according to MKN-10), i.e., the numbers recalculated per 100,000 (wo)men of the particular age group.

Figure 8. Comparison of malignant tumour incidence – relative numbers (0 – 4 age group)

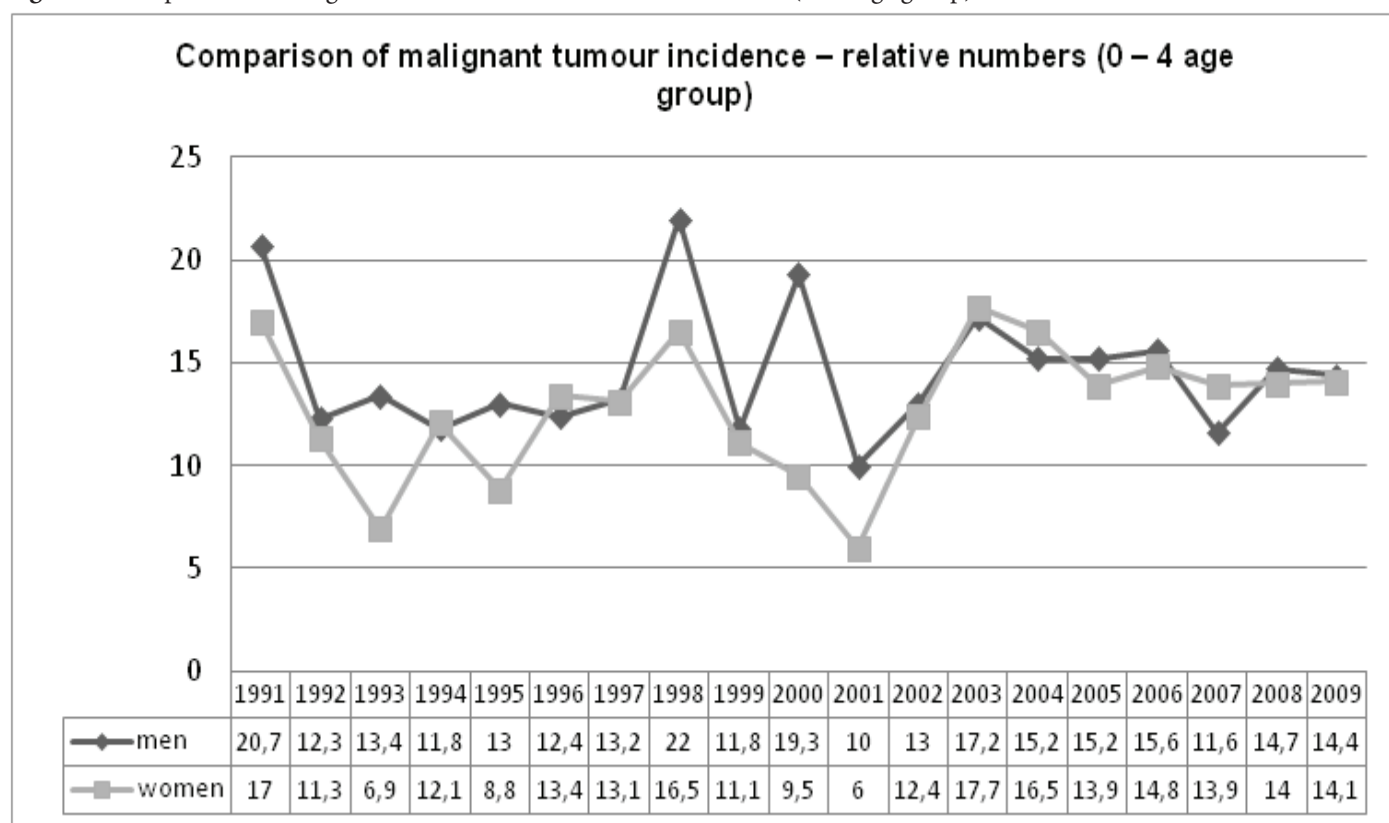


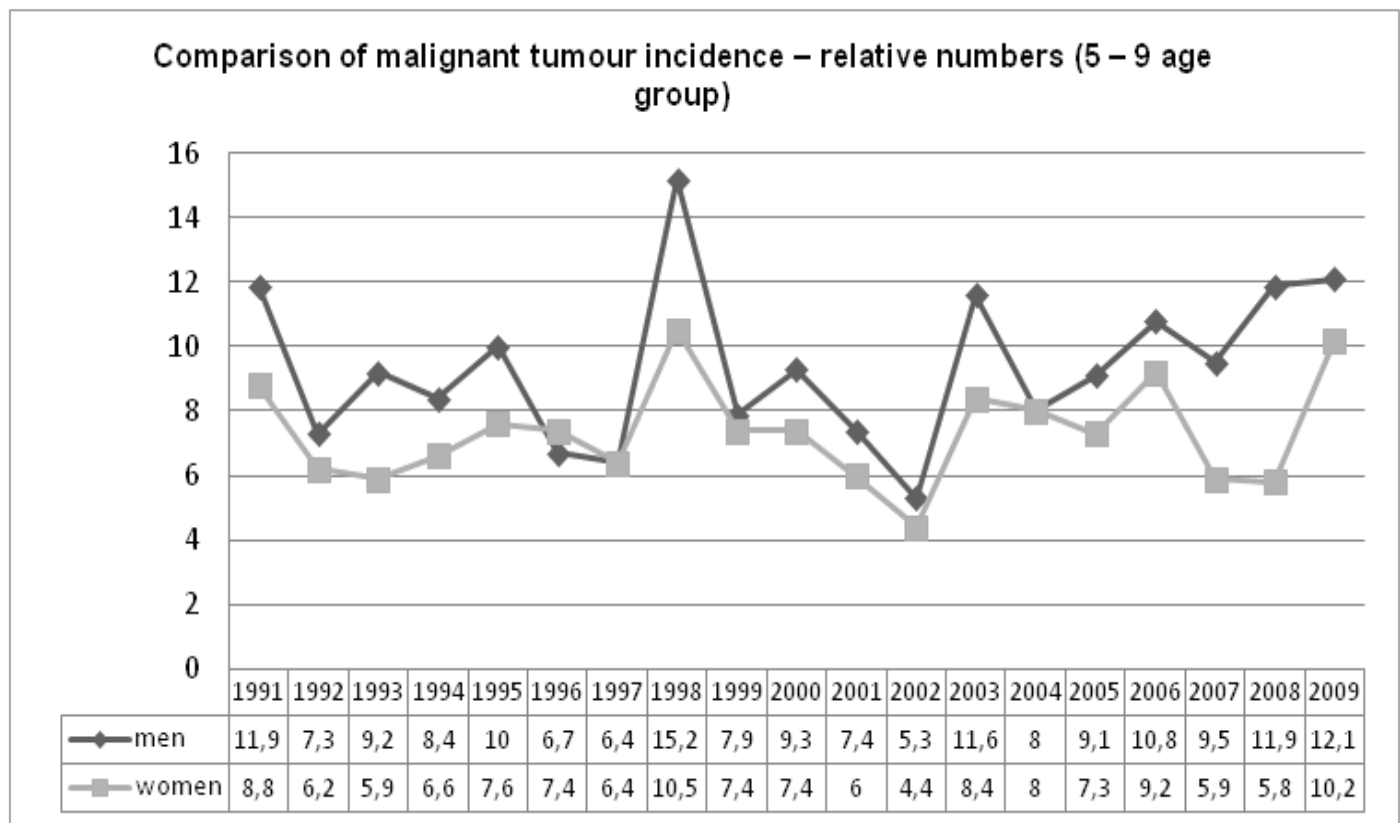
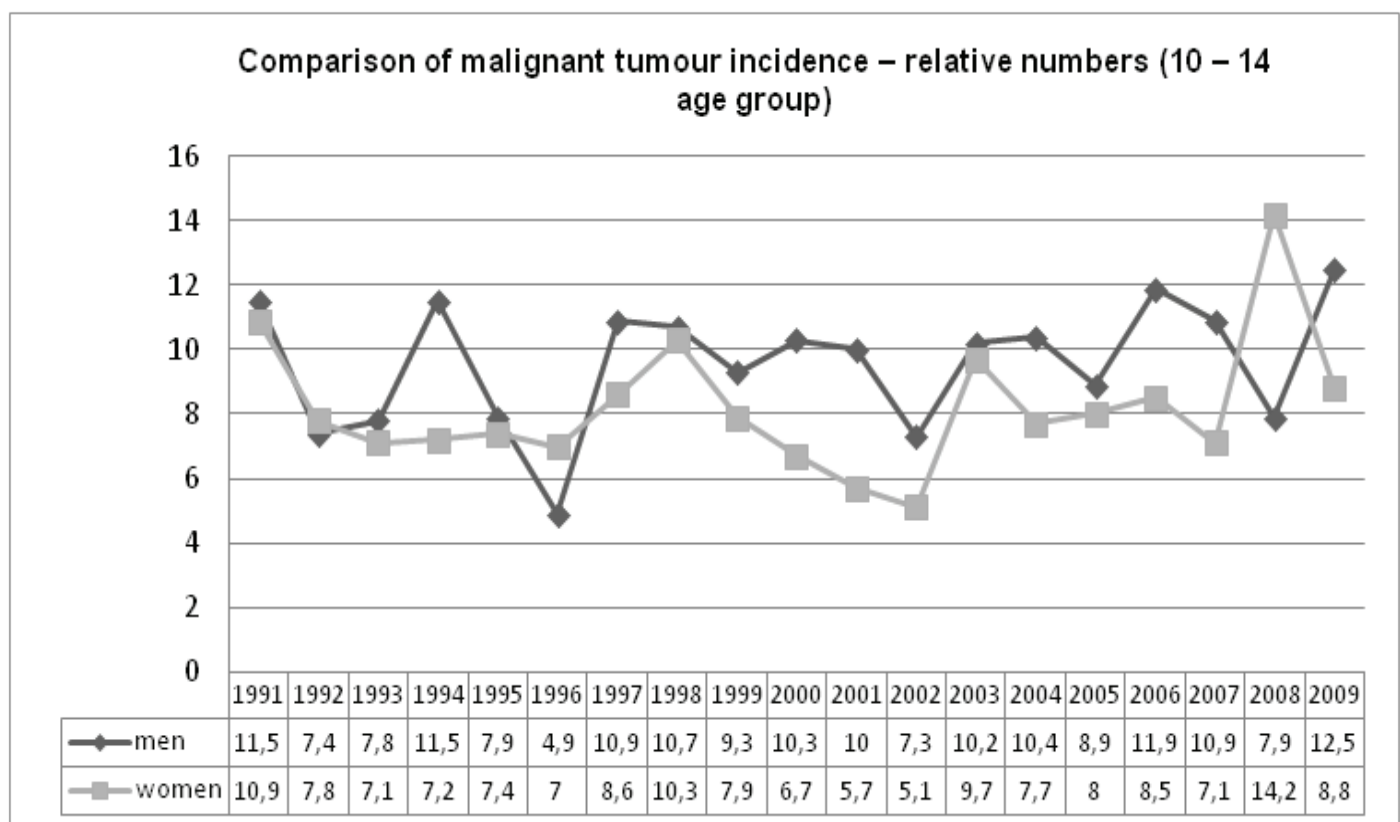
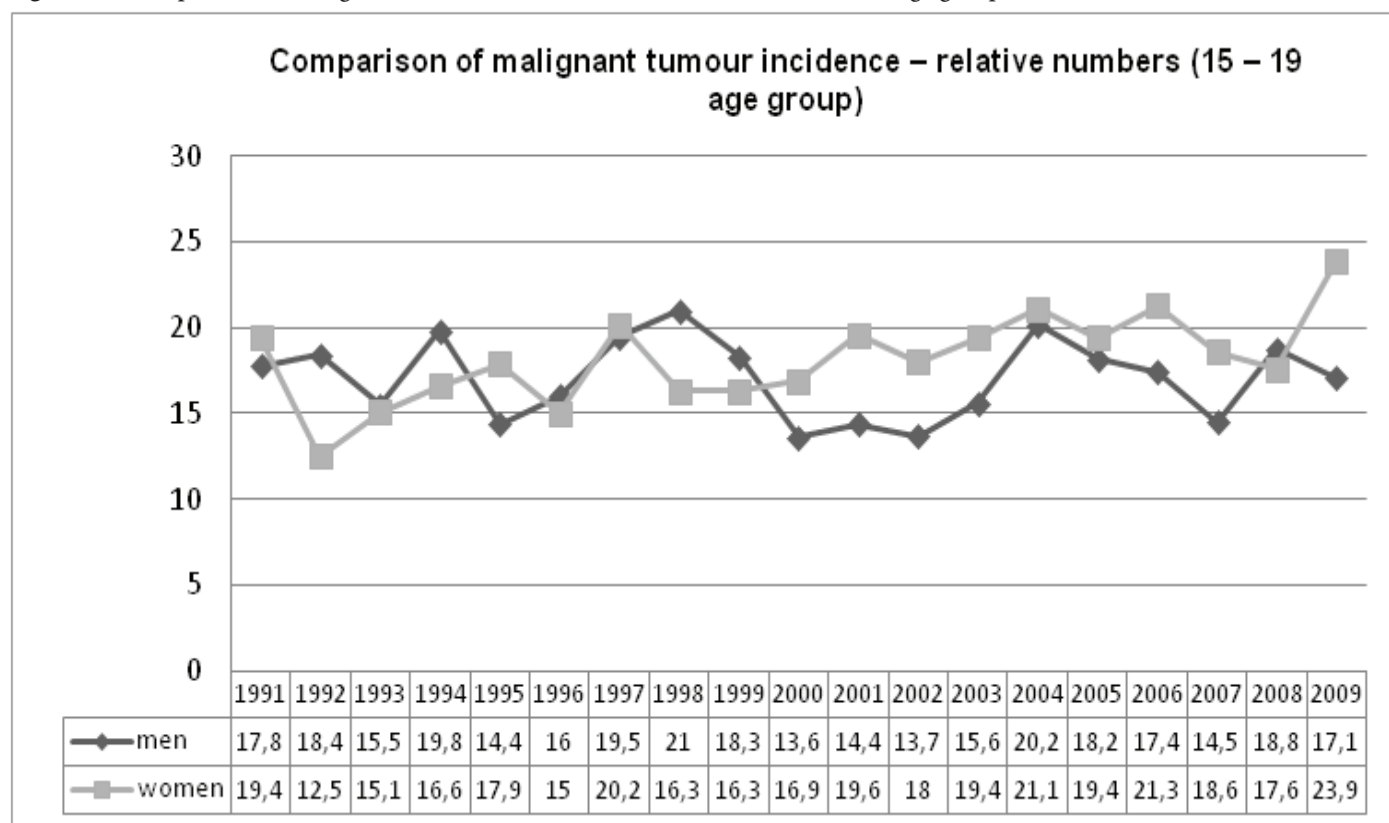
Figure 9. Comparison of malignant tumour incidence – relative numbers (5 – 9 age group)**Figure 10.** Comparison of malignant tumour incidence – relative numbers (10 – 14 age group)

Figure 11. Comparison of malignant tumour incidence – relative numbers (15 – 19 age group)

Not only do the individual gross incidence values for the CR set of persons studied depicted in graphs (Figure 8 to 11) differ within the individual age and sex groups but they also significantly oscillated during the individual years of the period of time monitored, i.e., between 1991 and 2009. Upon cross comparison of gross incidence values for both sexes in the CR population in individual age groups, different temporal incidence trends were identified.

DISCUSSION

The results confirm that the incidence of tumours in children and adolescents in the Czech Republic differs in various age and sex groups not only in terms of absolute numbers but also in gross incidence values. In spite of the fact that according to the total absolute incidence numbers (Figure 1 and 3) it may seem that malignant neoplasm incidence in children and adolescents has stagnated over the past ten years, over the past 19 years of the period monitored (i.e., from 1991 to 2009), according to the recalculation per 100,000 men and women in the particular age group monitored, malignant tumour incidence has increased for both sexes in the 0–19 age group in the CR and the total time trend of malignant tumour incidence in children and adolescents is instead growing. This growth trend in the incidence may be seen particular-

ly in the 15–19 age group, where the risk for tumour development is higher than in children younger than 15 years, based upon the prerequisite of longer carcinogenic exposure, cell aging and the related decrease in change (decrease in telomerase, somatic mutations, etc.).

It is important to continue in the trend of centralizing the treatment of child oncology patients, improving diagnostics and collaboration of all employees concerned as well as using up-to-date, less invasive treatment methods. Further, it is very important that the newly obtained experience with oncological diseases brings significant benefits in tumour disease treatment in children and adolescents. That is why, to maintain this trend, further improvement is necessary for collaboration between professionals at individual institutions, along with timely recognition and diagnosis of tumour disease resulting in timely treatment in specialized oncological centres. Stabilization and further education of medical staff support for clinical studies and sufficient financial resources for anti-tumour and support treatment are also of key importance.

The standardization methods are based on existence of hypothetical, standard population which is invariable in the long term. The standards indicate composition of population within individual age groups and these are usually included in elemen-

tary epidemiological handbook. The world, European and African standards are used as the principal ones. These standards vary especially in share of people in higher and lower age groups. At the level of individual countries, it is possible to use even local standards in well-founded cases. The thesis used values of direct age standardization which are based on the knowledge of age-specific rates of incidence in the population to be studied.

For the future, we must be ready for the increase in malignant neoplasm across individual age groups, not only in the Czech Republic but also as concerns the global growth in the number of oncological diseases. This situation must be accounted for in the present. Simultaneously, improvement in the primary and secondary prevention of oncological diseases must not be neglected.

Based on analysis of oncologic registries, it is clear that increase in incidence of cancer among children and adolescents is Europe-wide trend. Some contribution on this increased trend can be due to improvement in efficiency of registration of eligible cancer cases. A large part of the increase is due to the rise in leukaemias in young children and lymphomas (especially for Hodgkin's disease) in adolescents. Aetiological studies show that not only traditional risk factors, but also changes of birthweight and exposure to infection might be good candidates [23].

When comparing the results with study by AIRTUM Working Group, it is clear, that between 1988 and 2008 was significant increase in incidence rates was observed for all malignant neoplasms in Italian adolescents (15–19 years). In incidence dominates Hodgkin lymphoma, thyroid cancer and melanoma. Conversely, lymphoid leukemia is showing a long-term decrease in adolescents. Similarly as in Czech Republic, it is apparent increasing trend in thyroid cancer in adolescent girls [24].

Repeated CT scan exposure at childhood and adolescence significantly increases risk for many types of cancer, especially lymphoid cancers, thyroid cancer, melanoma and leukemia. That's why CT scan in childhood should be strictly indicator and with the lowest possible dose of radiation [25].

Italian multicentric epidemiological study on risk factors for childhood leukaemia and non-Hodgkin's lymphoma (SETIL), investigated the risk of childhood cancer in relation to parental occupational exposures. Increased risk for childhood leukaemia is associated with maternal occupational exposure to aromatic and aliphatic hydrocarbons, particularly in the preconception period. Increased risk of non-Hodgkin lymphoma was also observed for paternal exposure to

oxygenated solvent and petrol exhausts [26].

Early diagnosis of childhood cancer can be influenced by mothers' knowledge about signs and symptoms of cancer, when mothers doesn't underestimate and underplays the first symptoms, but on the contrary they pay attention to them [27].

CONCLUSIONS

The Czech Republic is no exception. Because the Czech Republic possesses a standard national oncology register (NOR CR) which has been systematically maintained since 1976, this article summarizes epidemiological data for malignant childhood tumours reported in the CR population over the past 19 years, i.e., from 1991 until present.

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THE SOCIAL EXCLUSION OF ROMANIES AND THE STRATEGIES FOR COPING WITH THIS PROBLEM

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Key words: **social exclusion; social inclusion; Romany minority; preventive programs; education**

Abstract

The position of disadvantaged marginalized groups of Romany inhabitants, the quality of their life and the danger of their social exclusion is a complex problem which concerns both human and social development. The problems of Romanies inevitably draw the attention to the necessity of preparing programs which would contribute to the solution of their situation and would help overcome barriers and raise the quality of social dialogue and the quality of their life. The help provided is based on the most basic requirement for people's co-existence, and it is the respect for the dignity of each individual. To prevent social exclusion, preventive actions are taken with the aim to support social inclusion and integration. All the efforts are concentrated on diminishing the difference in economic development as well as on the rising living standard of Romanies via political reforms and programs, whose aim is to help escape the vicious circle of social exclusion. The main emphasis is on mobilizing the internal resources of the Romany minority and on the struggle to overcome the fact of being prejudiced against by the minority population..

INTRODUCTION

Discriminated, underestimated and forsaken by the majority. They are looked at as a necessary evil as there is no other acceptable solution. Their social exclusion is being dealt with by experts on both theoretical and practical levels in all developed countries. The Romanies.

In Slovakia, the differentiation of the socio-economic situation is caused by the formation of the so-called elite and, on the other hand, by the growing number of people depending on state support. It is one of the most visible and least pleasing consequences of the social changes following the year 1989. Social inequality, in particular, is one of the aspects of social stratification and it is generally interpreted as an inevitable consequence of social life or its structure and organization. The position an individual occupies within the structure of the society depends on his position on the job market, which is closely connected with his qualification attained. The insufficient level of education lowers the chance of becoming employed and increases

the probability of becoming dependent on the state's social support and the impossibility of escaping the state of social exclusion.

THE RISKS OF THE SOCIAL EXCLUSION OF ROMANIES

The term „social exclusion” first appeared in the literature of the 70's of the 20th century and spread rapidly throughout Europe. There have been numerous attempts to identify its individual dimensions. J. Percy-Smith defined several dimensions and indicators of social exclusion such as economic, social, political, community-based, individual, group-based and area-based. (Rybárová, 2004, p.19) A series of research of Howarth et al. also resulted in the definition of certain common indicators of social exclusion:

- for the identification of areas exposed to social exclusion (larger number of overcrowded flats, lower extent of voluntary activities, worse health conditions of population, lower life expectancy, lower level of education of inhabitants, larger number of people without bank accounts, more instances of delinquency and criminality)

- at families with children (higher number of children in household without work, lower birth weight and higher child mortality, low school attendance and worse school results, higher birth-rate in lower age groups, higher number of children in offenders institutions). (Navrátil 2003, p. 35)

As to the economic indicators the greatest risks of the Romany social exclusion are long-term unemployment and poverty. As to the social indicators it is homelessness, criminality and youth delinquency. Regarding the area-based indicators it is the marginalization of the excluded into areas with unsafe influences, insufficient infrastructure and accessibility.

The aforementioned indicators of social exclusion appear in various forms, such as:

- restricted access to job market – temporary employment is one of the very few possibilities of being employed,
- accommodation and segregation – a significantly high concentration of Romany inhabitants in inappropriate and unsuitable old flats. Construction of new dwellings often reflects segregation tendencies of villagers based on pushing the Romany population to the periphery of the village,
- restricted access to services – geographically isolated Romany settlements often lack public services and the access to communal infrastructure is also restricted,
- rare or non-existent social networks – the geographical segregation is closely connected with the minimum extent of social contacts with the outer environment;
- hazardous manners and behavior – social exclusion and the probability of poverty support habits traded from generation to generation.

These manifestations of social exclusion make it obvious that one of the main things triggering social exclusion is education. Its level predetermines one's position on the job market. The vicious circle starting with the education becomes apparent here, as it is commonly maintained that the higher the level of education, the better the chances for employment. Education is considered to be the fundamental problem of the Romany ethnic group, as Liegeois says: „The biggest problem is the education, or more precisely, the lack of education of Gypsies. All other problems, including the integration of Gypsies into society, are derived from this shortage...” (Liegeois 1995, p. 176) This lack of education often leads to social exclusion. The choice on the job market is restricted, which results in low income usually not sufficient to satisfy

basic needs. This fact influences the quality of accommodation. Quite often, socially excluded individuals must move to a substitute dwelling. Such dwellings are most often situated in the peripheries of towns and villages, which results in segregation. In such segregated areas there are no social networks and there is a restricted access to social services. It is especially in such conditions that the probability of dangerous behavior of both individuals and the community as a whole increases.

Since the exclusion of the Romany minority is a complex social problem composed of different problems of different character closely interconnected, it is impossible solve it by aiming the solution at only one of these problems. The perils leading to social exclusion do not stand alone, but they either directly or indirectly determine one another. A change is only possible as a result of gradual and systematic problem-solving.

The vast majority of the Romany population is uneducated and unqualified and therefore unlikely to become employed. (Jurko 2008; Matulay 2003; Šlosár 2010) The generation losing its jobs after 1989 has raised another one, which follows the example of its unemployed parents. The current situation has a negative effect on the young generation of Romanies entering the job market. They represent a generation who has never worked and has never seen their parents, who live out of social benefits, work either. Therefore, work does not represent any value to them and thus they are not motivated to gain work.

Even positions not requiring special qualification are occupied by qualified specialists who are not able to find a job in their own field, rather than by Romanies. Seasonal work is a rather common option for Romanies which however offers only a very short-term and temporary alternative of proper employment.

I. Černáková also draws the attention to the worsening situation in terms of Romany employment, highlighting the obstacles in finding a job, such as a low level of education, a large number of young individuals without specialized qualification, lack of social adaptability, low standard of work ethics, irresponsibility, unreliability, low or no motivation towards the value or cost of work, the system of social benefits, the decreasing demand for unqualified workforce and traits of discrimination in the process of employing. (Černáková 2002)

Education is not considered important by the Romanies. Furthermore, they view the arrival of a child to school as a threat to the parents' authority, which is, especially during the first years, replaced by

the teachers' authority. The concentration of unqualified Romanies in certain regions without job opportunities is another reason for a high level of unemployment in such regions. This lack of education has later a strong influence on all other aspects of their lives, whether it is the inability to become employed and the consequent dependency on social support or unexcused absences from school, school-related failures, growing range of delinquency, crime, drug abuse and other socio-pathological phenomena. It often results in a weak cultural development, poor hygiene and poor health conditions.

The contemporary Romany family is in a poor socio-economic situation connected with poor housing conditions. The strong dependency on social benefits makes it often impossible for them to cover the housing-related expenses. As a result they become indebted and lose their homes. Thus they are forced to live in very restricted conditions. This often means more families in a very limited space and quality. Integrated Romanies represent an exception, obviously.

Although housing itself is not the only factor determining the quality of life, it can serve as a springboard helping disadvantaged groups acquire the values of society, change their attitude towards their previous way of life and awaken a desire for a change with the aim of attaining social inclusion and equality with the majority.

Another unavoidable factor is the difference between the philosophy and thinking of Romany and non-Romany population. These are, according to V. Zeman, based on the historical development of the respective nations and ethnicities. Prejudice against them, but most of all their own discomfort caused by being underestimated by the whole civilization have a negative effect on the Romany way of thinking. (Zeman 2006) The typical Romany lifestyle is the one „from one day to the next” and their typically consumer approach to state-provided aid. They are well informed about how and what to do in order to gain the right to benefits, they are well informed about their rights as well as about „gaps” in the law which can be misused for their good, this way significantly abusing the social system of the particular country. A failure in having their requirements fulfilled is automatically viewed as discrimination against them, not taking into account the fact that benefits must be distributed equally among all who rightfully require them.

PREVENTIVE APPROACHES TO THE MOBILIZATION OF INTERNAL RESOURCES OF THE ROMANY MINORITY

To remove poverty, each state utilizes an entire system of social guarantees. Especially European states make use of the principle of social partnership and the principle of the poor's know-how. (Tomeš 2001, p. 130) In March 2012 the European Commission introduced a strategy called „Europe 2020” with the aim to overcome the crisis and to prepare the economy of the EU for the following decade. This strategy includes three key growth factors, which need to be implemented both on the EU and national level:

- smart growth (supporting knowledge, innovation, education and digital society),
- sustainable growth (efficient production with regard to resources and current growth of competitiveness),
- inclusive growth (a high-employment economy, attaining skills and fighting against poverty). (Europe 2020)

The implementation of these initiatives is a common priority and will require steps to be taken at each level: EU organizations, member countries, local and regional administration.

The Romany community is currently experiencing a rather difficult state of its development. High unemployment rate, poverty, low income, lack of education, segregation and limited access to services all prove the fact that the Romanies are in danger of social exclusion. With regard to Slovakia's joining of the EU, but also to the slowly changing attitude of the majority to the Romany minority, the Romany question is reappearing. The government makes enormous efforts to solve the problems related to the Romany minority. Together with funds and nongovernmental organizations they invest significant amounts of money into their education, improving their living standards, increasing the employment rates and increasing the quality of their living conditions and environment.

The Slovak government has established basic principles on which the solution of the Romany question should be based. They involve: the citizenship principle – to respect the diversity of the values and lifestyle of the addressees, the solidarity principle – to gradually remove the prejudice and the negative approach of the members of the society, the participation principle – to secure the participation of citizens in the effort to solve the uneasy social situation, the personal responsibility principle – to emphasize personal responsibility for one's actions, the positive

stimulation principle – to encourage individuals who are unable to solve their problems for either subjective or objective reasons, the solution at the place of origin principle – to solve the problems in their natural social environment. (Zeman 2005, p. 9 - 10)

These principles should be applied in those areas of life which cause the separation of Romany citizens, such as upbringing, education and culture, employment, housing, social aid, health conditions and prevention of antisocial activities. It is exactly in these key fields that the programs of the Romany settlements' problem solution are being run. The targets can be reached through the solution of the problem of housing and building of infrastructure, through the support of education, requalification and increased

employment rate, through supporting business in particular settlements and through social work.

The Romanies' poverty and the danger of their social exclusion is not only a matter of the Slovak Republic. Eight countries of central and southeastern Europe altogether have accepted an initiative under the title The Decade of Romany Integration. It is being run between the years 2005 and 2015 and it embodies the first common efforts aimed at changing the lives of Romanies in Europe. It focuses mainly on four key areas: education, employment, healthcare and housing, whereas the regulations must be directed both onto a general level and a particular level of particular local conditions as well.

Table 1. Approaches - perspectives of solving the problems of marginalized Romany groups

Receiver's activity	<ul style="list-style-type: none"> • active regulations • passive regulations
Provider	<ul style="list-style-type: none"> • civil service (state institutions and organizations) • autonomy (villages, towns, autonomies) • non-state sector (associations, funds, the church)
Forms of aid – realized activities	<ul style="list-style-type: none"> • providing social benefits, state benefits and social services • supporting education and upbringing • requalification and increasing employment rates • solving the question of housing and infrastructure • supporting business in selected settlements • establishing community centers • outdoor social work • counseling, religious counseling • spiritual leadership at upbringing and educating Romany children • supporting and developing of the cultural heritage , supporting cultural activities
Problematic areas based on the legislative framework	<ul style="list-style-type: none"> • housing policy • social policy • education policy • healthcare policy
Demographical classification	<ul style="list-style-type: none"> • age limit • sex • place of residence • status
Place of activities	<ul style="list-style-type: none"> • natural family environment • community centers • institutions, residential establishments
Type of work	<ul style="list-style-type: none"> • individual – case work • group work • community work
Localization of the Romany minority	<ul style="list-style-type: none"> • intravillan areas • extravillan areas
Way of life(Rosinský 2006, p. 26)	<ul style="list-style-type: none"> • settled Romanies • semi-settled Romanies • socially most regressive Romanies

When talking about approaches and regulations solving the problems of marginalized groups of Romanies endangered by social exclusion, it is necessary to consider their division based on different perspectives, while these intermingle and complete one another and their combinations should effectively prevent marginalization: (Lešková 2008b, p. 83; Lešková 2008d, p. 81 - 92)

Receiver's activity. This aspect includes active and passive regulations which should prevent social exclusion. In case of active regulations the receiver participates in activities and does not only passively receive the programs. The counterpart of the active approach is passivity and the passive receiving of benefits including the help provided by the system especially resulting from being certain of their right to a certain extent of support.

The receiving of additional bonus besides the benefits depends on the active participation of the receiver, since while the benefits are a passive item, the possibility of receiving an additional bonus (for housing) activates the receiver. The offer of requalification and the reciprocal acceptance of this possibility reveal how much willing the unemployed is to advance his chances on the job market. While solving the problem of housing, it is advisable to include the future tenants into the building process itself. The existence of community centers and a proposal of programs is of course not sufficient to prevent social exclusion, therefore personal and active participation is necessary.

Provider. It would be neither correct nor effective if the problem of social exclusion would remain a problem of the state and the civil service only. Therefore it is necessary that more parties participate in providing help. Through legislations the state institutions and organizations are able to secure the active and passive policy of the job market, which is a crucial factor when it comes to preventing social exclusion; however, it is not the only one. The autonomies (towns and villages) together with the nongovernmental and nonprofit sector including associations, funds, and the church do contribute to a significant extent.

Form of aid – realized activities. Activities initiated either by the provider or the receiver must meet in one point, and it is the elimination of forms of social exclusion. Among these forms we can classify:

- providing of benefits and additional bonus – the benefit itself is not a motivating item, but it is possible to recognize certain features of motivation when it comes to bonuses. The housing bonus is connected with the receiver's duty to contribute to housing-related expenses. The activating bonus

supports attaining, sustaining or developing skills, knowledge and working habits. Passive regulations in the form of unemployment benefits and poverty benefits require no or only minimum activity from the side of the beneficiary;

- supporting requalification, increasing employment rates and business in selected settlements – this field includes strategies for increasing the employment rate by means of education and attaining qualification, means for the support of newly created jobs, and active regulations on the job market, i.e. projects and programs financially supported from the state budget or other sources;
- support of education – to secure better education of the Romany community it is necessary to secure long-term solutions in all aspects of educating and to strengthen the education system for Romanies as a whole. Unfortunately, the contemporary school does not satisfy the Romanies' requirements, it suppresses their natural spontaneity and thus leads to their alienation; it works as a means of assimilation;
- solving the question of housing and infrastructure – advancing the living and housing standards and hygiene in separated and segregated Romany settlements, implementing or completing basic infrastructure.

This area must be solved on a long-term prospect. Already in 1985 a government regulation was accepted (No. 102/1985 Regulations for advancing the further refinement of the gypsy population in SSR up to the year 1990) followed, in 1999, by an update of: „Example Projects of Family Houses Standardized for Nonconformist Groups of Citizens” from 1996 so that suitable conditions for building tenement houses could be created; (Lešková 2008a, p.139)

- support of existing and building of new community centers – these centers and project realized in them do not only serve to elevate the position of Romanies to the level of the majority population, but most importantly, their aim and purpose is to find a way to social integration. They enable a long-term dialogue between the minority and majority, which should contribute to mutual understanding and acceptance of different opinions. The creation of conditions for sustaining and developing the culture and identity of the Romanies also plays a very important role here. However, the question, how to maintain and continue these efforts and project realizations, causes certain dilemmas;
- supporting and intensifying the development of field social work – it involves getting closer to the

socially excluded, establishing direct contact with the – often segregated – communities. Field social work is a standard social service that can work very effectively with people living in exclusion.

Field social workers often encounter numerous problems while meeting clients who view their work as a kind of a necessary help and thus often misuse and abuse their services by manipulating them in order to achieve certain advantages. The clients view themselves as victims of the system which caused their disadvantageous position and is therefore bound and obliged to help them. Quite often their passive approach and the accumulated difficulties result in aggressive communication. This obviously corrupts the effectiveness of their cooperation and dialogue with the social workers. In such situation techniques against such manipulation are applied, yet the pro-client orientation must be borne in mind as well;

Counseling, religious counseling – these activities are characterized by an effort to reach the state of integration, to minimize separation, to involve the Romanies into the process of integration, to weaken social tensions and to support a positive system of values. (Lešková 2009a, p.37) It presents a symbiosis of social counseling and spiritual support of a client who is troubled by serious difficulties and religious or existential crises. With the aim to solve problems and help the client cope with difficult situations it operates on the phenomenon of faith and offers the client another life philosophy. Such spirituality helps the client seek and find an inner solution for his problems based on his own internalized values and beliefs, thus creating his inner security.

Other possible ways of preventing poverty and social exclusion are:

- careful identification of personal resources for overcoming poverty and social exclusion of individuals endangered by poverty and social exclusion, (Payne 2005, pp.31-33)
- joining the „Decade of Romany Integration” (2005-2015) and its continuing application, (Lešková 2009b)
- realization of the operational program „Employment and Social Inclusion for the period of 2007-2013”;
- State social politics aimed at the policy of employment and consequent avoiding of poverty and social exclusion,
- Support of community work and field social work, (Lešková 2009b; Truhlářová 2005)
- Realization of programs and diverse activities within the “European year of fight against poverty and social exclusion”;

- Support and intensifying of voluntary work. (Klepočová 2006; Uhál 2010)

CONCLUSION – WHAT IS NEXT?

The Romany population is unable to abandon its way of life which strongly depends on freedom. At the same time the majority population does not know or is unable to understand the Romany temperament, mentality, culture and way of perceiving the world and life. Currently, the social prejudice against Romanies is very strong. The problem must be looked at in the light of co-existence of different cultures and in the light of overcoming serious prejudice regarding their relations with the majority. The intention of the social policy of the Slovak Republic is to help the Romanies escape the finite circle of poverty thus preventing their social exclusion. Therefore it is necessary to:

- define the current state, key problems and reasons of social exclusion,
- ensure careful prevention and a set of efficient solutions,
- reasonably utilize accessible resources and potential,
- overcome existing barriers,
- ensure sustainability and continuity of programs.

This road is not easy since it requires a great amount of tolerance and cooperation, which needs to go hand in hand with the respect for human dignity and the support of social inclusion of groups of Romanies.

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INDISTINCT IDENTITY OF SOCIAL WORK AS A BARRIER OF GOOD PRACTICE (SITUATION IN CZECH REPUBLIC)

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social services; standard of quality; laws

Abstract

In the Czech Republic a law on social services has been in force since 2007. This law changes the value point of view, away from paternalistic concept of services from the era of communism and to the forefront puts the quality of life of their users. In practice, the quality of social services is perceived only as an administrative burden that distracts attention from the direct work with clients. This led to misunderstanding of the meaning of SQSS that endeavor to guarantee the optimal adjustment of the service for the users, to maintain the dignity of clients, and keep and strengthen their social inclusion. Social workers act in contradiction with the ideals of social work, which is trying to maintain or develop the social functioning that works on the value of every human being and of human rights.

Causes of this situation are found in education, in way of processing of the conceptual apparatus of social work for practice, and the attitude to the profession of social work, as well as in the confusion of the position, institutionalization and perspectives of social work. Theory of social work does not exceed the scope of industrial modernity and still lingers in the schema — the social problems are caused by companies/individuals. Then there is a problem with a fact that the threats and risks in the postindustrial modern are produced socially, while the need to cope with them is strictly individualized. Social work is becoming a service in the market of services.

INTRODUCTION

On January 1, 2007 Act 108/2006 Coll. on social services came into force in the Czech Republic (which brought the definition of social worker, social services, types of services, a new way of funding - the service is “purchased” by client from his/her care allowance, and also the requirements for service provider), which by changing the value basis meant a departure from a paternalistic conception of social services (Sládek, 2010: 110) (the residues of former communist regime, when the state was an exclusive provider and donator of social care (Šiklová, 2001)), when the life quality of care receivers gets under the spotlight as an overall indicator of adequate social service (Matoušek, 2007).

The Act introduced previously known, now reformulated quality standards of social services (SQSS) as a norm, whose implementation is also a precondition for the provision of social services (see

Act 108/2006 Coll. § 82, 88).

In social work practice, the quality of social services has become a ‘redoubtable norm’ and is perceived only as more paperwork hindering social workers’ performance and distracting them from direct work with clients (see Quality in Social Services, 2011, Hanzl, 2011). This leads to misunderstanding of the sense of SQSS that are the product of the quality policy of the Ministry of Labour and Social Affairs, which tries to guarantee optimal setting of social services towards the user, maintaining their dignity and keeping and strengthening their social inclusion (Act 108/2006 Coll.).

With regard to the ambiguity in meaning of SQSS, the fulfillment of certain criteria and sub-criteria of SQSS by service providers is complicated (Sládek, 2010: 116). Social workers are not able to take advantage of freedom given to them through a high degree of generality of

the definition of SQSS criteria (Čermáková, Johnová, 2002) and often produce written materials (requirements of many SQSS criteria for written methodologies) that are not effective, e.i. do not correspond with theoretical bases used in daily practice of an organization, but social workers understand them as a way how to fulfill SQSS. There are also many cases when some organizations copy methodologies of other organizations that have passed inspection without adapting them to their own specifics.

Social workers behave contrary to the ideals of social work as a discipline that seeks to maintain or develop social functioning of individuals, families, groups, communities and society while building on the value of each human being and human rights (see IFSW, 2012 Navrátil, 2001:11-12, Matoušek, 2011:15-16). Yet SQSS focusing on personal goals of service users enable providers to concretize these abstract ideals such as human dignity, autonomy, etc. (Sládek, 2010: 115). Furthermore, university education in social work in CR is largely determined by experts in social work (Accreditation requirements of the Ministry of Education, Youth and Sports are based on the Minimum Standard of Education in Social Work passed by the Association of Educators in Social Work (see Ministry of Education, ASVSP, 2011) who require minimum knowledge and skills in accordance with the above given definition of social work. On the other hand Musil (2011) states that the Minimum Standard does include the idea of complexity that meets current post-industrial modern discourse, however, it does not tell the students how to synthesize all the specific disciplines.

THE QUESTION

This leads to a question whether the reasons for this situation can be found on the side of social workers in their own way of processing conceptual apparatus for social work practice and their attitude to social work profession or in a broader context which then affects the work of social workers - specifically, I mean the ambiguity of social work position, institutionalization and perspectives of social work.

THE CONSEQUENCES OF THE CONCEPT AMBIGUITY OF SOCIAL WORK IN THE CZECH REPUBLIC

Musil (2013: 2-3) defines the consequences of the concept ambiguity of social work in the Czech Republic as follows:

- reducing the quality of social work due to workers

who lack professional qualification to help in dealing with problems in the interactions between them and their social environment,

- reducing the availability and quality of professional help of social workers due to the policy of contracting authorities (legislators or employers) when they neglect difficulties of citizens struggling with social environment and delegate this task to help those struggling citizens exclusively or unwittingly to the hands of other helping professionals who are not well qualified to provide professional social work,
- reducing the availability of professional help of social workers to citizens whose living difficulties result from problematic interactions between them and their social environment.

The ambiguity of the social work concept does not just bring the above mentioned barriers of good practice, they themselves produce other problems. We can identify other following consequences that limit the quality and availability of professional help of social workers to citizens with problems in interactions with the social environment – e.g. manifestations of social tension, publicly declared disagreements of representatives of disabled people with public authorities, violence against the homeless, illegitimate course of some distrains and other less-publicized manifestations of tension between members of the major society and people at risk of social exclusion.

THE ROLE OF SOCIAL WORKER AND THE INFLUENCE OF THE SOCIAL WORK CONCEPT ON THE PUBLIC

Let's return back to the role of social worker and the influence of the social work concept on the public in terms of good practice. In case of social worker it is the work with theories and interpretation of the role of social worker's profession. Musil (2008: 64, 2009: 80) based on his research of social workers in the Czech Republic defined four categories of the social work concept: administrative, professional, philanthropic and activist. Within these types one can interpret the quality of social work as well done paperwork, the other one as a good relationship with a client, etc. Hantová and Elichová (2013), however, found out that not only the public but also social workers view the social work profession only as an administrative work, which is confirmed by Musil (2013: 2) when he says that it is one of two common confusions of social work for the administration of state-funded or subsidized compensations (benefits and services) of personal deficits of citizens that prevent them from

meeting their needs.

The second common approach to social work in Czech society is social work confused with widely understood social services performed by helping workers of various professions with differentiated levels of qualification (e.g. psychologists, various profiles educators, doctors, nurses, caregivers, personal assistants, physiotherapists, so called art therapists, leisure time managers, etc.) or volunteers. This evokes in relevant subjects (the public, legislators, clients, workers of various helping professions, etc.) an impression that social work wrongly identified with social services can be performed by workers of the above mentioned fields. This results in commonly occurring belief, which is hard to prove, that professionally trained social workers who would provide people in distress with specialized assistance when dealing with problematic interactions (among others also with problematic interactions with the providers of social services and benefits) are not required (Musil, 2013: 2). No wonder the reputation of social worker's profession according to the investigation conducted by Hantová and Elichová (2013) was bad and social worker was often leveled with an official.

THE STATE OF SOCIAL WORK IN POST-INDUSTRIAL MODERNITY

Furthermore, social work as a discipline due to its fundamental linking with the development of modernism faces a relative crisis. As described by Chytil (2007: 64-66) social work was established as a 'working tool' of institutions of secondary sociability, whose task is to solve the problems of modern society generated by the process of modernization, which deprived people of traditional social pillars, but in the current second phase of modernity (or the post-industrial modernity, reflective or liquid modernity) modernization requires the reduction of secondary sociability institutions and organization of social work on the principles of market economy, because economics acts like a paradigm common to all humanities and social sciences. As a result of mutual competition for funding, other subsystems behave towards social field competitively. In addition, the delimitation of the field towards other helping professions is blurred (Matoušek, 2011: 16). This is due to the broad range of social work (just look at the list of typical roles of social worker: counsellor, services provider, case manager, agent of social changes and others (Rezníček, 1994)), because it is the discipline having multidisciplinary bases and typical of synthesizing features (Květenská, 2007), the position of workers in multidisciplinary teams and the

classical feature of social work, which is the theoretical make-up based on the large amount of findings of other sciences (Oláh, Schavel, et al, 2009), which are used within the social work and also modified for the benefit of clients of social work (Klimentová, 2001), but also by the fact that social work in the Czech Republic under Act 108/2006 Coll. can be performed in addition to social workers trained in social work also by special educators, lawyers, etc.

According to Chytil (2007: 66), however, the theoretical bases of social work do not go beyond industrial modernism and still linger in its scheme - social problems come from society/individuals (these words are confirmed by Matoušek (2011: 17-19) when he notes that 'big theories' of social work, which are reductive in terms of the complexity of the phenomena and outdated, they were created in the late 1960s). He does not know how to deal with the fact that the threats and risks in the post-industrial modernism are produced socially, while the need to deal with them is strictly individualized. Some authors speak about the resignation of the theoretical development of social work (Lorenz, 2005), some even predict the end of social work (Stoesze, 1997). According to Chytil (2007: 70) modernization does not lead to the end of social work, but social work becomes a service on the market of services and like other services it is profit-oriented. So we can view the law categorizing social services as the action in accordance with the above. Another element of the economic discourse can be seen just at the required quality of social services, when the client becomes a 'customer' who buys the services and requires their appropriate quality.

THE STATE OF EDUCATION IN SOCIAL WORK IN POST-INDUSTRIAL MODERNITY

In relation to education in social work it is then stated that it also does not reflect modernizing tendencies (Chytil, 2007: 66). The question is whether social workers are educated adequately and ready to compete in the current practice and respond to rapidly changing conditions in society. Musil (2011) states that the current method of teaching social work does not allow social workers to get social recognition, as it is not paying enough attention to problems in the interaction (the only exclusive competence of social work) and therefore the concept of the identity and role of social work is wrong.

RESEARCH TOPIC

Social worker is the one that determines the final form of social work. As stated by Elichová (2011: 30), generally speaking, helping organization is shaped by workers who give it a form, both by formulating its mission and other establishing and methodical documents and also by performing their helping job. The rest is in the hands of the state which forms organizations by means of social policy, as well as donors and indirectly also in the hands of the citizens who elect politicians, and indirectly shape the awareness of social problems. Therefore, it is necessary to find out how social work, now when facing identity crisis, is viewed in its live form by social workers themselves, who according to Musil (2011) just in liquid modernity have to define 'their role in the network' themselves, and how it affects the quality of social work. This topic is now in the centre of research project implemented by the University of South Bohemia in České Budějovice called The Concept of Quality of Social Work in Relation to Selfdefinition of Social Worker and Helping Profession.

SPECIFIC SOCIAL WORK IN THE CZECH REPUBLIC

I would like to note there is a specific form of social work in the Czech Republic and in accordance with the concept of Payne (1997) I believe that social work is a socially constructed activity which can only be understood in relation to the social and cultural context it arose in. Its theory and practice are in fact reactions to how real people perceive in a certain time period and in a specific location (region, country) social problems. Practical bases of social workers are also a product of the context they occurred in.

During the 20th century social work established in stable market democracies as a specific type of professional help with problems in the interactions between people and their social environment. In Czech society, however, the development after 1950 did not lead to a wider application of this approach to social work and social work here began to be confused both for social services, which should be provided by social workers, and for the administration of state-funded or subsidized compensations (benefits and services) of personal deficits of citizens (Musil, 2013: 2). The change came up with the Velvet Revolution in 1989, when the non-profit sector began to develop, there occurred new social problems such as homelessness or unconcealed prostitution and higher education in social work was reestablished (Šiklová, 2001).

EFFORTS TO CHANGE: THE REASONS FOR SUPPORTING THE LAW REGULATING SOCIAL WORK

At the macro level, the ambiguity of social work concept, which according to Musil (2013: 2) prevails in the Czech society and which has serious consequences for those Czech citizens who face difficult life situations and can not cope with them on their own, is now being solved by the Scientific Council of the Ministry of Labour and Social Affairs for Social Work. This council tries to support passing and implementation of the principle of the law on social workers and self-governing professional organization of social workers which was unfortunately removed from the legislative agenda of the government. According to the Scientific Council the indistinct identity of the social work concept will be reduced (Musil, 2013).

The purpose of the law is to support and regulate the professional quality of social work profession (Musil, 2013). The Council supports this law for reasons that relate to exercising professional help of social workers in Czech society, such as the need to clarify social work concept in Czech society in order to secure availability of professional help of social workers, to secure the conditions for negotiation between social workers, employers and educators, to secure the recognition of the legal regulations of social work by all resorts and sectors of public administration and economy including civil, non-governmental/non-profit sector, further the need to secure legal regulation of the cooperation between social work and public administration on the development of the field, etc.

Other reasons are related to the quality of the performance social work profession: the need to support the potential of social workers to negotiate in the interest of clients, the need to ensure control of respecting professionally justified rules for the performance of social work profession, including ethical rules for the performance of the social work profession, the need to ensure the regulation of discussing contentious issues and support of social work in disputes related to the performance social work profession and the need to encourage the motivation of social workers to lifelong learning in the field, etc. (Musil, 2013).

CONCLUSION

Not only the Scientific Council should be aware of the fact, as Ševčíková (2011) notes, that the

beginning of changes at the macro-level of social work does not mean success because the changes will not automatically trigger changes at meso and micro-levels, although these levels are inseparably linked, therefore in social workers who perform their profession at these levels, submitting authorities, public etc.

An interesting idea in the end could be a reflection on the statement of Gray and Webb (2007), who point out that social work is very delicate work that is focused not only on individuals, groups or communities, but also affects the whole culture (Ševčíková, 2011). When social work itself is not sure about its own identity, what impact it may have in the context of culture?

This idea is describes in more detail in Navrátil (1998: 44): In society there is a circular process under way, which on one hand includes individuals as the creators of social meanings, and on the other hand through this participation of individuals in the structures of the society creates conventions which people follow. It is a spiral process, during which the structures are constantly being created and reshaped. These changes affect the conventions and people live their lives according these conventions. If such processes take place in society in general, we can assume that they occur also in social work. It is sure that social and cultural factors determine the content and form of social work.

Let's hope, however, that some change will come, because the investigation outputs of Hantová and Elichová (2013) show that the indistinct professional identity has a negative impact on the profession and also, of course, on the clients themselves. However, according to the respondents the major consequence is the unprofessionalism of social workers and a reluctance to work. We see therefore unprofessionalism, unwillingness to act and comment changes in social situations (Chytil, 2007; Růžicková, Musil, 2009), particularly in those who, as mentioned above, are a decisive element in forming social work. Good practice under these mentioned conditions can not therefore exist.

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THE SPIRITUAL AND MORAL FOUNDATION OF SOCIAL WORK

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Abstract

Due to spiritual and religious issues bear on the patient's psychological state and social environment, social workers may be called upon to identify the religious or spiritual resources of patients and ensure that spiritual needs are addressed during transitions from hospital to community or community to hospital (Taylor, 2005). There are now a number of special social work interest groups and independent associations that focus on this topic, including the North American Association of Christians in Social Work, Society for Spirituality and Social Work, Canadian Society for Spirituality and Social Work, and Center for Spirituality and Integral Social Work at The Catholic University of America (Lemmer, 2005). There is even a Journal of Religion & Spirituality in Social Work that publishes research and discussions on spiritual issues in social work. Furthermore, at least two edited books and one authored book have been published by social workers on the topic (Canda, 1999). Despite the growing interest, however, there is almost no content on addressing spiritual issues in most courses required to obtain a master's degree in social work (Furman, 2004). This paper is written in perspective of region with mainly a Christian context of the faith.

SOCIAL WORK AND SPIRITUAL RESEARCH

Systematic research provides information on the attitudes and activities of social workers related to assessing and addressing spiritual needs. A survey of 221 social workers in the south-eastern United States revealed that religious-based interventions were judged appropriate by more than 50 percent of respondents and utilized by that percentage as well. High personal spirituality predicted positive attitudes and utilization (Stewart, 2006). A survey of 299 gerontological social workers found that most respondents supported the inclusion of religion and spirituality in education and practice as part of diversity and holistic assessment (Murdock, 2005). However, nearly 70 percent reported little or no preparation on spiritual issues during their social work education and less than 25 percent said they were satisfied by the preparation they received. Sheridan surveyed a random sample of 204 licensed social workers, finding that there was

considerable focus on religion and spirituality in both social work assessments and interventions (Sheridan, 2004). More than two-thirds of the sample reported they had utilized one of fourteen different spiritually derived techniques with clients. Again, however, practitioners' own personal beliefs and level of participation in religious or spiritual services predicted their use of spiritual techniques. Hodge describes an instrument called the "spiritual lifemap" that can be used in spiritual assessments by social workers. He indicates that it facilitates the transition from taking a spiritual history to planning interventions, and his article provides several cases to illustrate the instrument's use (Hodge, 2005).

Thus, there is considerable attention being paid by many social workers to spiritual issues, despite the fact that training on why, how, and when to assess and address spiritual issues has often been absent in social work education. Instead, as with physicians and nurses, it is the personal religiousness or spirituality of the

practitioner that determines whether this topic is addressed. Again, HP activities in this area should be driven by training, importance of the subject to patients, and relationship to health and support, not by the personal beliefs of the practitioner.

WHAT SHOULD SOCIAL WORKERS DO IN DAILY PRACTICE?

The ultimate goal of social workers is to improve people's lives by providing counseling, advice and direction, and by connecting them with resources. Medical social workers work with patients and families in planning discharge from the hospital back into the family and community, into either a safe independent living situation or a long-term care or rehabilitation setting. The medical social worker is the primary liaison person between the hospital and the community. The community social worker plays a similar role, although the focus can sometimes be in the other direction helping people move from the community into a hospital or long-term care setting. Community social workers often see individuals struggling with some kind of social problem, such as inadequate housing, unemployment, poverty, a serious illness, a disability, or substance abuse. They also work with families that have serious domestic conflicts, involving children or adults who are being abused in some way.

Thus, social workers seek out resources within the community to help support people and enable them either to live independently in the community or to find another living situation that is safe and secure. They also do a lot of individual and family counseling, often when people are at a low point in their lives. The social worker, then, is ideally positioned to screen for and address spiritual issues that come up when discharging patients from the hospital or when transitioning them from the community into another community setting or institution. These kinds of transitions are always stressful, and religious faith can play a big role in helping people to cope with such changes and in providing them with the community support that can help make transitions successful. The medical social worker should be familiar with the patient's religious background and experiences. This information can be gathered from the spiritual history taken by the physician, nurse, or chaplain, and can be supplemented with information gathered directly from the patient. Of course, if no spiritual history has yet been done and documented, then the social worker should be the person who does it. A much abbreviated spiritual history may also be necessary at the time of discharge (i.e., a question such as, "Were your spiritu-

al needs met to your satisfaction during your hospital stay; are there still some issues that you need some help with?"). With this information, the social worker can determine if there are any unaddressed spiritual needs that are still present at the time of discharge, and can help to develop a plan to meet those needs in the community after discharge.

The social worker should work closely with the chaplain to develop the discharge spiritual care plan, and depending on who has the available time, either the social worker or chaplain would then implement the plan by contacting the patient's community clergy (after obtaining explicit permission from the patient and documenting this). The discharge spiritual care plan might also include arranging for meals to be brought to the patient by members of the faith community, or perhaps arranging for faith community volunteers to help prepare the patient's home to ensure that the environment is safe (rails built on steps, commode raised, seats and rails put in shower, etc.). This might involve members of the faith community working together with an occupational therapist from the hospital. If there are spiritual needs that remain unmet, for either the patient or the family, then the medical social worker could make arrangements for counseling and support by the patient's clergy or other trained individual within or outside the faith community.

Spiritual needs might involve unresolved grief over loss of independence or loss of loved ones, spiritual struggles related to anger at God for unanswered prayers, fears about what will happen after death or desire for guidance on how to deepen one's religious faith or relationship with God. For homebound patients or patients moving into a nursing home, the spiritual care plan may involve arranging for someone from the faith community to visit the patient, pray with or read religious scriptures to the patient, administer religious sacraments such as the Holy Eucharist, or help the patient perform some other religious ritual that is important to him or her (perhaps arrange transportation to attend worship services, obtain access to foods so that a kosher diet can be followed, etc.).

Community social workers may have many similar roles, although often they will not have a chaplain readily available to consult. Instead, the social worker may want to develop a relationship with a chaplain or trained pastoral counselor in the community who can help develop a plan to meet the patient's spiritual needs either in the community or in a new institutional setting. If the patient is from a religious or spiritual faith tradition that is not familiar

to the social worker or if pastoral care specialists are not available, then direct contact with the patient's clergy (after permission has been obtained and documented) may be necessary to develop this plan. Often religious faith is very important and has been a source of strength for many years for people who are having social problems.

Helping to provide the spiritual resources necessary for these people to fully mobilize their faith during times of need can be a powerful way to facilitate adaptation during crisis. However, as emphasized earlier in this book, spiritual assessment and interventions should always be patient centered, and there is no room for coercion that interferes with the patient's free and independent choice a choice that may or may not involve spirituality or religion. If a patient is not religious or spiritual, as indicated earlier, special care must be taken to avoid coercion or inducing guilt over such matters. This is particularly true since a social worker may be acting as an agent of the state or hospital system.

EVIDENCE OF SOUL-SEARCHING ON PART OF THE PROFESSION

There is undoubtedly some deep meaning in the fact that meetings of professional social workers tend more and more frequently to include in their programmes questions related to moral and spiritual values. There must be something significant, too, in the tendency of discussions among small groups of thoughtful practitioners to gravitate towards inquiry into our deeper and more far reaching responsibilities towards the clientele we serve. Among those for whom social work is more than a mere job, there is a more insistent concern about the ultimate effectiveness of much that we do - as if the alleviation of material stress or the untangling of disabling relationships, however worthy and necessary this be, were somehow an unfinished thing. Perhaps there is a disquieting perception among some, or many, that the best skills, techniques, and resources of our profession fall short, somewhere, of reaching the ultimate sources of man's temporal distress and needfulness (Olson, 2003).

These and similar questions do preoccupy many social workers today. It would admittedly be an exaggeration to suggest that such soul searching is becoming anything like an epidemic within our ranks but there are unmistakable symptoms of its presence at every level of social work practice.

MORE THAN A DESIRE TO BRIDGE A GAP WHICH HAS GROWN

A superficial diagnosis of the condition might conclude that what is really being experienced is no more than a regressive homesickness for the simpler times when social work was mainly the form of the Church's official corporal works of mercy, when whatever efforts at alleviating community ills and personal misery were the traditional monopoly of religious congregations and authorities. While we today may have no particular affection for the twenty-first century stereotype of the "lady bountiful" or the proselytizing dispensers of moral indignation, we may dimly suspect that these prototypes of modern social work had access to certain strengths, which have somehow been filtered out of our mid-twentieth century formulae. We fully appreciate that the advances of sociological and psychological understanding have immeasurably enriched our ability to deal with social pathology. We feel no compelling urge to forego any of these gains in favour of casework by precept or community organization by sacred eloquence.

But with all our scientific assurances and skills, many of us cannot escape the impression that there is a further dimension of our work, which we no longer fully command and which nevertheless is decisively related to the success of its eventual outcomes. This feeling is much more than a simple nostalgia for the days of "social uplift" under ecclesiastical patronage.

MORE THAN A PRAGMATIC WISH TO EXPLOIT A COMMUNITY RESOURCE

We think that it is more, too, than an artfully motivated desire to draw maximum advantage from a long-recognized institution for community influence. Whenever we listen to an address or read a paper on the church as a partner in social welfare, we are alert to discover whether the objective is purely to remind workers that good public relations and wise exploitation of all community resources urge that we should not neglect this strategic source of collaboration. Such a principle of operation is undoubtedly a valid one in our professional philosophy but it misses the real point almost as widely as that which painstakingly reckons with religious values only as one cultural component, admittedly important, in diagnosis and treatment planning.

If the roots of our self-examination go no deeper than this, then the benefits to be derived from the exercise may be real but they will be meagre indeed. Because it will leave quite intact the essential

question of the intrinsic significance of the moral and spiritual dynamics in the shaping of personal and social destinies.

SOCIAL WORK CANNOT BE “ALL THINGS TO ALL PEOPLE”

First of all we might perhaps agree that social work should rid itself of any Messianic complex. It cannot successfully undertake to be “all things to all people.” This way lies a frustration. There are not few among us who are disposed to assume such global responsibilities from the reconstructing of international harmony, to the elimination of the last vestigial complex in the individual psyche. It is both a tribute to the earnest dedication of the social work professions and a commentary on its relative immaturity that so many of us feel that all of man’s needs must somehow find their satisfaction under our auspices. To resist this notion is not, of course, to deny that social work has a valuable contribution to make at every level of human interchange. But it remains a contribution, and does not become a monopoly.

The crucial point, therefore, becomes the question of what is this specific contribution, and how shall we make it. This, we believe, is the most urgent issue confronting our profession at the present moment. Within its answer will be contained the secret of how we shall appropriately relate to other established agencies of human betterment, to other human service professions, and to the infinitely varied children of Adam who turn to us for aid.

THE INTEGRATIVE FUNCTION IN A DIVISIVE SOCIAL ECONOMY

If, at the risk of oversimplifying a very complex matter, we should say that the principal task of professional social work today is that of putting together or keeping together the human person in the midst of a social process which seems more and more designed to divide and subdivide his personal unity and integrity, we would have identified what appears to me to be the essential function of our discipline. It is paradoxical indeed that at the very time when we are hearing proclaimed most insistently the twentieth century gospel of the rights of man, man himself is finding it increasingly difficult to maintain and even to discover his feeling of significance and personal control in a society which imposes ever more artificialities upon the business of living. This is neither the time nor the place to analyse the innumerable consequences which industrialization and urbanization

have brought upon the individual in terms of radical dislocations of primary human institutions. Man’s relationship to his mate and his children, to his intimate neighbour group, to his altar of worship, to the products of his labour and craft, to the larger society of compatriots - all these and many other pivots of personal security which have served him well since the dawn of history, have - by and large - been undermined by the inevitable logic of a technological age. And we have only begun to see, as in a glass, darkly, what further challenges will emerge from the nucleus of the atom. If there is any justification whatever for the familiar designation: “This Age of Anxiety,” it is to be found in the anguished cry of so many: “Who am I?”, “Why am I?”. It is precisely here that I see the providential relevance of the social work profession. Not, surely, to supply the ultimate and final answers to these questions. This is clearly the province of the philosopher and the theologian. But it is the province of social work to help man to rediscover and secure that priceless sense of purpose, value, and meaning in what he is and does amid these ever more numerous and ever more conflicting pressures in the specifically temporal and social order. The social worker, it would seem, has the vocation of being a generalist of human nature in a society which has surrendered to the specialists. I wonder indeed whether this may not be the unconscious substrate of the current emphasis on the generic as against the specific in technical social work theory.

SOCIAL ORDER AND HUMAN VALUES

Viewed from a slightly different perspective, it may be said that the overall moral responsibility of social work is to stand and act as a witness, in the community, for the principle that society is for man and against the principle that man is for society. This is why social work as we conceive it is basically incompatible with a totalitarian ideology such as communism.

It is, in the last analysis, a moral concept of the value of man which must justify our professional idea—an ideal which insists that however complex become the patterns of living, the institutions of society must be kept in harmony with the genuine interests of the human personality, that the rights and essential prerogatives of the person shall not be sacrificed to the tyranny of technological efficiency, legalistic convenience, economic advantage, or authoritarian whim.

If social work has a distinct reason for being, it will be found in this dedication to the notion that man’s relationships with his personal and social en-

vironment shall remain in harmony with the fundamental dignity and aspirations of his human nature.

THE IDEOLOGICAL ASSUMPTIONS OF THE PROFESSION

Having said this much and it is admittedly quite a mouthful it becomes necessary to look very closely at those slogans which have become the common coin of our profession that perpetual insistence on “the value of the human person,” “the essential dignity of man,” “the non-condemnatory approach,” and so on. These, we like to believe, are the axioms of our discipline. What we have not perhaps sufficiently realized, is that not one of these first principles of professional practice can long be successfully sustained apart from the spiritual and religious philosophy of life. A thoroughgoing materialism, whether frankly declared or disguised under the mask of sociological, psychological, or historical determinism can go only so far in justifying the position that the interests of the human person have inviolable priority over other temporal and social goals. Beyond this point, the materialist must become more dogmatic than the believer.

THE THEOLOGY OF SOCIAL WORK PRINCIPLES

Let us go much further than this, and suggest that these very principles which we acknowledge as axiomatic in our practice are in fact little more than direct implementations, in the social and behavioural order, of Christian doctrinal teachings by which our occidental political and social philosophy was shaped and inspired. It would be too far from our immediate subject to examine how the very theory of a democratic society must have its roots in a spiritual and moral definition of man. Let us rather consider what profound new insights are obtained when we connect some of our day-to-day professional assumptions, with the religious and moral compass points from which I believe they ultimately derive.

We speak, for example, of “the inviolable worth of the individual person.” This is a noble ideal indeed and one in the absence of which we have seen and are seeing in our own generation the most ghastly outrages perpetrated in the name of social progress. But upon what foundation does such an ideal rest? If man is no more than the sum total of his chemical components, then we are the sentimentalists and the others are the social realists. If, on the other hand, man is infinitely more than this, if he has a destiny be-

yond this span of years, if he has within him a spiritual principle, a soul, for whose final well-being an infinite price has been paid—then we may truly speak of his inviolable worth.

Or we speak of “the non-condemnatory attitude.” This, strangely enough, is frequently viewed with alarm by otherwise knowledgeable religious people, who suspect it is a cloak for moral indifferentism or a crude surrender to the Id. And yet, among all our principles I find none which echoes more searchingly the truest dictates of our moral and religious tradition. It begins with the truth that I am not my client’s better than we are both the heirs of our original parents’ fall that we each bear within ourselves that proclivity to error and unreason. It proclaims also our religious conviction that no man can be coerced into virtue or manipulated into paradise. And it denies the social worker the luxury of playing God, by acknowledging that rectitude of life is the fruit of divine grace, to be given when God finds the soul prepared. Sanctity is not something which can be ensured by edict or censure, but rather something that takes possession of a man when the dispositions of nature have paved the way. It is the social worker’s role to take away, by art and understanding and acceptance, the material, the emotional, the interpersonal, and the social stumbling blocks which cluster the human being’s pilgrimage through this life toward of the client as he comes to us, than the words of Him who, when the last scornful accuser had slipped away, raised up the woman taken in adultery: “Daughter, are there none left to accuse thee? Neither do I accuse thee. Go in peace.”

There is such a higher rationale for each one of the basic laws about which our professional ethic and skill are cast. It would be burdensome to consider in detail why our belief in the right of every individual to the means of decency is eventually inseparable from a theology which teaches that redemption is for the weak and strong alike; why our conviction in the necessity of social justice and mutual aid is bound up, not with a devious pursuit of indirect self-interest, but with the vastly more sublime precept of spiritual brotherhood which in my theology I would call the Mystical Body of Christ.

THE FUTILITY OF ROOTLESS PHILANTHROPISM

The foregoing remarks are certainly open to commentary from many quarters. To some they may seem no more than a quasi-poetic essay in plausibilities. To others they may seem an elaborate attempt at rationalization in favour of vested interests. To oth-

ers they may seem no more than an eruption of metaphysics in an area which has been adequately taken over by scientific positivism.

We must insist that they are more than any of these. It will always strike me as more than somewhat strange that we should have to remind social workers, of all people, of the essential spiritual component in their profession. And yet, in a somewhat larger context, it is worthy of note, that at the present time it is the physical sciences—the nuclear physicists, the biochemists, and the rest who are more and more frequently voicing the necessity of a rediscovery of moral and religious values, while the human and behavioural sciences seem to be sinking ever deeper into the strata of factorial analysis, cybernetics, and logical empiricism. Social work must maintain its commitment to the integral human person, and to whatever dimensions of that human whole may have an effect upon the individual's capacity to deal more successfully with the challenges of living in this uncertain and complex social era. We have long since agreed that this eventually becomes a matter of revitalizing the interpersonal relationships which sustain personal security and social wellbeing. But as Father Bowers said in Gotterer's book (2001), if religion is essentially man's relationship with the divinity from which he springs and towards which he moves, and if this, as seems inevitable, influences profoundly his relationships with all else which surrounds him, it would seem a dereliction of professional responsibility for social workers not to be at least mindful of this direct and indirect area of the client's relationship needs.

The fact, however and I might say the tragic fact is that this intimate connection between religious and spiritual values on the one hand, and the content of day-by-day activities and relationships on the other, has largely been lost sight of in contemporary scientific, political, and social thinking.

It is not merely that religion has become a compartmentalized aspect of living. It is rather that we, without fully realizing it, are living on borrowed spiritual and religious capital. The most alarming symptom of modern man's crisis is that, while engaged in a death struggle for the defence of certain human values, he has too often lost faith and confidence in the theological principles upon which these values are founded. In fact, we have, more often than not, actually forgotten these principles, while suspecting more or less consciously the weakness of the latter-day ideologies which have preyed upon them like parasites (Marshall, 1990). It is not surprising, therefore, that we speak of "This age of anxiety" but we firmly believe that, before all else, it is an age of metaphysical anxiety.

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PERSONAL IDEOLOGY OF THE PROFESSIONAL PERSON

Here, precisely, is the nub of the entire question in so far as it concerns the worker on the job. It would be idle to expect that every practitioner will bring a positive and conscious religious ideology to his professional tasks. To the extent that he/she fails to do so, of course, his/her scope for adequate empathy with his client whether individual, family, or group is proportionately diminished. But we have a right to hope that at the very least, he/she shall not systematically disregard the religious and moral preoccupations or needs of his/her case, or harbour a persistent blind-spot in their regard. On the other hand, the practitioner who has mature and enlightened convictions about the powerful spiritual potentialities in his/her own and his/her client's lives vastly expands his/her range of deep identification and at the same time finds access to new reserves of confidence and worthwhileness in his/her labours.

THE RELATIONSHIP BETWEEN PROFESSION AND CHURCH

The danger in all that we have been saying may lie in supposing that, if these things be true, then professional social work somehow becomes a branch of evangelism that the social worker, in his/her role of social worker, becomes something of a religious counsellor. Nothing we can think of would do a greater disservice to both religion and the social work profession than this confusion of roles. Despite their unique interdependencies, their proper and specific functions remain fundamentally distinct.

As a professional discipline, social work assumes responsibility for man in his earthly estate, using methods and resources proportionate to earthly effects, for the purpose of insuring earthly benefits for the individual and for the community. In its primary role, the Church assumes responsibility for man's soul in its earthly state, using methods and resources proportionate to supernatural for mankind.

If social work recognizes that moral and spiritual factors enter deeply into earth-bound problems, it must so deal with these factors as to permit the achievement of desired social outcomes. If the Church recognizes that material and social factors enter deeply into spiritual problems, it must so deal with these factors as to permit the achievement of desired supernatural outcomes. Social work, as a professional dis-

cipline, is not called upon to save souls. This is not its competence. But its practitioners, as believing people, will not be oblivious to the eternal destiny of those they serve. The Church, as an agency of supernatural life, is not called upon to reconstruct the city of man. This is not its competence. But its representatives, as socially minded people, will not be indifferent to the earthly condition of those to whom they minister.

THE PROBLEM OF COLLABORATION

The net conclusion of all the foregoing is surely that social work and the church should be working together in a relationship of utmost harmony born of reciprocal need. Let us not be so naive as to pretend that this is typically the situation. All too often, if there is not an elegantly disguised mutual suspicion, there is not much more than a casual nodding acquaintance. Far too seldom indeed does there exist that truly dynamic teamwork which would be required to make what I have said anything more than pious philosophizing.

Without attempting to give you any gimmick or trick formulae to get the church and social work working hand in hand, may I merely suggest a few of the basic prerequisites for fruitful collaboration: First of all it would seem to us, we have to do something about the problem of simple verbal communication. If social work has sometimes been rightly characterized as a "culture within a culture," the same can be said with due modifications about the world of ecclesiastical affairs. Each has developed a technical terminology that effectively renders intelligible dialogue an almost lost cause. Terminology, of course, is really no more than symptomatic. Even if the schools of social work and theological seminaries added a course in comparative semantics to their already overcrowded curricula, we would not automatically overcome all the stumbling blocks in our common pathway. What is perhaps more needed is a relatively better understanding on either side of what the other is really trying to achieve. Only thus will the occasional spasms of scepticism cease to encumber our collaboration.

Only thus will the mechanisms of defence intrude less frequently into our dealings with one another. Only thus will the profession be less likely to reproach the Church for unwarranted insistence upon moral technicalities; only thus will the Church be less likely to censure the profession for arbitrary secularism.

How this quality of improved mutual understanding can be brought into being is probably too large an issue to be dealt with adequately here.

In summary, I believe it must await a spiritual maturation on the part of the social work profession and on the part of social work practitioners, no less than it must await a scientific-social maturation on the part of those who formally speak for the spiritual and moral values in modern life. This undoubtedly has implications for the educational programmes on either side—and I have the impression that the challenge will be and is being met.

The fruit of such efforts will be not only better understanding, leading to more effective communication, but a heightened respect for one another between these two agencies of human betterment. I cannot think of an outcome more ardently to be hoped for because it can only result in advantages to the individuals, the families, the groups, and the communities which, each in our own way, we have assumed the mission to serve.

CONCLUSION

Medical and community social workers help patients and their family transition from one living situation to another one, easing such transitions by providing counsel and identifying resources for support. Relevant to such transitions are the religious beliefs of the patients and their families and the faith communities to which they belong. As a part of a holistic, patient-centered care there is observed in some settings (especially in palliative care) growing interest among social workers (in some countries) to identify the spiritual needs of patients and families and to ensure that those spiritual needs are met during such transitions. Medical social workers are ideally positioned to ensure that spiritual needs identified during hospitalization continue to be addressed as patients are discharged back into the community. This is often done by working closely with the chaplain to locate resources either within or outside of the patient's religious community to meet those needs, depending on the patient's choice. Community social workers play a similar but broader role that involves identifying spiritual needs and identifying spiritual resources in an environment where pastoral care specialists may not be readily available.

In hospital settings, the medical social worker should not duplicate the work of physicians, nurses, or chaplains in identifying spiritual needs, although he/she may have to conduct and document a spiritual history if it has not already been done, and may need to follow up briefly at the time of discharge to ensure that spiritual needs were met during hospitalization. Because most social workers are not trained to ad-

dress spiritual issues, however, any in-depth spiritual counseling should be left to pastoral care specialists whenever this option is available. As it is currently a wide experience in many hospitals in Slovakia and other European countries, there is still ongoing need for improvement into identifying of spiritual needs by social workers and delivery it to the patients by pastoral team and chaplains. Social workers are unreplaceable component of social spiritual dimension of care. If the patient is from a religious or spiritual faith tradition that is not familiar to the social worker or if pastoral care specialists are not available then direct contact with the patient's clergy (after permission has been obtained and documented) may be necessary to develop this plan. Often religious faith is very important and has been a source of strength for many years for people who are having social needs.

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MONITORING OF THE LEVEL OF SATISFACTION OF PATIENTS AND FAMILIES WITH THE PROVISION OF HOME NURSING CARE

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Abstract

The authors concentrate on a search focused on satisfaction of patients and family members with nurse care in home nursing agency, as well as evaluation of differences in perception of the satisfaction between both groups of respondents. The obtained results can contribute to gaining an overview of not only the mutual relations and communication but also of development trends in relations towards home nursing agency staff. Finally they recommend an improvement of home nursing agency position by constant improvement of provided services with an adequate legislative support as a requirement of the society.

INTRODUCTION

Home nursing care contributes to making the trend of health and nursing care in Slovakia moving towards the provision of treatment and nursing care in home environment. An important factor in increasing the level of quality of health and nursing care is a subjective perception of satisfaction of patients and their families with treatment and home nursing care. So we decided to pay attention in our survey for the determining of level of satisfaction of patients and of level of satisfaction of family members with care provided by nurses working in the ADOS (Association of Home Nursing Care). Patient satisfaction is one of the important indicators of the quality of nursing care. To some extent, it can also affect the clinical effectiveness of nursing care. It should be used as a standard yardstick by which the quality of health and nursing care is evaluated while creating a suitable tool for suggestions for the improving of its level.

MAIN OBJECTIVE OF THE SURVEY

To determine the level of patients and their families satisfaction with the provision of home nursing care.

PARTIAL OBJECTIVES

01: to determine the level of communication skills of nurses working in ADOS

02: to determine whether the expectations of patients and families with the provision of nursing care through ADOS were met

03: to determine the sources from which patients and their families learned about the possibility of the of ADOS services

04: to determine whether the care provided to ADOS patients - recipients of nursing care - through ADOS was sufficient

05: to compare differences in the level of patient satisfaction with the level of satisfaction of their family members

WORKING HYPOTHESES OF THE SURVEY

H1: We expect that 80% of respondents learned about the possibility of using ADOS services on the recommendation of their general practitioner.

H2: We assume that communication skills of nurses are encouraging for patients and their family members in more than 50%.

H3: We assume that satisfaction with care provided by ADOS nurses will be evaluated by more

than 50% of the patients and their family members positively.

H4: We assume that time devoted by nurses working in ADOS to patient will be evaluated by patients and their relatives as completely sufficient.

RESEARCH SAMPLE AND SURVEY METHODOLOGY

Basic sample consisted of a total of 600 respondents of which 300 were patients and 300 were family members.

The main method was questionnaire survey research method. The questionnaire was developed for the sample of patients and for their families. Content form of those two types of questionnaires was identical, differing only in the formulation of questions. The core of questionnaire consisted of 9 surveyed questions.

Questionnaire items were formulated in closed form, one item was formulated as opened. In closed items respondents labelled only one alternative response. In open item were respondents provided with the opportunity for free expression. The questionnaire was anonymous in order to follow the ethical aspects of research in the area of nursing care.

Implementation of the survey and data processing
The time period of survey: January 2009 - October 2012

Demographic data of basic sample /respondent samples/

Table 1. Distribution of respondents by gender (patients, family members)

Answers	Patients		Family members	
	n	%	n	%
women	230	77 %	100	33 %
men	70	23 %	200	67 %
N	300	100%	300	100%

Table 2. Distribution of respondents by age - patients

Answers	Patients	
	n	%
61 – 69 years	50	17 %
70 – 79 years	150	50 %
80 – 89 years	80	27 %
Over 90 years	20	6 %
N	300	100%

Table 3. Distribution of respondents by age - family members

Answers	Family members	
	n	%
61 – 69 years	180	60 %
70 – 79 years	80	27 %
80 – 89 years	40	13 %
Over 90 years	0	0 %
N	300	100%

Table 4. Distribution of respondents by the length of care in ADOS (patients)

Answers	Family members	
	n	%
less than 1 month	20	7 %
1 – 2 months	30	10 %
2 – 3 months	90	30 %
more than 3 months	160	53 %
N	300	100%

In terms of ADOS care 7% of patients were in the care of ADOS less than 1 month, 10% of patients within 1 - 2 months, 30% of patients within 2 - 3 months and 53% of patients were in the ADOS care more than 3 months.

EMPIRICAL ANALYSIS OF DATA FROM THE QUESTIONNAIRE SURVEY METHOD

Table 5. How would you rate the communication skills of ADOS nurses?

Answers	Patients		Family members	
	n	%	n	%
encouraging	220	74 %	260	87 %
average	70	23 %	40	13 %
without interest	10	3%	0	0%
N	300	100%	300	100%

This item answered all 600 respondents. 220 patients (74%) and 260 family members (87%) rated communication skills as stimulating and only 10 of the patients evaluated skills of ADOS nurses in communication as with disinterest.

Table 6. From what sources did you find out about the possibility of using the services of home care agencies (ADOS)?

Answers	Patients		Family members	
	n	%	n	%
on the recommendation of the district physician	200	66 %	200	66 %
during the hospitalisation in hospital	50	17 %	20	7 %
from a person who used or uses the services of ADOS	20	7%	50	17%
from relatives	20	7%	20	7%
from mass media - radio, television, the Internet	10	3%	10	3%
N	300	100%	300	100%

This question answered all 600 respondents, ie 100%. The same number of patients and family members, (66%) of the potential uses learned about ADOS on the recommendation of a general practitioner.

Table 7. How do you assess the time that ADOS nurses devote to you during the visit?

Answers	Patients		Family members	
	n	%	n	%
fully sufficient	10	3 %	20	7 %
partially sufficient	280	94 %	270	90 %
insufficient	10	3%	10	3%
N	300	100%	300	100%

This item answered all 600 respondents. 280 patients (94%) and 270 family members (90%) assessed time devoted by ADOS nurses during their visit as partially sufficient. 10 patients (3%) and 10 family members (3%) rated this as an insufficient time.

Table 8. How do you assess the time that ADOS nurses devote to you during the visit?

Answers	Patients		Family members	
	n	%	n	%
yes	270	90 %	290	97 %
partially	30	10 %	10	3 %
no	0	0%	0	0%
N	300	100%	300	100%

This item answered all 600 respondents (100%). 270 patients (90%) and 290 family members (97%) marked yes - ADOS service met their expectation of providing nursing care.

Table 9. How would you assess the cooperation of nurse in taking care of you?

Answers	Patients	
	n	%
excellent	210	70 %
above average	10	3 %
average	80	27 %
below average	0	0 %
insufficient	0	0%
N	300	100%

This item answered all 300 respondents. 210 patients (70%) indicated that cooperation of ADOS nurses in patient care is excellent, below average and unsatisfactory cooperation of respondents did not mark any respondent (0%).

Table 10. How would you assess the cooperation of nurses in caring for your relative?

Answers	Patients	
	n	%
excellent	180	60 %
above average	10	3 %
average	110	37 %
below average	0	0 %
insufficient	0	0%
N	300	100%

This item answered all 300 respondents. 180 family members (60%) indicated that cooperation of nurse in patient care is excellent, below average and unsatisfactory cooperation of respondents did not mark any respondent (0%).

Table 11. Mark in the following table with a cross as you are satisfied or unsatisfied with the interest and care of ADOS nurses in these biological needs:

Answers Biological needs	Patients		Family members	
	arithmetic average	standard deviation	arithmetic average	standard deviation
food/fluid intake	4,7	0,7	4,6	0,8
urination	4,6	0,8	4,6	0,8
defecation	4,4	0,9	4,5	0,8
hygienic care	4,6	1	4,6	1
sleep/rest	4,5	0,8	4,4	1
comfort/pain	4,3	1,1	4,3	1,2
activity/exercise	4,6	1	4,6	1
TOTAL	4,5	0,9	4,5	0,9

Based on the standard deviation and the arithmetic mean of patients and family members, as indicated in the Likert scale table, respondents chose only answers 5 very satisfied and 4 partially satisfied. In neither case, their response was 3 I will not express, 2 dissatisfied or 1 very dissatisfied.

Table 12. Do you encounter difficulties in collaboration with nurse?

Answers	Patients		Family members	
	n	%	n	%
yes, often	0	0 %	0	0 %
rarely	20	7 %	10	3 %
no	280	93%	290	97%
N	300	100%	300	100%

This item answered all 600 respondents. 280 patients (93%) and 290 family members (97%) said they have no difficulties in collaboration with their nurse.

EVALUATION OF WORKING HYPOTHESES

In the working hypothesis H1 we assumed that 80% of patients and family members learn about the possibilities of using ADOS services on the recommendation of a general practitioner. Working hypothesis H1 was verified by questionnaire item 1. We found that 66% of patients and family members learned about the possibilities of using ADOS services on the recommendation of a general practitioner, 17% of patients and 7% their relatives in hospital during inpatient care, 7% of patients and 17% of their relatives from people who used before, respectively using, the services of ADOS, from relatives learned about it

7% of respondents and from the mass media, radio, television or internet only 3% of respondents. In the survey we found that the greater prevalence of the patients or their relatives are aware of ADOS services from their primary care physician. On this basis, we can conclude that working hypothesis H1 was not confirmed.

In the working hypothesis H2 we assumed that communication skills of nurses are by patients and family members assessed as stimulating in more than 50% of respondents' answers. Working hypothesis was examined with item 2. Patients rated the communication skills of nurses working in ADOS as encouraging in 74% and family members in 87%, as the average reported those 23% of patients and 13% of families, with disinterest rated them 3% of patients. Based on the above, we can conclude that working hypothesis H2 was confirmed.

In the working hypothesis H3 we hypothesized that satisfaction with care of ADOS nurses will indicate more than 50% of the patients and their family members as positive. Working hypothesis H3 was verified with items 5, 6, 7 and 8. In the survey, we focused on the evaluation of the care for biological needs, on the cooperation with nurse in the care of a patient and if patients encounter a difficulties in working with their nurse. Cooperation nurses in patient care rated as excellent 70% of patients and 60% of family members, 3% above average was achieved in both respondent samples, below average or unsatisfactory did not mention any of the respondents. Item aimed to determine the level of satisfaction of patients and family members was prepared in tabular form, in which respondents had a single item to express their satisfaction or respectively dissatisfaction. It was subsequently evaluated using Likert scale. The assessment showed that all answers of both patients and family

members were positive. Patient satisfaction (4.5) and family members satisfaction (4.5) were high. Item whether the respondents face difficulties in collaboration with nurses working in ADOS answered that never met 93% of patients and 97% of family members, rarely reported 7% of patients and 3% of family members, often did not mention any respondent. On this basis, we concluded that working hypothesis H3 was confirmed.

In the working hypothesis H4 we assumed that the time ADOS nurse devote to working with patient will be evaluated by patients and relatives as completely sufficient. Working hypothesis was examined by item 3. We found that the time nurse pays to the patient assessed the majority of respondents as partly satisfactory and 94% of patients and 90% of relatives, as wholly sufficient time to indicate the 3% and 7% of patients, family members and inadequate 3% of patients and family members. On this basis, we can conclude that working hypothesis 4 was not confirmed.

DISCUSSION

Based on a comprehensive analysis of the survey we can conclude that the satisfaction of patients and family members with care of ADOS nurses aimed to meet the biological needs of the family member was evaluated positively.

Part of the survey was the assessment of differences in perceptions of satisfaction among patients and family members. The evaluation found that there are not any significant differences in the perception of satisfaction.

Many answers to questions in both basic groups of respondents were consistent; it could be considered that among patients and their family members exists positive interaction and communication between them is good. Home nursing agencies during the transformation of healthcare passed since its inception, a number of changes, which can be regarded as positive.

They seek the optimal autonomy in the provision of nursing care, recognition of nursing skills, they are fighting paternalistic approach by not only some doctors, but also by health insurance.

Development of nursing care as science requires any knowledge that can contribute to the improvement of patient care. The knowledge gained from this survey may appropriately serve to nurses who work in the ADOS as well as to other nurses in comprehensive nursing care in clinics and the like.

RECOMMENDATIONS FOR PRACTICE

The conclusions in recommendations for practice are essential for continuous improvement of status of home care agencies in the system of health care facilities in legislation and they can help to resolve financing of ADOS. We should also extend training in community nursing. We should inform the general public through information brochures, leaflets as well as the professional medical community with organizing conferences, lectures, seminars, discussions and disseminating information about home care through the media.

Home nursing care is especially important for the patient, because in his home he heals faster, but also for family members who may also be involved in the providing of nursing care. Social demands for professional nursing home care are increasing and at the same time are becoming an important element in the health care of the individual, but also of the society.

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STUDENTS AND GRADUATES OPINION ON WORK CAREER IN SOCIAL SECTOR

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Abstract

Survey on employment capacity of students and graduates in social sector in Slovakia has been accomplished as part of joint international project. Youth unemployment is a serious problem. Young graduates face considerable problems in making the transition from education into employment due to shortage of job offers mainly. Survey discovered general satisfaction with university education, but also necessity to have better capacity in some areas appeared. Study analysed strong and weak parts of education and issues of transfer from study to work. Generally society is not giving priority to social sector development. There are sources for higher employment due to rapid social changes within Slovak society.

INTRODUCTION

Relatively low proportion of Slovak working force is engaged in social investment activities to compare with other EU member countries. Both entrepreneurship and self-employment in social sector represent suitable pathways for young graduates to escape from unemployment.

Slovakia starts to experience ageing similarly like other European states, but still there is low engagement of young people caring older people. Young graduates may find job possibility in it.

Feminization in sector with high proportion of night shifts composes problems in framework of living and working condition harmonization. Changing role of man and woman in family and its own rapid changes has to be reflected in future plans of social sector.

Negative changes in financial capacity of clients, growing or stagnated unemployment are main factors behind the rise of poverty. Slovakia has necessity to develop social capacity in solving ageing problems, older people employment participation deteriorated, "return" of long-term unemployed to labour, humanization and ethnic "Roma" question. Many other new challenges are ahead. Some of them are these: missing el-

derly education, family services; work with youth, community centres and human capacity building. Rather modern and elaborated scheme of social protection suffers from heavy austerity measures. Many parts of Slovak society are in danger of poverty – even young people. Young people used to be proclaimed as the weakest segment of society.

Basically Slovakia is missing social economy, social cooperatives and very rare are social enterprises as well. Relatively low proportion of working force is engaged in social investment activities to compare with other EU member countries. In the so called white collars professions is lot of unused job possibilities. Slovakia is giving relatively smaller proportion from its budget to social sector activities (health and social protection) then is standard within EU average. (Hetteš, 2013a, p 47, p 157)

Social workers have to fulfil certain qualification requirements based on the law on public employment service, employment and social services. Slovakia is missing professional organization of social workers. This organization could protect and help in promotion professional in social sector.

Social work and social policy are interconnected by system of human rights, social and economic rights, which ground is human dignity. Slovakia has reached relatively high GDP per capita with very low labour cost. Long-term unemployment, unemployment of young people, generational discrepancies and regional differences are among the most important

obstacles for inclusive growth.

OECD December 2012 report on Slovakia urged to do more to tackle problems on the labour market with long-term unemployment being among the highest in the 34-member organization of industrialized nations. Slovakia has one of the highest rates of unemployed youth and graduates (about 13 % higher than EU average). School leavers belong among marginalized group from the point of view of the labour market. In some regions over 40 % of them are unemployed. Young people are more often in risk of poverty than retired people. (Hetteš, 2013b)

Youth unemployment remains a serious problem in many countries like in Slovakia. This situation reflects the mismatch between their skills and labour market needs, now also a lack of demand for labour, as well as insufficient development strategies for youth employment in the past. The main measures to increase the employment of people up to 29 years of age, according to National Social Report from the year 2012 will include improvement of the training of school leavers entering the labour market and reallocation of resources. Through active labour market measures government could support the creation of jobs in the public and private sectors through projects for employers who will create new jobs with an emphasis on regions with the highest unemployment rate.

In general carers of older relatives in most countries are economically inactive but a substantial number remain active. Relative number of carers of older people among economically active and inactive young people (between 15 and 30) in Slovakia is very low. This resulted from low intergenerational solidarity. Also it means that there is possible future capacity in the social sector activity of young people. Slovakia has to develop labour market demanded skills by encouraging and enabling people to learn throughout life; fostering international mobility of skilled people to fill skills gaps; and promoting cross-border skills policies. The Slovak Republic can put skills to effective use by creating a better match between people's skills and the requirements of their job and increasing the demand for high-level skills.

SURVEY METHOD

This study was part of international project of five EU member countries (Italy, Czech Republic, Slovakia, Slovenia and Romania) focused on young graduates' job possibilities within social sector. The survey in Slovakia has been taken among the graduates of social work, active social workers (operators) and

managers (decision making persons) in social sector organizations in Nitra Region and the western part of Slovakia during the first half of the year 2013.

National sample was identified according to the objective and the target of the joint project. Thus we needed a review of the present job opportunities for young people in the social sector, the education background of present workers providing social services, their previous work experience and the professional profiles.

There were relatively large number respondents – 425. The people were questioned or interviewed by the Slovak research team in time period February – May, 2013. Altogether 131 social workers, 250 current students and 43 managers took part in the survey. It is important for good working education scheme to have feedback from practice. Gender composition of student respondents represented the rate of feminization of the social sector in the country.

The history of Slovakia as a part of then Czechoslovakia reflected in country of the respondents' origin. 95.3% were from Slovakia and 4.7% from the Czech Republic. Slovaks have still strong ties with the Czech and vice versa. Slovak young people use to prefer to study in Czech Republic more probably than in other countries. To the less extent the Czechs study in the Slovak schools.

STUDENTS

The objective of the survey among current students was to identify the competence gap they perceive they have to manage a position in the social sector. The first part of the analysis deals with the characteristics of the students questioned, while the second part focuses on their expectations and perceptions.

There is common woman preference in favour of social work study in Slovakia and the female majority in respectful social sector employment. Number of foreign students is slowly growing and some Slovak universities actively offer their educational services abroad as well.

Students mostly live with partner and less often with their parents. Marital habits rapidly have been changed during the last decades. Living together out of wedlock for a longer time is frequent way of sharing the life especially during the time of studies. Joint living is less expensive when it is going on rent for accommodation. Dormitories are not all the time at disposal. The survey has been done among the students of universities oriented mostly on social work study program in Nitra and Bratislava.

The majority of students obtained certain work expe-

rience during their studies (Figure 2). From Slovak practice we know, that to the many former internship/ placement participants it was offered to work in this placement, after finalizing the studies. This kind of work practice formed advantage for later work career. Daily students also were using opportunity to work as volunteer within this opportunity.

Overwhelming majority of respondents was in opinion of high level education necessity for work in social sector. This outcome is in correlation with generally accepted position of highly skilled labour force requirement in both health and social sectors.

As for the main social needs which social sector should face today there were many different answers (Figure 2). The first position obtained the issues of employment/unemployment. This problem is commonly accepted as the most serious problem among population of Slovakia. Changing role of family and danger of poverty resulted from unfair distribution of national welfare reflected in the second and third position of social sector challenges. Low fertility rate is threatening future sustainability not only of the Slovak society, but also its neighbour countries.

What are the adequate competencies to face current needs? Result shows importance of humanistic and social ("soft") skills within framework of social sector activities. Employers give preference to the possible employee with suitable skills. Management and project planning skills are important for successful economic and financial institutions performance of many social institutions. Not always are students prepared very well to deal with these latter tasks. Study program provides competencies for work in social sector and there was common satisfaction with

obtained knowledge. Despite of satisfaction with obtained education, respondents articulated need for more technical skills and in less extent as well management skills (Figure 3). Knowledge and ability to work with computers has higher capacity then is required by opinion of respondents. Digital literacy is in satisfactory level according to students.

Students feel that they are good in acquiring of new knowledge, that they are open minded, able to work in team. The weakest point among strong points is low knowledge of foreign language. Unfortunately lot of social workers want to work abroad, due to shortage of job possibilities and high labour cost dumping in Slovakia especially within social sector, to compare with nearby Austria, Czech Republic, Germany, etc. This intention could be behind this feeling.

Study program is good starting point mainly for personal development, in less degree for future career and for further learning. Life-long learning is expected also in the field of social economy. There is certain disappointment with future career, which reflects national situation in labour market, particularly in social sector segment.

The majority of students do not feel disappointment with their own study program. They confirm their interest to study and possibly later to work in this field. Importance of work autonomy is accepted as very high.

Importance of job security has the highest importance for Slovaks in general public opinion pools. The importance of job security could be in social sector even more serious. Students of social programs are very eager to obtain new knowledge and to acquire new skills. Slovak labour force earns generally only

Figure 1.

Did you take part in one or more work placements/internships related to the social sector as part of your study programme?

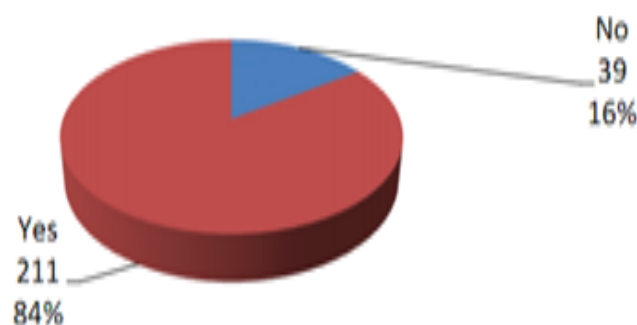
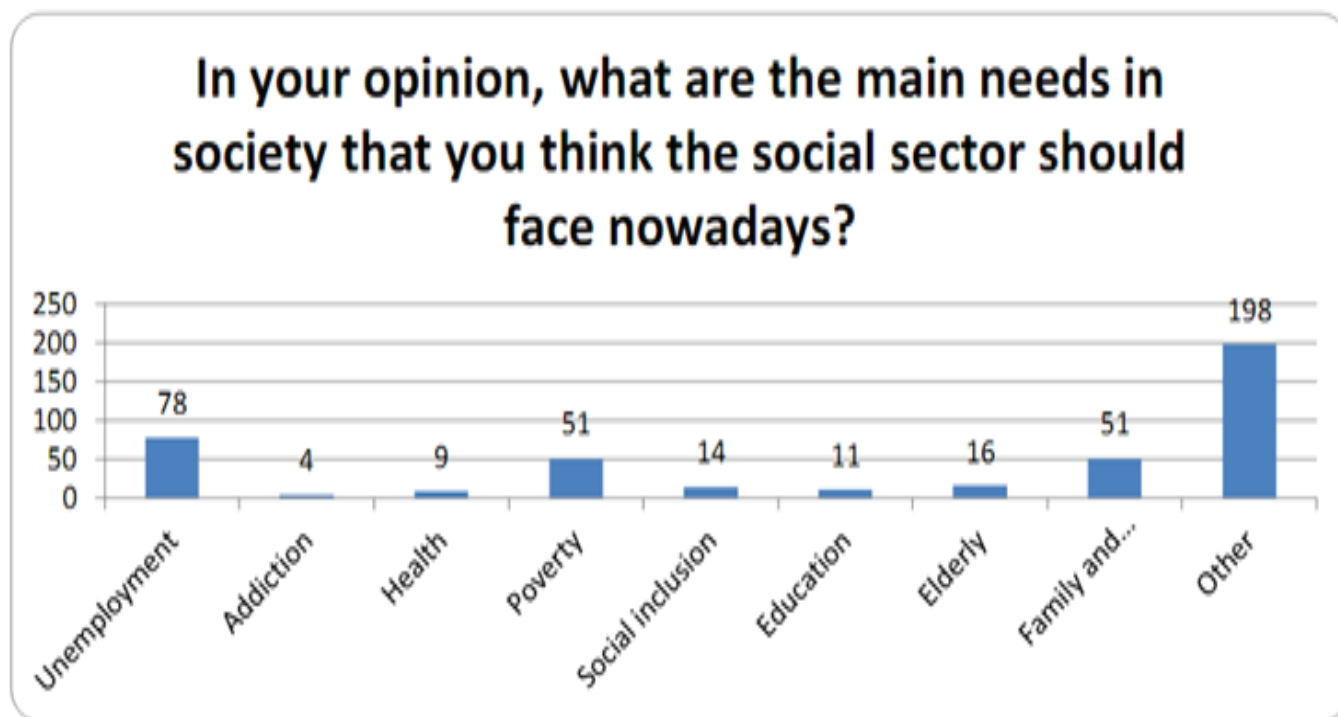


Figure 2.



30% or less of EU average in economy with 76% GDP (of the EU average) per capita in Slovakia. Surprisingly the importance of good income did not obtain higher importance. The work in social work (sector) was more important than pure source of money income for them.

Students are open for new challenges, which are good attitudes in changing world, ageing, globalization and new tasks. Good career prospects have balanced importance for students. They are important, but not exclusively. Results showed certain underes-

timation of free time importance. Readiness to work hard is relatively positive attitude. Heavy burden and overloading can destroy many future long-term work careers.

Social status has less important position. Good career, better income and new knowledge are more desired. Possible interpretation is that students want to help others without publicity. Feeling of importance of balance living and working conditions is positive for future family policy in the country. Overwhelming majority of students does not hesitate in

Figure 3.

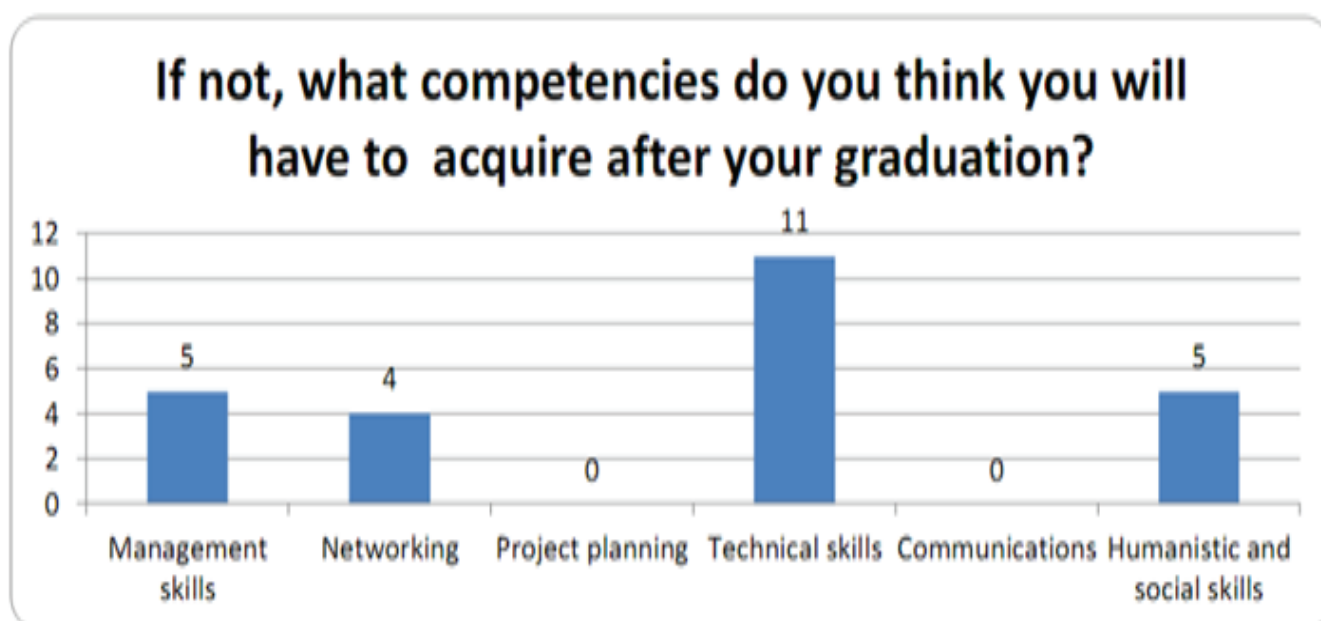
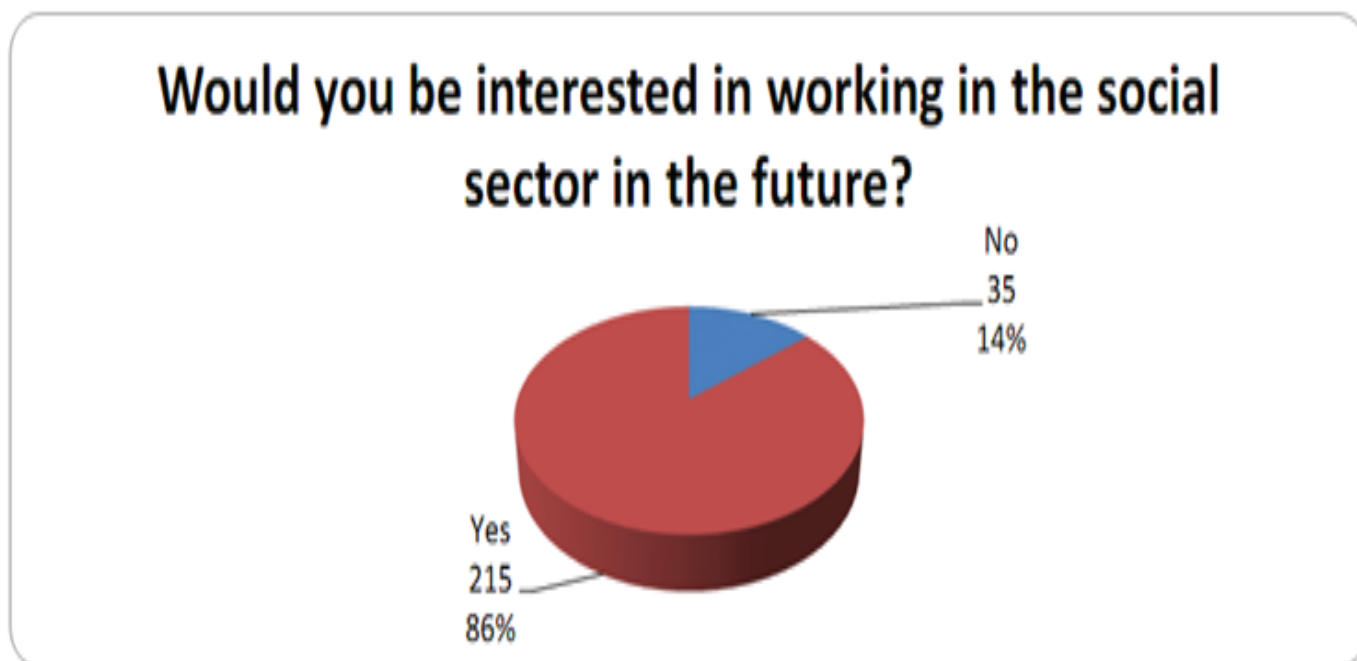


Figure 4.



their opinion of the future interest to work in social sector (Figure 4).

SOCIAL WORKERS

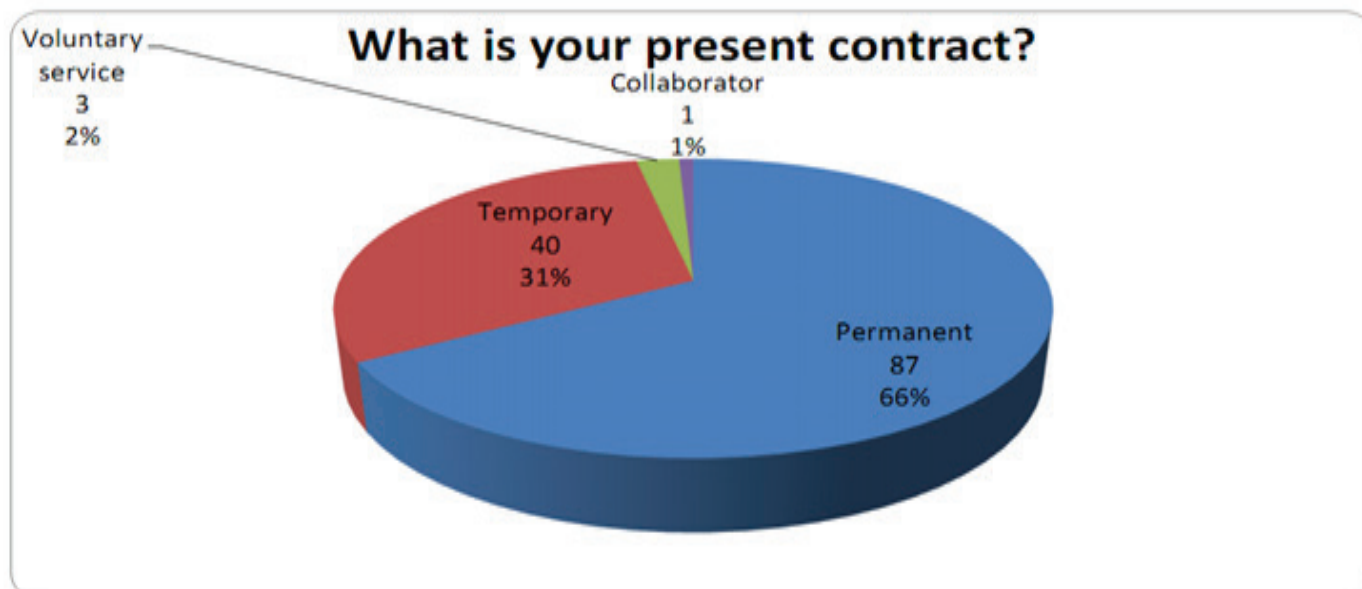
The objective of the survey among social workers was to identify what kinds of profiles are presently needed in the social sector to face the new society needs. In the first place the questionnaire focused on collecting data useful to understand the characteristics of people working in the social sector, in the second place it was asked them to name what they believe to be the new needs, what kind of profiles are presently not working in the social sector but would be suit-

able, in the third place it was asked them what kind of skills and competence these new profiles should possess and if they consider the university study program proper enough.

Prevalence of female respondents as is typical in social sector in Slovakia. Interviewed workers were in majority from the age group of 35 -44 years. From one fifth to one quarter of the respondents from this sample have some experience with work abroad.

Success in finding the job depends on own initiative, family and friend help and as well on approaching by employer. Part of former interns has been selected by employers to become their staff after finishing the school. Permanent job contract is de-

Figure 5.



creasing in favour of temporary job possibility. Current job contract is still mostly full time and permanent (Figure 5). Generally in Slovakia part-time jobs have approximately 5% share on overall employment. The result of part-time jobs in this survey was 5 times higher than is national average.

Prevailing opinion for the education prerequisite for working in social sector is university degree. The result correlates with present practice in this sector. Similarly like in student case, the preference is given to socio-pedagogical orientation and humanistic study programs by workers.

Becoming of expert is long-term process, therefore is important stability and less work place changes in sectors. Generally respondents answered their satisfaction with knowledge and skills they have now. Half of the respondents admitted their participation on different courses and training during the past 6 months. The reason behind was mostly to improve the knowledge and better fulfilling of tasks within present employment.

The main reasons for changes in employing organization were mostly resulted from reorganization and changes in personal tasks. Another important problem is massive lay-off that destabilizes social sector and its workers.

Interviewed workers were from various organizations with the size up to 59 employees which represented 41% of all. Vacancy filling with suitable/proper employee takes relatively short time. Accommodation to working conditions could be longer. Generally organizations do not have financial capacity to employ more staff.

Social workers admitted necessity to have capacity mainly in project planning and to less extent

in networking. Among the strong points of social workers we can add abilities to perform under pressure and coordination of activities. Weak points are connected with foreign languages, with asserting of own authority and surprisingly they have low competency in digital technology still. There was among social workers prevailing opinion of good satisfaction with study program for starting the job. Future career the majority of workers in this sample still see quite positive as a result of study program. Interviewed social workers admit high importance of study program for their personal development. Study program is not giving enough knowledge for entrepreneurship.

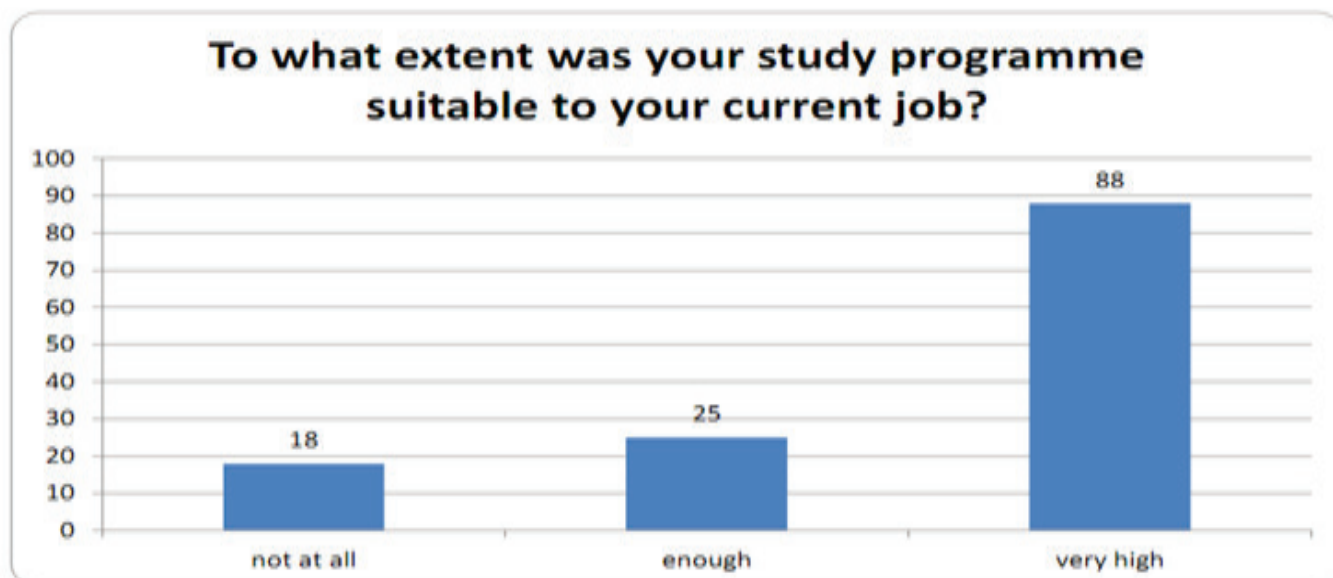
Even after time of working in practice there is wish to repeat the same study program. The results are similar like among students. Personal importance of work autonomy is very high under all circumstances. Opportunity to learn is perceived very high personally and also within framework of current job.

Importance of income overall is high, but in current job it is not hottest issue for workers. New challenges are important in personal career and also significant in current job with less difference as was in previous case with wage. Also good career prospects are highly appreciated in personal life, but are not the main challenge in the current job.

Social Workers evaluated importance of using leisure time higher then students. Proper using of free time and need to have enough time for family and rehabilitation is important for social worker (burnout danger).

Social status is equally important in private and public life. We can see difference between importance of income and status. Status and chance to do good for society is very important for workers in so-

Figure 6.



cial sector equally for private and working life.

Working and life harmony is very important for social workers. Social responsible policy is important to be in the force and has to be developed by employer.

There was high interconnection between current job and study program (Figure 6). Workers did not use placements/internship in such a level as is now common among current students. 17% of interviewed workers took part as volunteer during their studies. The number is growing now among students. Volunteering is good step before the possible later implement on the same spot.

Only 32% of workers did take part in social sector training course. Respondents admitted certain gap between school knowledge and employment requirements. That represents necessity for more post-gradual studies. Main subjects of these training courses were focused on supervision, caring, socio-psychological skills and community planning.

In the connection with survey there were tens of interviews with managers in social work sector. Their opinion and answers are very different and sometimes broad and specified. It is not easy to summarize their positions and statements.

How can social work managers describe competencies of their employees/staff? The majority of the managers appreciate their ability to work under the pressure, mastery of their field or discipline, ability to coordinate activities and digital literacy on the first place. The weakest point is not ability to write and speak in foreign language and missing ability to assert their authority. Personal awareness was weak point in other answers as well in this survey.

CONCLUSIONS

Slovakia is practically missing social economy, social cooperatives and very rare are even social enterprises. Development of social sector has high potential also for improvement of young graduates' employment.

Youth unemployment remains a serious problem in Slovakia. Unemployment affects important part of young graduates. This situation reflects also the mismatch between their skills and labour market needs. The Slovak Republic needs to improve matching of skills and the requirements of labour market.

Young graduates face considerable problems in making the transition from education into employment due to shortage of job offers overwhelmingly.

Finding of employment is not easy, requires lot of interviews and longer time. Within the active inclusion into the labour market, emphasis has to be particularly put on disadvantaged groups, especially on young graduates.

Despite the general satisfaction with university education, respondents articulated need for more technical skills. Social workers admitted necessity to have better capacity mainly in project planning. Employers (managers) give preference to the possible employee with soft skills. Management and project planning skills are important for successful economic and financial institutions performance of many social institutions.

Study programs accepted as good starting point mainly for personal development, in less degree for future work career. Life-long learning is expected also in the field of social economy. Certain disappointment with future career of young graduates reflects national situation in labour market, particularly in social sector segment.

Preference is given to socio-pedagogical orientation and humanistic study programs by social workers. Generally managers accept current scheme of study, but recommend more practical attitude and experiences.

Among the strong points of social workers and managers we can add abilities to perform under pressure and coordination of activities. In opposite weak capacity is in foreign languages literacy. Asserting of own authority is low and surprisingly still is gap in competency in IT within workers.

New services require improving of soft skills, better ethical approach to client and standards. Importance of humanistic and social ("soft") skills within framework social sector activities grows.

The social organizations have limited capacity to hire more staff-members, even there is demand for more social services in society. This decreases capacity to solve the poverty and social inclusion problems in Slovak society. Crucial is to improve position, remuneration and awareness of social workers otherwise social sector will remain marginalized.

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QUALITY OF SOCIAL WORK IN SOCIAL SERVICES IN THE SLOVAK REPUBLIC

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Key words:

quality; social management, social work, standard

Abstract

Many Organizations and Institution of Social Work in the Slovak Republic are not in alignment within the structural system that corresponds with the aim of services harmonization within EU member states. Necessary managerial and system changes cover not only organizational systematic structure, but also specialist capacity and competence, which can be considered as sensitive. Analysis of established practice in Social Services Institutions reveals that fear of organizational and professional changes, as well as procedures are slowing down development of the Organization and act as a barrier for possibility of continual development.

Among typical signs of risk factors for management of public and non-public Social Service Providers, we can include insufficient methodological management, as well as lack of co-operation with people in practice by Academicians. Managerial and expert staff are often left on their own without specialist knowledge, time, space or financial support for methodological work or research. MoLSAF abolished its Methodical Centrum in Poprad and in practice now has minimal interconnection between Academicians, politicians and staff. This factor influences personal management, knowledge management, change (reforms) management and quality management.

Management in Social Work and in Social Services is influenced by humane and existentialist theories. Both theories (models) are oriented toward a human as an autonomous being who has value under any conditions, are focused rather to his/her internal world than to immediately behavior; and has raised the questions of the sense of life to transcendental categories. Among humane and existentialist schools belong also therapeutic approaches as for instance Carl Rogers' Person Centered Therapy, Frits Perls' Gestalt Therapy, Victor Frankl's Logotherapy and Existentialist Analysis, and finally, also Shape Therapy Theory.

In our State, a relatively new method in Social Work is Social Management. We define Social Management as purposeful Social Work, target oriented, manager activity using suitable standards, scientific recommendations, strategies and cooperation by a whole team of social workers. Social Management works with living material, which is human. It is not working with a 'unit' we want to program, or to establish as standard data by which we can measure some final product.

Both the object and subject of Social Work and Social Services is a client with changeable ideas receiving social and health support. We identify the necessity of preparing and developing correct routes to managerial planning and organization management practice and methods of work with a client respecting the uniqueness and extraordinariness of that human being and their rights. We acknowledge as important to give appropriate space for research projects in Social Work that help in elaborating of verifiable and usable practices and methods of work.

A precondition of professional help and useful control is a competent social worker who is able to cooperate with professionals in a functional team of organization. In addition to political and societal expectations, that give a framework for this profession, the efficiency of Social Workers has influence on the historical context of the Social Work Organization and current legislative background.

Real vision of management systems in Social Work is focus on these subsystems:

- Management of individuals, families, social groups, communities, societies in managing unpleasant social situations and in help and support for solving of social events.
- Professional Social Works teams management, arranging and guaranteeing their joint practice in fulfilling this profession.
- Social processes management through using State Social Policy.

Knowledge of managerial quality is expected from top and middle professional management.

Topicality of proposed steps:

On Nov. 30, 2012, at the last National Conference in Banská Bystrica organized by the Association of Social Service Providers, the organizers, speakers, and discussants demonstrated the need for processing methodology for quality conditions that are specified in the Annex 2 of the Act. In Slovakia, the quality of Social Services has been a topic of discussion for over a decade. Today, we are not discussing the need to address quality, but how to ensure quality care in the current legislative environment and economic crisis. However, in the social field in Slovakia, we lack specialists and specialized literature on quality management and also methodical and comprehensive material of applicable standards. We find discrepancies, errors and systemic flaws not just in relation to the professional activities of staff.

In the current situation, each Social Service Provider is looking for solutions as to how to prepare fulfilling of quality guidelines. That Institutions of Social Work are not able to implement conditions of quality that have been in force since 2009, is proof alone of their inability, to meet requirements without outside experts. We believe that it is not appropriate to postpone application terms of quality just because there is a bad economic situation. On the contrary, we argue that it is necessary, as it is in other EU countries, to take responsibility and prepare us, by the year 2016, to fulfill professional standards of quality and to demonstrate the quality in public as well as in non-public Social Service. We think it is right that the academic team, with specific capacity for elaboration of professional training methodologies, processes and analyses, in cooperation with selected experts and with the representatives of the Ministry will take the responsibility for solving of these tasks.

Development, based on an analysis of the current situation of Social Services providing, the meth-

odology to analyze sustainability of compliance with the quality of the selected pilot bodies according to offered kinds of Social Services; develop methodology to assess the quality conditions by offering models (methods, practices, techniques, model documents, forms...) for procedural, staff and service conditions of quality; develop a draft model for implementation of quality standards; to process applied research results into legal rules (generally binding legal rules, internal guidelines etc.); develop a training course for methodologists and train the first methodologists; to compare results of applied research with standards of quality guaranteed in neighboring EU states; present the results and outcomes of projects to Founders and Social Service Providers, representatives of national local authorities association, the Ministry (MoLSAF) and representatives of Social Work Departments in Universities on a national level (expert workshops and at an international conference). Such a Research project is challenging to Academicians, professionals and politicians.

We understand standards of quality, with proper modification, as one of the direct instruments for improving service quality in Institutions of Social Services, and has influence for introducing and raising service quality for a client's life, for receivers of Social Services.

Actual objectives:

1. Develop methodology to analyze sustainability of compliance with the quality of the selected pilot bodies.
2. Develop methodology to assess the quality conditions with industrial designs.
3. Develop draft of model for implementation of quality conditions.
4. To conduct research and process applied research results into legal rules.
5. Develop training course for methodologists and train the first methodologists.

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CONFLICT BETWEEN EMPLOYEE AND EMPLOYER IN TERMS OF SOCIAL WORK

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Key words:

compromise way; work conflict; cooperation.

Abstract

It is important to point out the quality of employee relations which is highly dependent on the mutual respect of the legitimate demands of employees and employer (managers) in the workplace. Collective negotiation is a very important tool to protect the economic and social interests of the employees. The employees must be actively involved in decisions concerning their working conditions.

INTRODUCTION

The quality of industrial relations is important for the success of the organization and job satisfaction objectives or interests of employees and employers (managers).

On improving employee relations is now heavily involved compromise industrial conflicts (between employee and employer), which seeks to reach a negotiated solution that respects the requirements and demands of both parties (employees and managers) in the process of collective bargaining.

Human dignity in labor relations is an important attribute that greatly affects the relationships between employers and employees (senior staff) from the perspective of social work.

WORK CONFLICT IN THE WORKPLACE

The conflict is a clash of differing ideas, opinions and interests. It is also about various conflicting tendencies, which are often the cause of serious conflicts between individuals or groups in society (Stepanik, 2008).

The hallmark of the conflict in particular:

1. very personally focused arguments;

2. the use of terms like, you will have to and so on;
3. readout, blaming (McConnon, McConnon, 2009).

By Vruzek (1999) situations that are conflicting, can be characterized as:

1. relationships between at least two individuals or groups;
2. mutually exclusive priorities.

Conflict is necessary for the formation and improvement of each individual. It is an important stimulus to problem solving (Mayer, 2009). Conflict leads to delimit problems in interpersonal interactions and greater motivation to address certain problematic situation in terms of creating a balance in relations. Processing (adoption) conflict is an important part of a balanced personality of each person (Shapiro, Pilsitz, Shapiro, 2004). An important aspect of the personality of each individual's ability to cope with life situations which are typical conflicts or contradictions with other people.

By Brounsteina (2001) to achieve positive economic results in the organization, it is necessary to address particular labor conflicts. Effectively resolved labor conflicts increasing significantly affect job performance, which leads to an increase in the economic success of the organization.

Work conflict is a condition where the views or interests between employees and employers (senior

staff) are different. Conflict is a natural part of working life (Porvaznik, 1999).

Vruzek (1999) states that the conflict in the interests of the company as a manifestation of social conflicts in society. Very often conflicts arise between employees and employers (senior staff), resulting in strikes, layoffs and the like.

Labor conflicts distinguish:

1. internal (intrapersonal) conflict - are labor conflicts of the employee, with myself. Often there is a conflict between two operational objectives;
2. „external (interpersonal) conflicts - are labor conflicts between two or more employees. The cause of the various competing interests and different work values;
3. inter-group conflicts - are a specific group of industrial conflicts, which are influenced by different orientation of the working groups (Adamkova, 2006).

According to the impact on workers, labor conflicts are divided into two groups:

1. mobilizing conflicts - leading to the development activities. This is a promotion of new working methods or reorganization of the workplace;
2. destructive conflicts - are the negative effects in the workplace. Negatively affect the social climate and do not lead to problem solving (Bohumel, 2012).

Very frequent positive process of industrial conflicts are:

1. awareness of the problem among the people involved;
2. knowledge of career prospects for employees;
3. providing incentives to the employer (senior staff) to a greater extent with staff (Fehlau, 2003). Labor conflicts have a positive impact on employees, in the form of awareness of the importance of effective and intensive communication in the workplace.

THE CAUSES OF INDUSTRIAL CONFLICTS AND THE POSSIBLE SOLUTION

Solutions to industrial conflicts depend on their causes. Causes of industrial conflicts may be different interests or values (Plaminek, 2006).

If the parties (employees and managers) look only to their own values, inevitably results in a labor conflict (Harvard Business School Press, 2007).

When creating a positive working relationship is necessary to recognize the sources of industrial conflicts and try to find effective solutions. The causes of industrial conflicts may lie:

1. in personality and social behavior of individuals - some individuals are conflicting, aggressive, lawless. The solution is to allocate the individual from the collective;
2. in confusion - may be caused by poor communication or lack of qualification of workers. The solution lies in education of employees and employers (managers), which focuses on issues of communication and leadership;
3. deficiencies in personnel work - the reason may be deficiencies in obtaining workers or pay employees. The solution is to change the personnel policy;
4. in the style of leadership in the organization - lack of respect for the interests of employees. The solution lies in changing or improving the style of leadership;
5. in the process of forming the team - little attention has been paid to personality characteristics of team members (employees) and the personality of the employer (chief executive). The solution is oriented to better psychological assessment staff in creating a team;
6. changes in technology, work organization - changes are made without respecting the views of employees. The solution is aimed at explaining immediate changes to employees;
7. in the place of work and working conditions - the location of the workplace raises labor disputes in relation, for example. with distance from the material warehouse. When it comes to working conditions and sources of conflict may be: a cramped space, physical working conditions and so on. The solution lies in creating separate units with displaced persons (Koubek, 2001);
8. in causes that are outside the organization - these are the reasons that relate to the welfare of employees, but also to the economic situation of the company (crisis, unemployment, etc.). The solution is oriented to the employer (managers) who must be ready to cause changes in behavior of their subordinates. Prerequisite for the efficient solution is to create an atmosphere of open communication between employees and employers (senior staff) (Koubek, 2003).

Working unresolved conflict between employees and employers (senior staff) affects the productivity of employees in the following ways:

1. staff turnover;
2. low staff morale;
3. high rate of employee absence (Shearouse, 2011).

The management practice to use these five ways of resolving labor conflicts:

1. dominant method (enforcement) - used by operators of high interest for themselves and a low level of interest in others. It is a preference for self-interest and disregard for the requirements of other people;
2. minded way (dispute) - is based on a low order of himself and high interest of others. Terms of promoting positive relations with communicating partners;
3. evasive way (retreating) - a low interest in themselves, but also for others. One partner avoids relationship with communicating;
4. compromise the way (slowing the) - is based on a particular interest of themselves and of others. Partially giving up a part prioritizing relations with communicating partners (Porvaznik, 2011);
5. friendly way (co) - is based on mutual cooperation, which leads to the achievement of all individuals involved. Communicating partners have a high interest in promoting their own interests, but also the requirements of other individuals (Urban, 2003).

Effective solution for industrial conflicts are particularly important principles:

1. if labor conflict arises, it is necessary to follow reason, not emotion - it is important to clearly identify the cause of labor conflicts;
2. analyze arguments, the other side“;
3. it is very necessary to work together to find solutions to the problem Trip (Novy, Surynek et al., 2006).

A common cause of industrial conflicts are the working conditions of employees. If the adverse working conditions for employees, often results in dissatisfaction and staff leave the organization (Kulková, 2012-07-20).

Michel (2010, p. 90) points out that, „occupation (job) is for people very important part of their personal identity and socialization. Everyone has the need to be a full member of society and create goods and services. Employment (work) for a wide range of human social relations through which create space for self-expression and self-esteem.“

The role of managers (management) is primarily prevention of conflict situations. Among the

important measures shall include preventive deployment of staff in their professional and traits (Bohumel, 2012-07-29).

According to Spiess and Fading (2008) among the most important means of preventing labor conflicts include:

1. open communication;
2. effort to understand the other party;
3. achievement of common goals.

SURVEY PART

The main objective of the survey was to determine whether a compromise conflict resolution improves relationships between employees and senior officials from the perspective of social work in industrial plants.

INTERMEDIATE OBJECTIVES

Based on the main objective of the survey we have identified the following milestones:

C1: Find out, which is related to a compromise deal with conflicts between employees and senior staff of the employees in industrial undertakings.

C2: Find out what strategy to resolve conflicts with employees prefer managers in industrial enterprises.

EXPLORATORY HYPOTHESES

H1: The compromise solution of conflicts between employees and senior staff of the scheme is related to the action of the representatives of the employees in industrial undertakings.

H2: Managers prefer a compromise strategy conflicts with employees in the surveyed entities in industrial plants.

SURVEY SAMPLE

Own research was conducted from 09. 08. 2012 to 27. 01. 2013 by questionnaire. The core set were randomly approached staff and managers in industrial plants, where it was distributed 113 questionnaires. This basic set was chosen because that was in line with defined objectives and research hypotheses. Of the 113 questionnaires were properly filled and returned 98 questionnaires in research, representing a 86,7% return usable questionnaires. These 98 respondents consisted of exploratory sample (the sample).

Examined subjects consisted of the following industries:

1. industrial companies (over 300 employees): SB INMART, and. s. in Bardejov, CEMM THOME SK, et al. s. r. about. in Presov, I. C. A., et al. s. r. about. in Svidnik;

They studied subjects: industrial enterprises we have chosen for the reason that it is the busiest actors in which there are conflicts between employers and employees (senior staff) from the perspective of social work.

EXPLORATORY METHODS

In selecting respondents, we used random sampling technique. We used two types of questionnaires:

1. for employees;
2. for managers, who act on behalf of the employer.

ORGANIZATION AND PROCESSING SURVEY

Their own survey was conducted from 09. 08. 2012 to 27. 01. 2013 by an anonymous questionnaire survey.

Of the 113 questionnaires were properly filled and returned 98 questionnaires in research, representing a 86,7 % return usable questionnaires.

Staffing Survey are:

1. examiner, t. j. student - graduate student;
2. respondents who participated in the survey: employees and managers.

Information is divided into:

1. primary data and information - questionnaires;
2. secondary data and information - literature, internet.

In cases in which we investigated the most common response from the perspective of employees and managers, were applied two-stage sorting acquired data (two-dimensional contingency table), which were set absolute and relative frequencies for the observed category.

Two-stage (two-dimensional) separation is oriented to describe the relationship between two categorical variables (<http://rimarcik.com/navigator/ds2n.html#kt>, 2012-11-02).

Numerical calculations were performed by the statistical program SPSS (Statistical Package for the Social Sciences).

Questionnaires were prepared and evaluated in SPSS (Statistical Package for the Social Sciences) program and graphically represented in the survey results.

In the empirical part we examine a selected problem primarily through quantitative research. We performed a correlation research, in which we focused on relationships between pairs of variables in the research hypotheses.

SURVEY RESULTS

Using the statistical program SPSS results we have used us to verify hypotheses.

The data in Table 1 show that the category of employees working in the industry, the largest percentage rate, t. j. 35,4 % of respondents perceived importance, activities of employee representatives for employees within the meaning of compromise conflict resolution between employees and employers (senior staff).

Table 1. The important significance activities of employee representatives for employees under the focus of economic activity (employees)

Answers	Industry (economic activity)		Total	
	n	%	n	%
Improving the working conditions of employees	52	27,5	111	21,8
Agents constructive communication between employees and employers (senior staff)	24	12,7	90	17,7
The compromise solution of conflicts between employees and employers (senior staff)	67	35,4	146	28,7
Improving relations between employees and employers (senior staff)	46	24,3	162	31,8
TOTAL	189	100	509	100

Table 2. Favoring strategies of conflict resolution by the employer (managers) as the focus of economic activity (managers)

Answers	Industry (economic activity)		Total	
	n	%	n	%
Cooperation Strategy	6	46,2	10	34,5
Strategy compromise	3	23,1	10	34,5
The strategy argument	4	30,8	9	31,0
TOTAL	13	100	29	100

Based on the results shown in table 2, we found that the working category managers in industry, in the largest percentage rate, i. j. 46,2 % were considered the preferred strategy of cooperation to resolve conflicts when employees fail to agree on a common solution. Response, the strategy of confrontation „strategy adjustment“, „enforcement strategy is „and avoidance strategy“ did not have any of the respondents.

DISCUSSION AND RECOMMENDATIONS FOR PRACTICE

The aim of our research was to determine whether a compromise conflict resolution improves relationships between employees and senior officials from the perspective of social work research subjects. We used two types of questionnaires:

1. for employees;
2. for managers, who act on behalf of the employer.

The research was carried out in industrial plants in Svidník, in Bardejov and Presov. Of the 113 questionnaires were properly filled and returned 98 questionnaires in research, representing a 86,7 % return usable questionnaires.

We found that in the category of employees working in the industry, the largest percentage rate, t. j. 35,4 % of respondents perceived importance, activities of employee representatives for employees within the meaning of compromise conflict resolution between employees and employers (senior staff).

We can conclude that hypothesis 1 was confirmed.

The survey shows that the labor category managers in the industry, the largest percentage rate, t. j. 46,2 % were considered the preferred strategy of cooperation in resolving conflicts when employees fail to agree on a common solution. Response, the strategy of confrontation „ „strategy adjustment“, „enforcement strategy is“ and avoidance strategy“ did not have any of the respondents.

We can conclude that hypothesis 2 is confirmed.

RECOMMENDATIONS FOR PRACTICE

1. important activities of employee representatives should rest with the compromise resolution of conflicts between employees and employers (senior staff);
2. employer (managers) should primarily favor the cooperation strategy to resolve conflicts with employees;
3. highlight significant impact cooperation strategies to resolve conflicts with employees to improve mutual relations employee.

CONCLUSION

Labor conflicts in the workplace is a very negative way involved in employee relations and effective mutual cooperation between employees and employers (senior staff).

Hard to wage and working conditions, health and safety at work, employee training, labor is a common cause of conflict in the workplace. If the employees' interests are not accepted by the employer (senior staff), employees can exercise the right to strike as a last resort settlement of labor disputes with the employer (senior staff) in the process of collective bargaining.

The optimal solution of industrial conflicts in the workplace is based on the fact that managers favored a compromise strategy conflicts with employees who will respect, accept and provide for their mutual needs and interests.

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MANAGEMENT – THE SPECIFIC HUMAN ACTIVITY IN SOCIAL WORK

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Key words:

social management; social workers; social work; authority; skills, ethics

Abstract

Management in the social work can be classified as a managers' activities - social workers, aimed at achieving the objectives for which it is necessary to use suitable means, scientific advice and strategies, but the manager can not take place without the cooperation of the whole team of collaborators in this area. Manager – the social worker must devote his work responsibly and with a predetermined vision must plan activities so that it is carried out effectively, with a sense of emotion and ethics in the management of his working team. Social workers has always been interested in being effective and making a difference, therefore in this article, we are looking at why good management and leadership matters in social work.

Current and future demands of social work services require many changes. The research and reviews pointing out that doing of the same will not deliver what is required in the future. Demand and expectations are high, the focus of social services will be on what improves outcomes for service users and ensure these are done consistently (Moynagh, Worsley, 2005). Social work is at very important stage of development, and is currently facing challenge and more critical reflection as well as more high skilled approach to practice. A major challenge for management across the social work services is one of change management. To provide what social work of 21st century requires, we need to first transform the whole thinking about services with establishing the right culture and climate for change (NHS Scotland 2005).

Every social worker at every level should know something about discipline called management. There is however lots of questions if the same should apply the other way around, whether every manager should have social work practice background. Although, it does have to be accepted that today's managers of social work are employed not for the social work skills from

practice only, but mainly for the managerial skills that are in great importance in social work practice. Being a social work manager means being involved in many activities. The social work manager must ensure that everyone remains focused upon the management of practise whatever services are provided, and no matter how senior you rise within the organisation.

The management of people who deliver social work services therefore is a very important part of the manager's role. People are social work's greatest assets and without good employees quality services cannot be provided and delivered (Coulshed, Mullender, 2001) Social work manager is not only responsible for recruitment of the best staff but as well as for very important part as development of those staff is. Without proper training and further follow up the top quality service can't be provided. Supervision is a key by which managers can quality assure social work practice issues. It is crucial for social work managers built networks with the people they work with within their own organization and with people from the other organizations. In order to gain more experience and theoretical knowledge, they can contact other professionals and sort out potential barriers to effective working through these relationships. This can be very difficult when the man first begins as a manager, but

he will have probably picked up key skills as a social worker. The professional leaders should have a clear vision in their role, especially when comes to developing and maintaining practice (Rosenberg, 1995). A good manager should actively involved and inspire their staff.

Being able to take an action and deal with conflicts that go also hand in hand with managerial role. Social work services have built on values such as choice and self-determination to help to develop practice that is person orientated and emphasis social inclusion, trust, engagement and partnership with service users. It is based on interventions from skills in assessment, planning and review, supporting independent living and alternative care, networking, communication and partnership.

The suggestion that all social workers are managers is probably, at first glance, not a welcome one. Those who are about to become managers may be facing the transition with mixed feelings, they are ready to learn the new techniques and gain the rewards of the competent leader but they may also feel losing touch with direct practice and in certain ways perhaps becoming deskilled. The stereotype of the manager who has sacrificed social work values to the importance of filling in forms or gathering data on computer and who gives priority to what his manager in turn expects rather than users and practitioners demand.

Many leadership theories suggest that some people are born to be leaders, what makes them be taken for natural leaders. However there are some other theories that suggest that leadership can be taught through experience, skills, ability, intelligence and sociability of each and every person. Most people however prefer theory of “healthy balance” explaining that good leadership may well be combination of both. Traits and behavior (Lambley, 2009). Whether you are a born leader or a “made leader”, the leadership style should reflects your style of work and should be in context within the services which you work. We are aware that social work managers are working in not very tidy environment with real people and real problems (Hardina, Middleton, 2007). Therefore good social management and leadership must be relevant to the context within which it is practiced. Managing of people is social work belongs to very important tasks in social work manager’s role. People are the most important and greatest assets and without good staff and quality services cannot be provided and delivered. Supervision is the key and with its help manager can be easily involved in quality measurements of provided services and also monitor of the staff, although still

stay in touch with social work practice (Lambley, 2009). Leadership is not a fixed style of performance. It must be said, that with practice, it should emerge from the balance of role, task, role and relationship with the team and situation being faced (Payne, 2001). Leaders that are trusted by group, are able to encourage people highly participate, and well placed to delegate with confidence. However the new leader or the one with poor relationship with the team as well as no real influence can be in difficult position. In such circumstances, it is often advised to focus on the job, not the relationship with the team. As with so much in management, flexibility is the key (Jackson, 1999).

People may tend to think, that the main task of management is controlling work of others of the behalf of the wider organization. This can be quite unfamiliar term for the first time managers. For them responsibility, sometimes can be more difficult than just getting on and doing the work oneself. In social work, managers do not have a freedom to appoint their own deputies to help them with their workload. What is probably most important is the fact of managing themselves. Good managers should be responsible for their actions that should also be based on values which are in context within the organization. Manager of social work should first seek to understand and then be understood. He should be able to understand people he works with and find the way to compromise and negotiate. Uncontrolled conflict is often a sign of poor management. In social work, management and leadership, is evolving. Alongside professional social work, and it is important that the values and ideas that shape an individual’s commitment to social work can be adaptive and that managers encourage all staff to be proactive and adopting the best of work (Fletcher, 1998).

The great challenge to the public services is to construct a management model which would fit the function and purpose of the ideal of service to people. Ethic is very closely connected to the social work manager role. Ethical issues in social work arise for managers, because of the decisions their taking, which have implications for others and also because managers are taking responsibility to ensure that the quality services and organization activities are in line with public interest and standards. An ethical based management suppose to inform us about the particular organization or service provider and how they will go and achieve effectiveness. Every social work manager should represent and develop his personal ethic. Four principles which lead to healthy and no conflict management are. Autonomy, beneficence, non-maleficence, and justice (Hugman, Smith, 2001).

Those four principles, depending on the situation and circumstances, can carry different weights of the particular ethical issue or problem. However the principles are the basic standards of management practice across the different disciplines.

The most obvious concerns is the management of people. Whether this is service users, careers, the general public or those who regulates service provision, management, just like practice, involves the ability to write and speak clearly and to engage in interpersonal relationship. Today's generation of social work students take an active interest in such widespread issues, and if the new generation keep their energies, they are well placed to make a difference in the future. The study of management and organizational theory can be about how to work and learn together where every assumption has been turned upside down, where the most valued skill may be the ability to think outside of the box. This is where principles and skills come together and confirms that good social work as lying at the heart of good management. Every social worker has a part to play in management, and every manager, social work qualified or not, has a lot to learn from social work (Statham, 2004).

It may help to realize and remember that managing people is at the heart both of providing services to users through social work methods and of organizing and working towards the effective delivery of those services by others.

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SOCIAL-WORK AND PSYCHOLOGY IN A MUTUAL DIALOGUE

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Key words:

psychology; social work; theory of social science

Abstract

Social workers in congruence with psychologists possess a field of help, support, accompany; not as a system of support, where the centre is client-individual, family, group, community and ambition to implement the values into interventional process. These professionals have inbred ambition to help people in danger. They aim to solve the problems on the basis of classifying the needs of a client and to project and implement the interventions accordingly.

In the last decades, we concentrate more on the physical world than on ourselves. Physics and Chemistry have made a great progress in recognition of reality regulating signs. However, at the same time, the science about people was developing quite slowly. Even at the time of Sigmund Freud and Ivan Petrovič Pavlov, the Platoon's dialogues were an important artefact of thoughts, ideas, and information about human way of thinking, action and emotions.

Nowadays, the psychology is a system of more than 60 psychology sciences, which are dynamically evolving, and belong to humanistic science. The main aims of psychology-science are to describe, explain and predict human behaviour and living to increase man satisfactory and (Plháková, 2003).

Apprise of information about social-work and psychology allows people to get some idea about their own psychic life, to understand its own living and behaviour, feelings and motivation so one can control himself, plan and predict. This can help to understand behaviour of others, which creates good human relations, precede conflicts, or solve them effectively. It assists in one's and others' life enhancement and negotiate traps of nowadays. Even in this one, we should see the value of acquiring the knowledge of this science.

It is very hard to define the Social-work, because it is never-ending process during which

the discipline tries to analyze and solve constantly changing society. (Matoušek and col., 2001). Montreal definition of Social-work (In: Matoušek and col., 2001), here he speaks about Social-work as about „profession, which supports social changes, problem solving in human relations, delegation on people so they can free themselves and increase their prosperity. Utilizing the theory of human behaviour and social systems –SP, interfere into a point where people interact with their environment. The base of Social-work is the principal of human rights and social justice“.

N. Hartmann (In: Hašto, 2005), in his concept of teaching about segments in the beginning of 1920, provided the philosophic-ideological role, according which the human is a “layered” being. The lowest layer is inorganic, which is studied by physics and chemistry, right above is the vital layer, that is studied by biology with all its disciplines, and following is the psychic layer which is an object of psychological sciences, the last one is a social-spiritual and it is an object of social sciences and clergy discipline. „In the biology layer, we may also find physical-chemical laws of lower layer, but with respect to some laws which are unknown within inorganic stage- e.g. aimed adaptation. Higher layer-over

biological- is psychological, as thinking and performing human. There are many expressed individual specialties which are clearer in final sight (in which are some complex of causal processes). Social-spiritual layer is over individual determinations and it has a merit to all human society: sphere of social communications, spiritual, ethical and religious values. Transcend awareness of individual. Each of layers has its own rules and specifications, and the higher layer is dependent on the lower layers. Lower layer are the base for higher ones and therefore "stronger" than that ones. Higher layer can not exist without lower layers. However, lower one can exist without higher" (Hašto, 2005, p.87).

Wide consensus of professional community and its use in practice, has already gained bio-psycho-social role, which was first introduced by George Engel in 1977, this integrates biological, psychological, and social aspects of human being. Nowadays, this role is accepted by humanities and it is resource to holistic, systematic, multivariable approach to client. Acknowledge of biological, psychological, and social factors as cooperating aspects in aetiology and treatment to sickness, as well as a solution to social and psychological crises in human lives, implicates needs of interdisciplinary approach – close cooperation and constant dialogue of all concerned disciplines. Their good connection and collaboration can be considered as a key to health, happiness, wellbeing and personal growth.

In the spectra of humanities, Social-work and psychology are situated quite close to each other in particular. Despite specifications, we find a lot of their conjunctions and similarities in many parts of theories and practices. It concerns relationship of psychological scopes, terminology, work methods, as well as research procedures or ethic principals.

Social-work and psychology insists on assistance to client so his life quality may increase in his social environment. They lead the client to understand his living and behaviour, to identify mechanisms and processes that may influence all this and to know the social context which relates to it. They help individuals, families, groups and communities, in trustful atmosphere. Both of them are characterized by a great rate of multidisciplinary, because they all link up other disciplines, including Sociology, Pedagogy, Law, Philosophy, Psychiatry but also Economy, Somatology and medicine.

Conjunction of these two disciplines can be seen in application of its basic interventions and methods. Oláh and Schavel (2006, p. 11) e.g. it refers to fact, that "what we find common in between psychological

and social counselling, is for sure the approach to a human, on the principal of accepting his uniqueness and general rules that are part of counselling process. In general, it is know that, the client expects advice, help and solution to his situation, from his consultant. The present times, in social sphere, prefer approach based on the support, help and accompanying of client as assumption of his motivation for mobilization and involvement in solving his problems." Very interesting is elevation on connection between socio-therapy, psychotherapy, and social work by L. Lozsi (2011), which is using an imaginary 3D model for illustrating differences and similarities between all these sections. The three variables of this model are height, width and depth and by their help it tries to get some fixed point of these disciplines. However, the author includes that, "no matter what our operational area is, whether socio-therapy, social work or psychotherapy; it will always be a client centred area " (Lozsi, 2011, s. 2). Therefore client centred area may be considered as some other great intersection between psychology and social-work.

She associates with Haštova's (2005) theory about plurality of methods, according to which, it is obvious, that professional – social worker and psychologist, is "moving" within the client's layer; whether he realises that or not. It is genuine that she considers some different levels – level of sociology, pedagogy, law, philosophy, psychiatry, but as well economy, somatology and medicine. Needless to say, that we have to consider a social level too. However, if we had ignored it, we wouldn't be able to ask some very important questions and look for their answers. , "We would have to resign to risky social and protective factors in formation, possibility of aimed work with public and social aimed prevention. Strictly considered, we would have to resign to psychotherapy too, because it is as well a social interaction" (Hašto, 2005, p.88).

In practical level we may find some concrete activities, which are performed in the interaction with the client by social workers and psychologists. We may include, e.g.:

- identification of clients, who need the help;
- reviewing of client's background and life situation, including identification of their needs as well as strong and weak points;
- examination of client's needs, their situation and support network for determining their objectives;
- providing help for client's adapting to changes and challenges in their lives, including bad social situation, e.g. divorce or joblessness;
- providing help during critical situations like natural disasters;

- providing help to client while in wide range of situations as accepting a child till dealing with the death of a relative;
- providing individual, group, family, pair therapy or consulting;
- compiling of a therapy plan with the client in co-operation with other specialists;
- support the clients in discussing their emotions with the aim of understanding and enhancing human relations;
- evaluation of developing ones clients.

Psychology owns its strong position in social-work. It helps to enhance clinic experience of social worker following the solution or alleviation of the client's problems. Psychology assists the social worker in better understanding of his client and at the same time it gives him a better opinion of self-knowing and self-developing.

Social workers, as a professional help, perform their profession in close contact with their clients and other specialists. Therefore, it is necessary for them to have knowledge and skills in area of working with people, so they can offer them in helping their clients as well as for their own health and comfort.

Along this line, knowledge of psychological theory and practice for social worker are unsubstitutable. These may help the social worker to understand the individuality of client's way of thinking, living and needs which are base for individual and optimal approach to client. They help to understand the client's life situation and his motivation to change. Wide range of support, for social worker, may be knowledge of communication, as well. It is including the understanding of communication process itself and handling of specifications of communication with different types of clients, more precisely cooperating specialists. Area of handling pressure and stress is non neglectable, so psychology can help to identify factors that influence managing and solution of social situations and problems, as well as requirements of everyday life. It is obvious, that these information can be (and should be) used by social worker not for client's benefit only, but as well for keeping his own health.

Competence and wide view of specialized working activity that is provided by social worker on everyday bases, requires many specifications and demands. These refer to special preparation and experience as well as the personable maturity and ability to respect the ethic norms and values, while in practice. It is obvious to have attributes which are being developed and formed in the whole life process. It is unnecessary

to understand that it is impossible to consider them as some automatic part of specialists in Social-work. Despite individuality of each person, we can suppose and expect that social worker will be equipped with "package" of qualities, attributes and skills. This may not only be a reason of his quality interaction with client, but as well for much more aspects in his profession. In the beginning of this "package" must be ability to self-reflex, of self-understanding and ambition to self-develop.

Training of social workers in the sphere of psychology is therefore a key part of a program of Social-work. Theoretical basics of general and evolution psychology, psychology of personality and social psychology together with basis of psycho-pathology are as important as practical preparation and plaction of psychological knowledge through socio-psychological trainings. The aim is to learn the communication and consulting skills, understanding to individual needs, behaviours and livings together with deep self-understanding of frequentants in trainings.

Social workers in congruence with psychologists posses a field of help, support, accompany; net as a system of support, where the centre is client-individual, family, group, community and ambition to implement the values into interventional process. These professionals have inbred ambition to help people in danger. They aim to solve the problems on the basis of classifying the needs of a client and to project and implement the interventions accordingly. Social workers and psychologists can not stay aside when some individuals are in a collision, danger or when sometimes even reject the practical hits of help. They have to respect ethic principals, client's right for self-estimation and to help the client with identifying and clarifying his objectives.

Psychology clarifies even some controversy questions to social worker, for example, how far can client participate in self-destructive activities by the law; what should be the reaction of a social worker when an oppressed woman decides to go back to violator, or she does not want to leave him; with psychiatric client who decides to discontinue his psychiatric treatment even of the fact he was advised so; approach to suicidal client, or homeless that prefers to sleep in the street rather than in refuge. Balance between these professions can be seen in the commitment of client for self-determination and in protection of clients from damage. On the behalf of client's protection, they help the clients to solve and cope with their everyday problems and heal their mental, behavioural and emotional problems.

Social-work and psychology study person's

behaviour and living laws together with external and internal variables that regulates them. Both of them can be described as science disciplines, thanks to which we possess enough of certified information about thinking, perception, activities, statements, emotions and personal variables. Nevertheless, we may not form some complex theorem or closed system, which would be universal or valid for every client at the same time and same place as for instance a law of gravity. It brings not only intuitive but also experimental approach of obtaining information while they are interested in wide context of human existence and complex phenomenon as well as in connection with more science disciplines.

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