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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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Key words: **evidence-based practice; social work; education**

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.

ARTICLE

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).

The 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 criteria.

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). The definition of Evidence-based behavioral practice from 1992 was the 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 characteristics, state, needs, values and preferences of those who will be affected. This is done in a manner 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 the 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 judgment 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 previ-

ously framed.
- Critically appraise the identified evidence for validity 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 undesignated 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 color 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 emerged 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 psycho-social intervention models such as 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 byNIMH, 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 psycho-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 (Sacket, 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 is a professional discipline that introduces expertise and specialized knowledge, ethics and skills aimed at addressing difficult human

problems, including various 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).

VVery 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 its 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 modernization agenda for social services (Bonner 2003). In fact, the need for underpinning practice with an evidence base has consistently been emphasized 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).

Beside 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) 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 competence and responsibility of Social Work across various European, American and Australian countries. For instance, in the USA, the Educational Policy and Accreditation Standards expect Social Workers to employ evidence-based interventions as well as research findings in their professional practice. In Australia Social Workers must demonstrate their ability to utilize research in practice (Australian Association of Social Workers 2008). In the UK, the critical evaluation and appropriate use of research findings has been formally recognized 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 various important Universities in USA, 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 programs and, in general, the issues arising from the implementation of EBP in the cur-

riculum 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 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 organizational and interdisciplinary procedures (Jenson, 2007). Notwithstanding, this model has been criticized 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 before, it is a formal demand that Social Work trainee, as well as graduated practitioners generally need to establish an appropriate use of relevant findings from research studies. But there is a question as to which EBP is being embedded within Social Work programs. In point of fact, to integrate a new subject into an already dense curriculum like that 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 in, 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 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, a 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 programs 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 programs only to a modest extent that interventions and approaches of dubious efficacy continue to be prevalent within such programs. 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 programs, 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 discussion of this issue should be contextualized by looking at the debate that the expansion of EBP from medicine to Social Work has originated within the profession. As we know, along with strong enthusiasm from some fields of the Social Work profession, an EBP has also been received with considerable skepticism 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 that it 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 randomized, 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 evidence cannot meet 'the sometimes contested and divergent knowledge brought into play in the many places and ways in which Social Work is practiced' (McDonald 2003). Sackett et al. (2000) describes EBP's very nature as: 'a philosophy and process designed to forward effective use of professional judgment 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, organizational 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 randomized 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' programs, 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 program is that such a scary experience will deter the youngsters from future criminal behavior. 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 program 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 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

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 make 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 implementers 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 organizations. 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 standardized 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 minimizing 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 consid-

erable 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 a 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 thereby 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

Supervision in Social Work was amended through the Slovak legislative system Act No. 305/2005 on socio-legal protection of children and social care. In this way, professionalization of the helping professions acquired a considerable edge over other countries in Central Europe. This initiated an ongoing discussion regarding the importance of Supervision as a method, 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). Interest in Supervision, as well as its performance, has increased in the last five years. This motivated us to perform the first examination concerning Supervisors in the field of Social Work in Slovakia. This article explains the part that analyses the structure of Supervisors in Slovakia.

ARTICLE

INTRODUCTION

Specific characteristics that Social Work Supervisors who work in the helping professions should have are altruism, willingness to help, ability in cross-cultural work, flexibility in the methods and interventions, to be open to new knowledge and approaches, etc. However, a good Supervisor must also be a good teacher and a good adviser. A Supervisor respects his/her supervisees' personality, their progress as professionals, be sensitive to individual differences (race, ethnicity, gender, etc.). A Supervisor's authority and competence are seen as natural aspects of the Supervisor's role. A good Supervisor is pleased to be a part of the worker's professional growth. A Supervisor has a sense of humor, which helps both Supervisor and supervisee, to get through difficult periods during their partnership in order to achieve good prospects for mutual cooperation.

Professional skills of a Supervisor include extensive training and experience in working with clients; skills which help a Supervisor to gain a broader perspective in their field. A good Supervisor knows how to use a wide range of supervisory interventions and can properly select the one that is most suitable for his/her supervisees according to their learning needs, learning style and personal characteristics. A Supervisor continues to develop through continuous learning, self-evaluation, feedback from supervisees, clients, other Supervisors and colleagues.

A good Supervisor having the characteristics of a good teacher can properly apply teaching theory, appreciate the efforts of the supervisee to learn, but also is a supportive adviser able to objectively evaluate problematic situations, provide alternative perspectives and concepts of problem situations, direct the search for solutions, and so on. These parameters encouraged us to start the initial investigation focused on a wide-ranging analysis of the structure of and encouraging further research activities for Social Work Supervisors in Slovakia.

RESEARCH GOALS

The goal of this quantitative research was to capture feedback from 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 ques-

tionnaire of 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' $\chi 2$. If the level of significance – p-value (Sig.) of the test used was less than 0.05, we accepted 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). We considered it a significant difference 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. A sample of 40.86% from the base file that we had identified participated in the research. We consider this proportion as representative, offering an effective probe into the phenomenon analyzed 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%).

The results reveal the statistically significant representation of women as Supervisors in the 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 in which 79.64% (105) were women and 20.45% (27) were men.

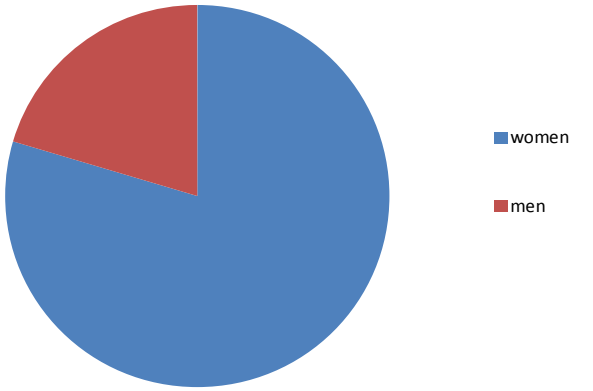
Table 1. Structure of supervisors in Social work in Slovakia by gender – the sample

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

When analyzing the sample, we were also interested in knowing in which region the Supervisor works. According to the pre-research activities, we decided to accept the possibility of multiple responses. There is a possibility that several autonomous regions might represent one catchment area for a Supervisor. N, in this case, does not indicate the number of the respondents but the number of their choices.

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



n = 132; p < 0.,01; $\chi 2$ = 46.08
Source: own research, 2013

Looking at the result of the test criterion $\chi 2$ we can summarize a 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.

Another demographic characteristic we studied was the age structure of Supervisors. Respondents were offered the option to insert themselves into an 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 situa-

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

tion 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 in prime of their work life; the professionals whom we can assume sufficient work experience; who can offer professional views to the third, disinterested party; and, who would lead to more effective Social Work.

Education is an important aspect to perform Supervisory activities. Nowadays, the education status condition is at least the second level of a University

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

Degree; a Master's Degree in Social Work or a related field of study. It is the adjective 'related' that very often causes much embarrassment. Clearly defined by Act 448/2008, what we presented with a basic file description. But, it is only related to 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.

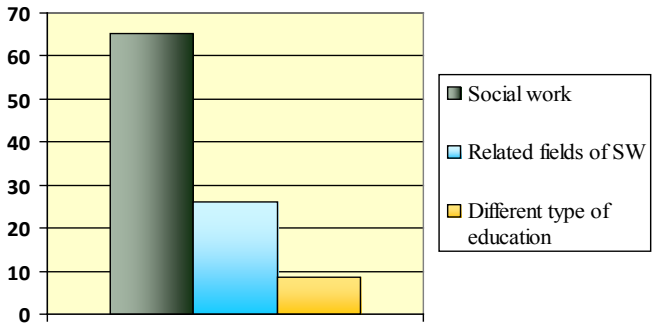
For these reasons, we have decided to focus our attention even on this area. Educational profile was recorded using three categories:

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.

We followed the educational profile of Supervisors from the point of their highest academic or scientific degree achievement. It is a very well-known fact that Supervisors are often professionals who en-

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

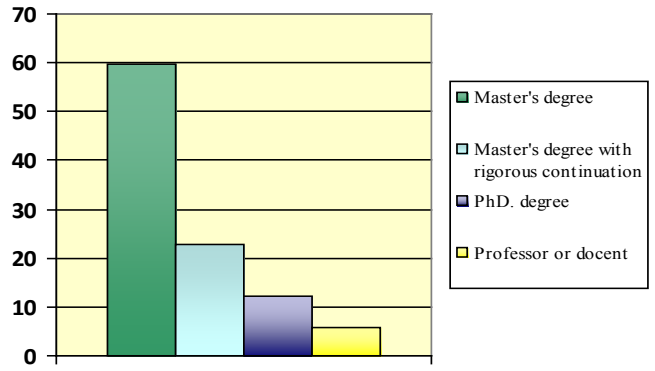


n = 141; p < 0.01; $\chi 2 = 71.26$
Source: own research, 2013

hance their professional competences during their whole career. This fact was confirmed.

Over 40% of the Supervisors who participated in our research achieved a University Degree higher than the second level; 59.57% (84) of the Supervisors involved in our research achieved the second level of

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

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, professional experience is extremely important for the Supervisor's performance in Social Work. Therefore, this has become our subject of interest. We are pleased to confirm that nowadays Supervisors have sufficient experience to perform their profession.

Only 7.8% (11) of the analyzed sample Supervisors have professional experience in Social Work less than 6 years: more than 58.8% (83) have professional experience in a range of 11 years plus. A generally acceptable limit of professional experience in a

range of 6-10 years is fulfilled by a statistically significant proportion of 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; χ2 = 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 in which fields of performance 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, An equally interesting finding is the relatively low level of professionals who are active in the fields of management and governance of the Social Services subjects – 2.84% (4).

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

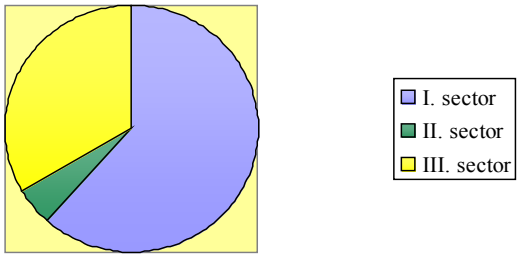
Fields	%	z-score
Education and research	9.92	- 2.14
Socio-legal protection	20.57	1.24
Social services	47.52	9.83
Street work and community social work	9.22	- 2.37
Management and governance of the social subjects	2.84	- 4.40
Others	9.92	- 2.14

n = 141; p < 0.01; χ2 = 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.

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)

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



n = 141; p < 0.01; χ2 = 68.08
Source: own research, 2013

Supervisors work in Sector II. These are individuals or the organizations established for the purpose of income production. This sector is also called private sector or profitable business sector. Sector III consists of the organizations that are not included in the Sector I and II. It is a non-government sector, non-profit sector. It is financially and organizationally 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 University Degree and field of study of Social Work; she has been working for 6-10 years in this field. This simplified generalization is made only on the basis 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 a 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 evaluated the statements of patients receiving outpatient chemotherapy administration. Through a questionnaire survey they look for the level of satisfaction of patients including the approach of physicians 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.

ARTICLE

INTRODUCTION

In our research, we focused on the patients themselves; their level of satisfaction with the provision of health and nursing care; approach of medical staff; the issue of information about their medical condition; 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

TTo 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, respectively 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 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 a 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 250 patient respondents were treated with outpatient chemotherapy in OÚSA Bratislava. Age of the respondents was 29 - 65 years.

Table 16.

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

Table 17.

Resindence	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.

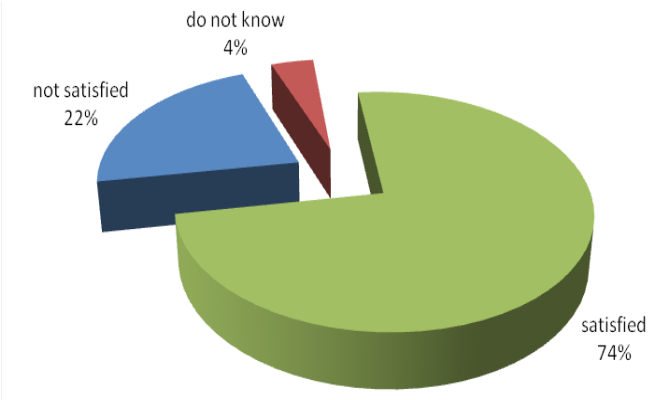
How do you rate telephone connection with ambulance?	n	%
Very good	170	68,0%
Good	60	24,0%
Passable	20	8,0%
Poor	0	0,0%
I do not know, I have not tried it	0	0,0%
N	250	100%

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 outpatient facilities in which chemotherapy is administered. This working hypothesis was verified in items 3, 4, 5 and 6.

Figure 1.

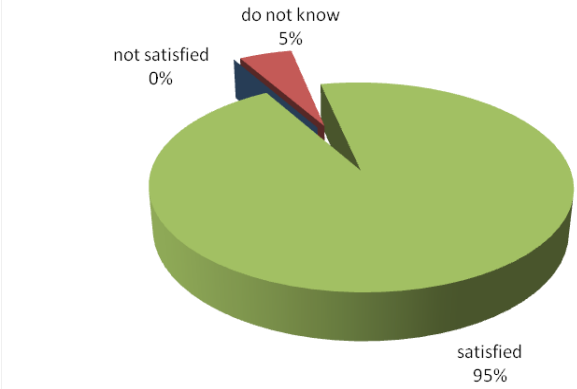


We found that 74% of respondents were satisfied with the organization of the work; 22% expressed dissatisfaction - mainly with confined space prior to the administration of chemotherapy; 4% of respondents could not express.

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

In the working hypothesis H2, we assumed that healthcare 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.

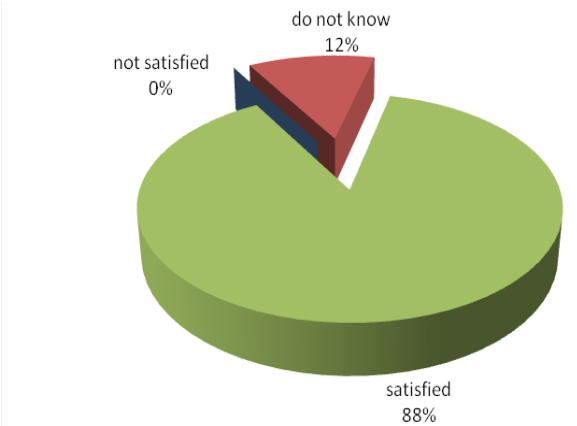


We found that 95% of respondents rated the medical and nursing care as very good and at a high professional level; 5% of respondents reported that medical and nursing care was at the professional level.

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.

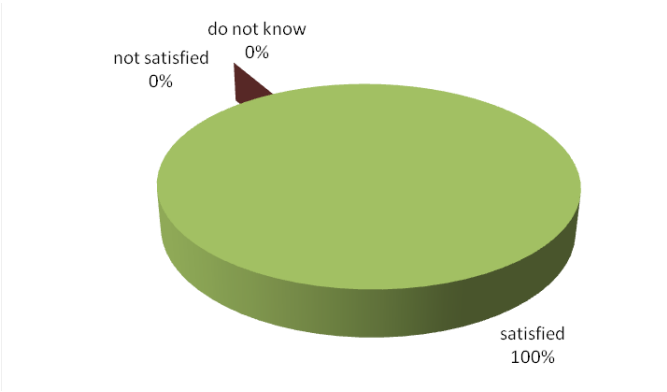


We found that 88% of respondents were satisfied with the level of provided information about their health and 12% of respondents were unable to comment on the issue.

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, the patient should have confidence in them and should not feel that their multiple issues are "a burden or time consuming"
- Nurses should be particularly attentive to non-verbal as well as verbal expressions in contact with patients
- Ensure that there are enough information brochures in the waiting room: 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 studios and the like
- Nurses should pay attention to their behavior and demeanor even in telephone contact with the patients and their family members
- Head 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 RECURRENCY IN PATIENTS WITH COMPLICATION OF HYPERTENSION AND CARDIOVASCULAR RISK OF THEIR REALATIVES

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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 homecare 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 the family.
Methods: This prospective analytic study used a questionnaire method. Respondents were 100 patients with complications of hypertension by Homecare Agency SANAS Topolcany and other Homecare Agencies in Slovakia (Group A) and 50 first-degree relatives of patients with complications of hypertension who are or who were in care of Homecare Agency SANAS Topolcany (Group B).

ARTICLE

INTRODUCTION

Nurses from Homecare Agencies (HCA) are often meeting with patients with severe complications of hypertension, most often cerebral stroke. These patients are immobile, completely dependent on supportive activities of their lives. The reason for this situation is that hypertension is often untreated or treated without effect.

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

The aim of this study is to evaluate the universal risk of homecare patients with manifest CVD, as well as to evaluate universal 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 inappropriate lifestyle?
- Are the patients with complications of hypertension endangered by the recurrence of complications?
- What is the universal cardiovascular risk in their first-degree relatives?

METHODS

The research problem in this study was related to "risk population" which included:
1. Patients who underwent complications of hypertension (cerebral stroke, ischemic heart disease, atherosclerosis of lower extremities)
2. first-degree relatives of these patients.

To be able to evaluate a global risk of patient's recurrence and the universal risk of CVD for their relatives we determined two Hypotheses.

Hypothesis No. 1: We suppose that a majority of patients with complications of hypertension are at high risk of recurrence of complications of hypertension.

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

Respondents were divided into two groups:

The 1st group (group A) were 100 patients

with complications of hypertension in care of Homecare Agency SANAS Topolcany and other Homecare agencies in Slovakia. The 2nd group (Group B) were 50 first-degree relatives of patients with complications of hypertension who are or who were in care of Homecare Agency SANAS Topolcany. Entrance criteria were aged 18 to 100 years. Collection of data was done in the second half of 2012.

Our study is a prospective analytic study which used a questionnaire method (a questionnaire with 53 items about patient's skills and lifestyle) completed with clinical and biochemical records and with statistical evaluations. The clinical and biochemical records were correlated by a nurse from the HCA after return of the questionnaires. These records provided information about weight, belt circumference, hips circumfer-ence, blood pressure, glycemic and cholesterol levels. All investigations were done to four standards: (1) Recommendations for normal practice; (2) Recommendations for optimal diagnosis and treatment of dyslipoproteinemia in adults; (3) During identification of modifiable risk factors for CVD we used Methodic Manual for work in advisory centers of health; (4) Guidelines for management of arterial hypertension.

All data were analyzed in program MS EXCELL 2010 using its statistic functions and calculations in contingent tables. Hypotheses were tested by Bionomic test on the level of importance p = 0.05.

On the basis of identified fixed as well as flexible risk factors, we established the cardiovascular risk (CVR). For determination of risk indexes in patients with complications of hypertension of 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)

With the risk-relatives, we used a system for an 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

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 the research, we evaluated every respondent individually and found that only 1% of patients and only 1% of relatives has no observed modifiable risk factor. Presence of 5 or more risk factors was found in 20% of patients and in 24% of relatives.

Hypothesis No. 1: We suppose that the majority of patients with complications of hypertension in care of Homecare Agencies are in high risk of recurrence of complications of hypertension.

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

Table 2. Stratification of cardiovascular risk for determination of prognosis

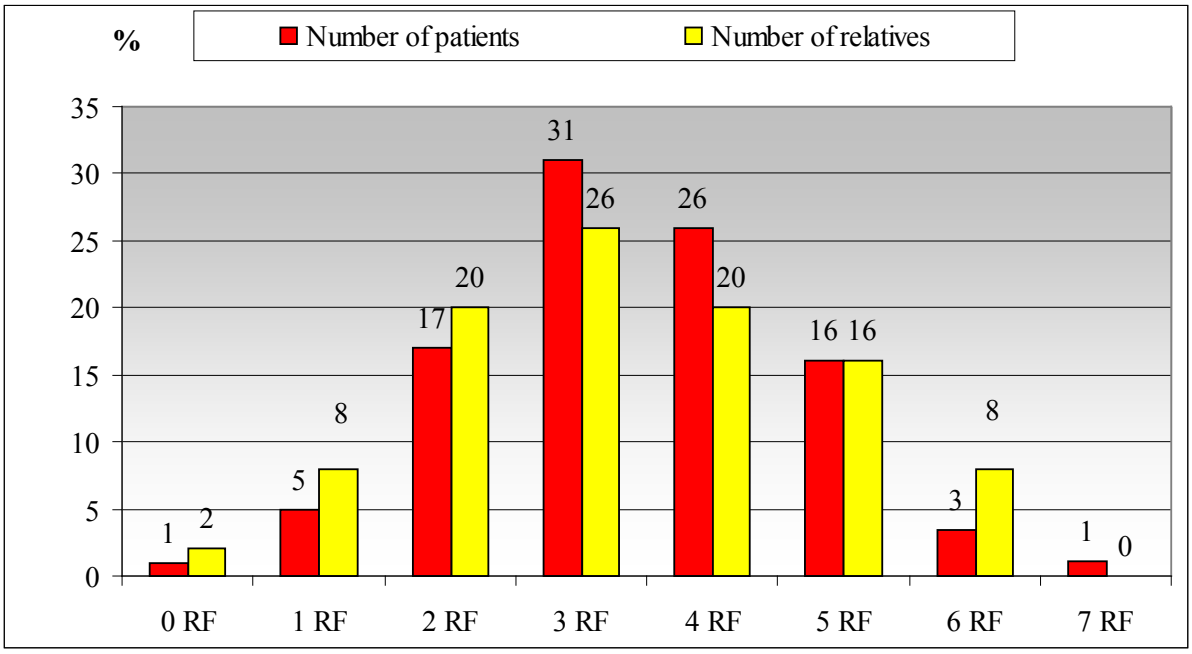
Other risk factors and history of other diseases	BP normal 120-129/80-84	Higher normal BP 130-139/85-89	1. degree 140-159/ 90-99	2. degree 160-179/ 100-109	3. degree ≥180/≥110
No other risk factors	Average risk	Average risk	Low added risk	Mild added risk	High added risk
1 – 2 risk factors	Low added risk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



risk factors:

Positive history of cardiovascular disease.
Blood pressure ≥ BP 140 / 90 mmHg = 1RF
BMI – ≥ 30 = 1 RF
Glycaemia ≥ 5,6 = 1 RF
Cholesterol ≥ 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

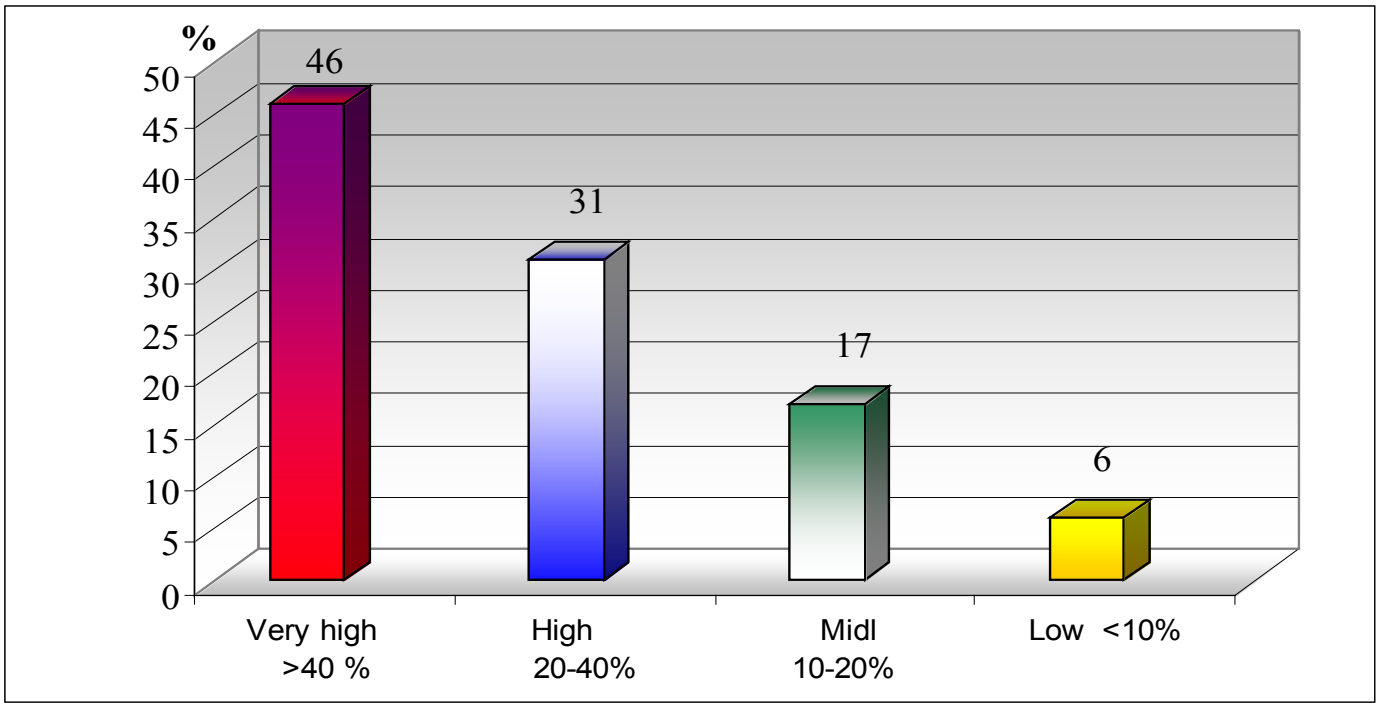
According with the table demonstrating 10-years risk of cardiovacular disease we determine how grade of risk is present in particular patient (Table 4, Figure 2).

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 in the group where the high added risk is present (3 or more risk factors); patients with low and moderate risk (2 or less risk factors) were placed to a 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: $Z0 > Z(1-\alpha)$: $6,415854 > 1,644854$: $p < 0,05$. Difference is statistically significant.

Hypothesis No. 1 is confirmed: Majority of patients 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 a majority of first-degree relatives in families of patients with complications of hypertension have moderate to high added risk of cardiovascular disease.

The level of added risk of cardiovascular disease compared to the 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

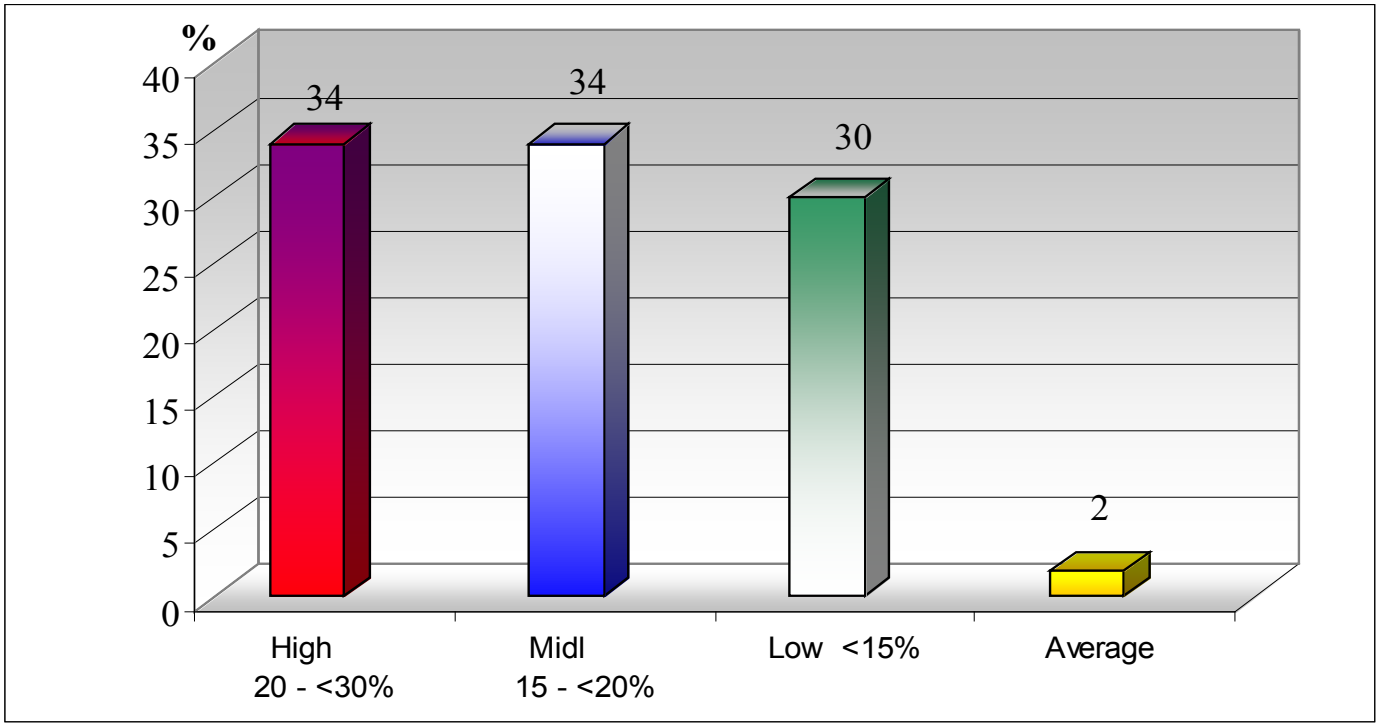


Table 7. Result of complete cardiovascular risk in first-degree relatives

	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 (α = 0,05) was used: Z0 > Z(1-α): 2,72853 > 1,644854: p < 0,05. Difference is statistically significant. Hypothesis No. 2 is confirmed: Majority 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 the European Society for Hypertension (5) including BP, BMI, glycemia, cholesterol, smoking, physical activity, DASH diet.

In the results of the MONIKA project in 2002 it is quoted that 1 to 3 risk factors were detected in 85.3% respondents, but they observed only 4 modifiable risk factors (6). Raslova (7) declared that in a

population of 40 year old men and women, 34% of Slovak people had 3 and more risk factors of atherosclerosis, but they did not declare how many factors they observed. In our group of relatives there are as many as 70% respondents with more than 3 risk factors.

For setting the universal risk of recurrence of Ischemic Heart Disease in the group of Homecare patients, we used the table which is published in Methodic Manual for work in advisory centers of health. But it is necessary to say that the risk of every patient with manifest cardiovascular disease is high. This means that correction of every other risk factor in this group of patients is very important (3).

Using stratification of individual risk of recurrence of complications as well as setting of risk indexes in patients with complications, we learned that 31% of patients had high risk and 46% of them had very high risk of recurrence of CVD within 10 years. It is more than a 30% difference compared to 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 the moderate grade of risk we noticed an increase (17% versus 10%); in high added risk there is also an increase (31% versus 17%); in the very high added risk with an accumulation of more than 4 risk factors we noticed a 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). Compared to 2007, we noticed an increase in every grade of added risk compared to the healthy population. Similar results are published in an evaluation of prevention programs in Slovakia. Using the SCORE model: in 10-year risk (≥ 5 %) 30.1 % men and 6 % women aged 40 to 65 years (9).

In Hypothesis No.1, we supposed that a majority of patients with complications of hypertension in care of Homecare Agencies is in a high risk of recurrence of complications of hypertension. In the group of patients from Homecare 77% had high risk of recurrence. Our supposition was statistically confirmed. This high percentage of risk of recurrence is caused by the high presence of modifiable risk factors. Therefore, it is necessary to focus secondary prevention to this specific group of patients. Practice shows that our country has a big defect in the care of patients with complications of hypertension. Treatment with medicine is stressed much more than education in spite of the fact that research shows that if education is improving, self-management of patients is improving and this leads to a reduction of necessary anti-hypertension medication and the risk of complications decrease (10). It is necessary to improve our education programs and to engage homecare nurses who have ideal possibilities to educate directly in the micro-community of patients, it means in families.

In Hypothesis No. 2, we suppose that the majority of first-degree relatives in families of patients with complications of hypertension have moderate to high added risk of cardiovascular disease. In this group of relatives of Homecare patients, 68% of relatives had high added risk of cardiovascular disease. Our supposition was statistically confirmed. This result is even worse than published results in the normal population. Therefore, it is necessary to focus primary prevention to this group of the population where risk of cardiovascular disease is genetically inherited and increased by life-style of family relatives. One of the possibilities to improve the care of these patients is to encourage family doctors to care for them. Unfortunately, there is a non-existence of family doctors in this country.

CONCLUSION

Our research confirms our suggestions that a majority of patients with complications of hypertension in care of Homecare Agencies is in high risk of recurrence of complications of hypertension. As this is a result of a lack of education for these patients, it is necessary to improve our educational programs and to engage homecare nurses who have ideal possibilities to educate directly in families. Our research also confirms that a majority of first-degree relatives in families of patients with complications of hypertension have moderate to high added risk of cardiovascular disease. Therefore, it is necessary to focus primary prevention to this group of population where risk of cardiovascular disease is genetically inherited and increased by life-style of families.

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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

he aim of the study: To describe the time trend of tumor 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 obtained may serve as clearly laid out data for cross comparing tumor 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 tumor disease among children and adolescents in years to come.

ARTICLE

INTRODUCTION

The importance of malignant tumor 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 tumor 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 tumors reported in the CR population over the past 19 years, i.e., from1991 to the present.

In spite of the rare occurrence of tumor diseases in children, they represent approximately only 1–3 % of the total number of tumors [1 – 3], holding the second-highest position among causes of mortality in children up to 15 years of age. Tumor 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 unfavorable prognosis compared to other childhood diseases. After traumas (accidents and injuries) they are the second most frequent cause of mortality in children. Pediatric oncology is not just the oncology of adults applied to children but an entirely independent follow-up field focused on specific issues. Pediatric oncology significantly differs from adult oncology in the occurrence of individual tumors and in terms of organ localization. In children, most tumor diseases consist of hemoblastosis and hemoblastoma – tumors of the nervous tissue, mesenchymal cells and immature cells of embryonic leaf while 80% of the tumors 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 tumor 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.

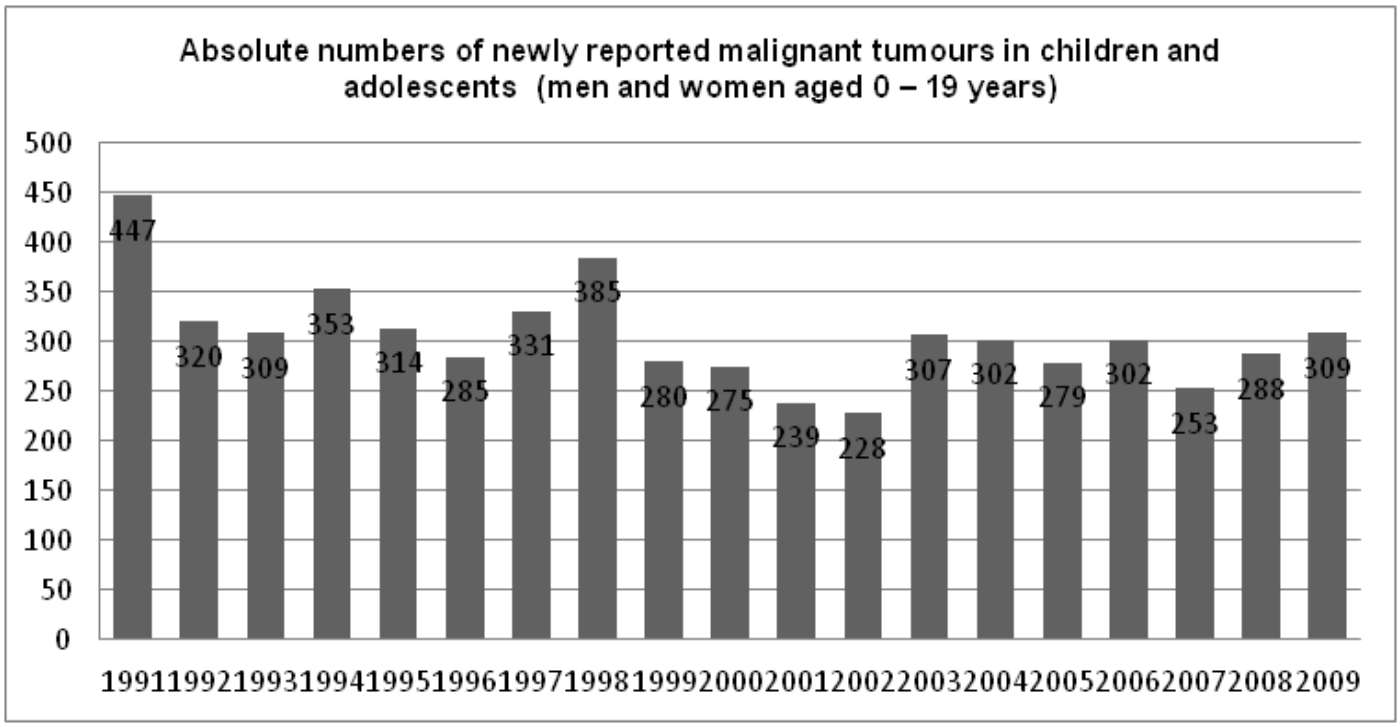
The results presented in this article come from data gathered and processed from 1991 to the present [4-22]. Individual data on the incidence of the malignant tumor diseases reported were divided into four age groups (0 - 4 years, 5 - 9 years, 10 – 14 years and 15 - 19 years). The data obtained was used to prepare outputs in the form of tables and graphs expressing the temporal evolution of tumor 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 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).

RESULTS

The values indicated in absolute numbers serve as basic indicators for tumor disease impact on the population. These absolute numbers indicate the number of newly reported tumor 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 (below) 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 tumor 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 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

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



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 tumors 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 tumors in individual age groups in the set studied. The figure shows the highest numbers of newly determined tumors in children are in the adolescent age group between 15–19. This age group in the set also has a higher risk of tumor development than children younger than 15 years, based upon the prerequisite of longer carcinogenic exposure, cell aging and the related decrease in

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

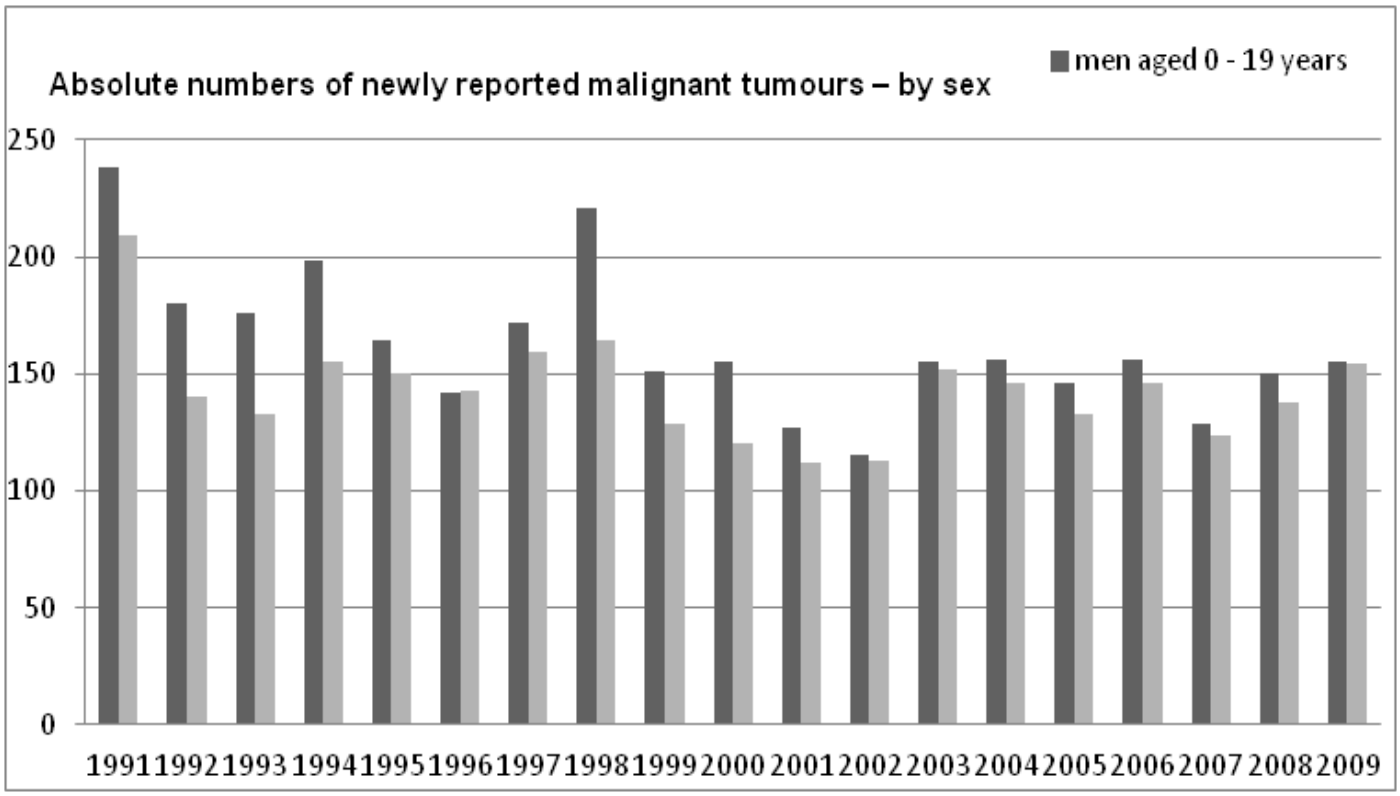
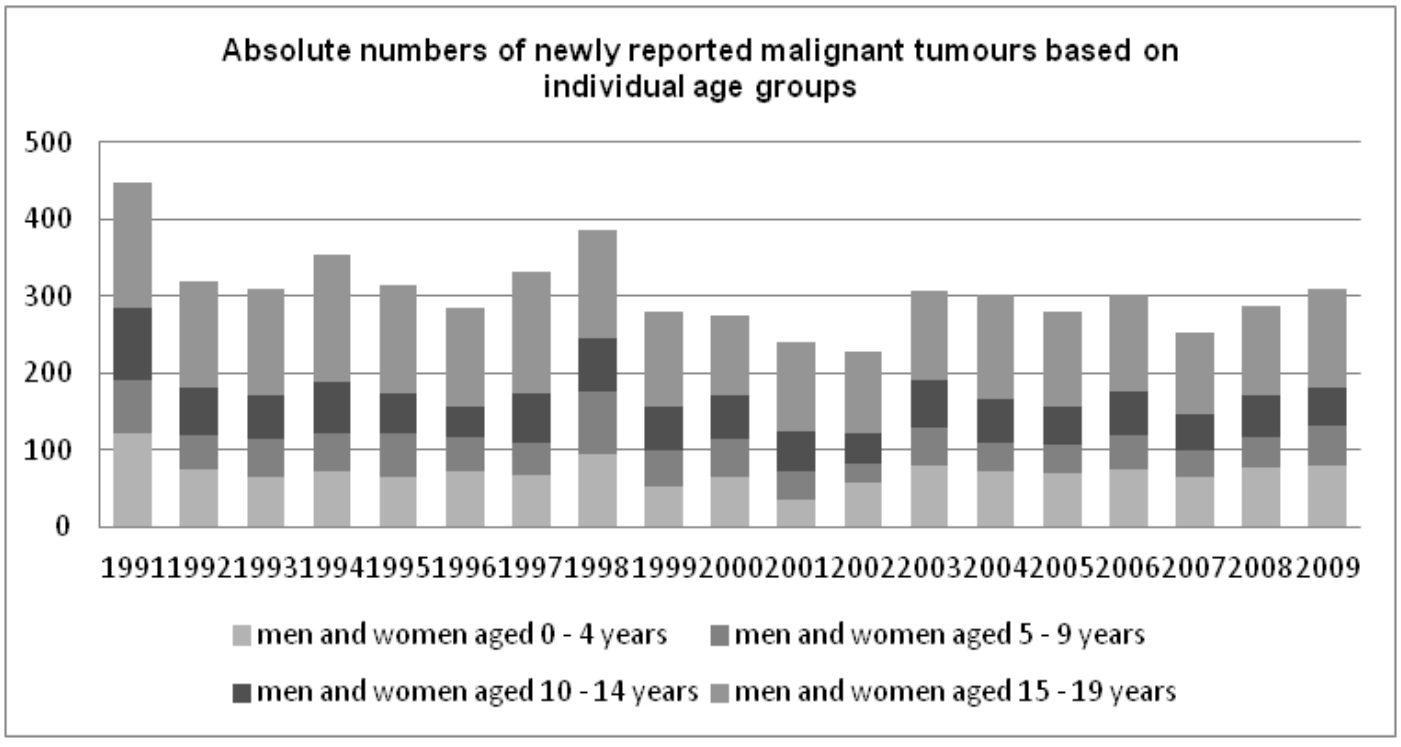


Figure 3. Absolute numbers of newly reported malignant tumours based on individual age groups



changes (decrease in telomerase, somatic mutations, etc.).changes (decrease in telomerase, somatic mutations, etc.).

Another group of four graphs (Figure 4 to 7) depict the total absolute numbers of newly reported malignant tumors independently by individual age groups and sex in the set studied.

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

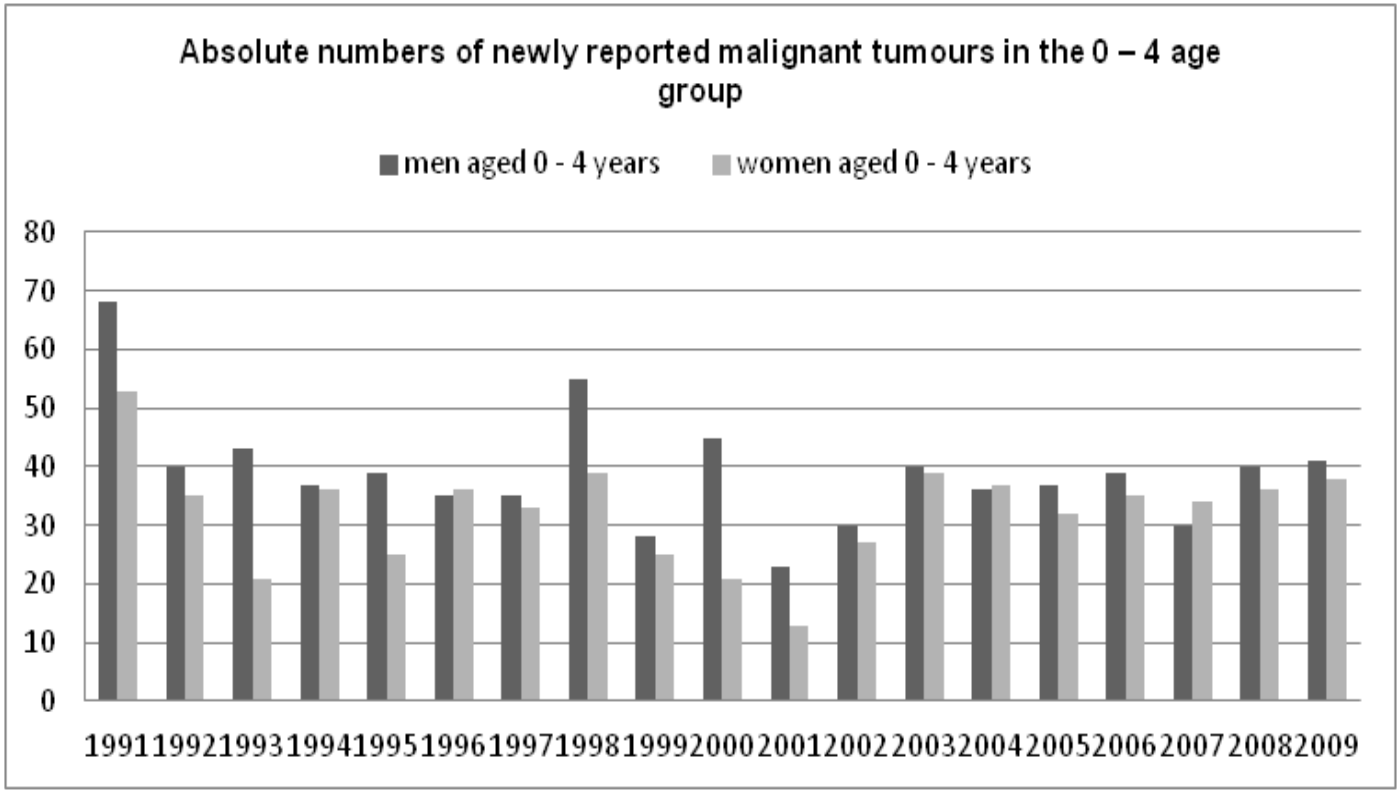


Figure 5. Absolute numbers of newly reported malignant tumours in the 5 – 9 age group

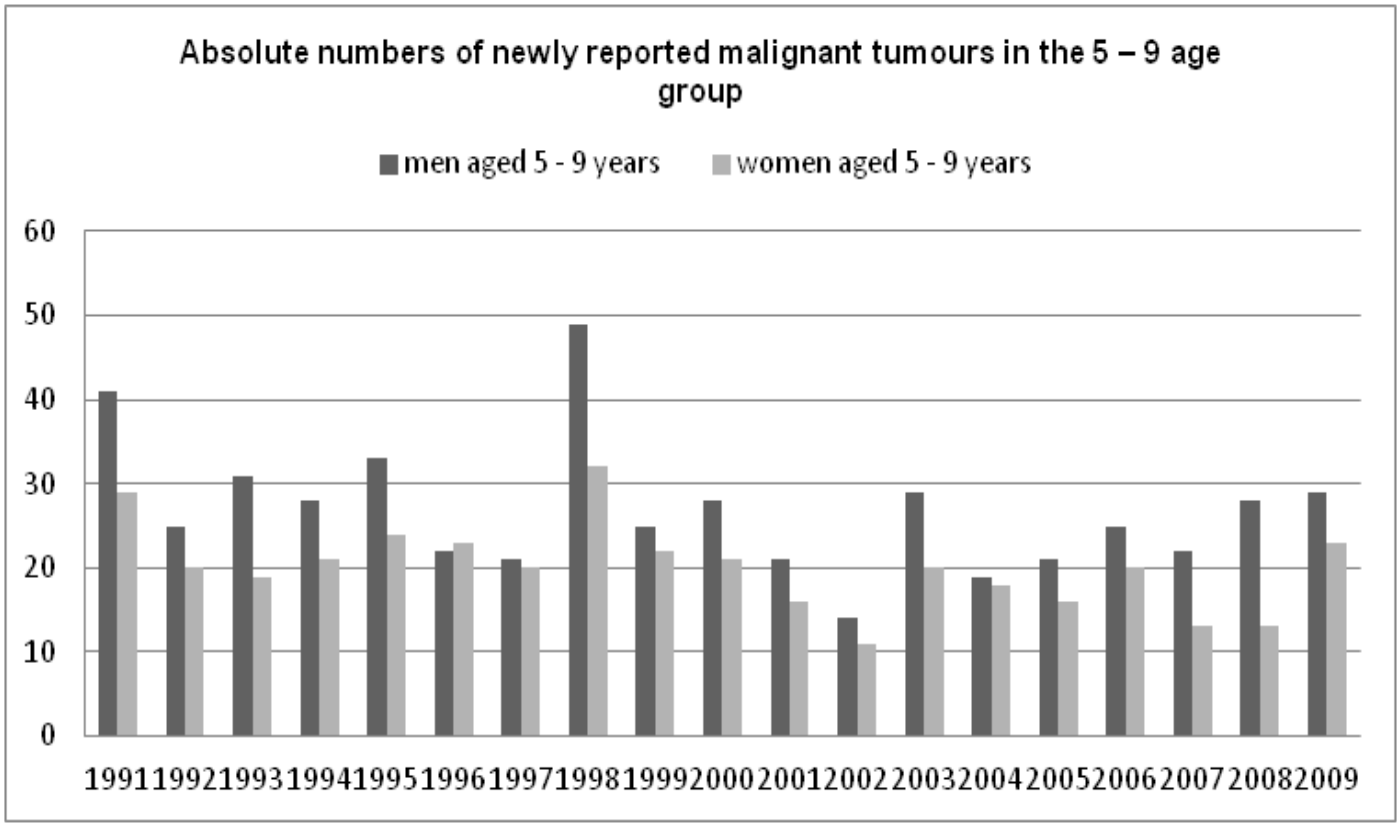


Figure 6. Absolute numbers of newly reported malignant tumours in the 10 – 14 age group

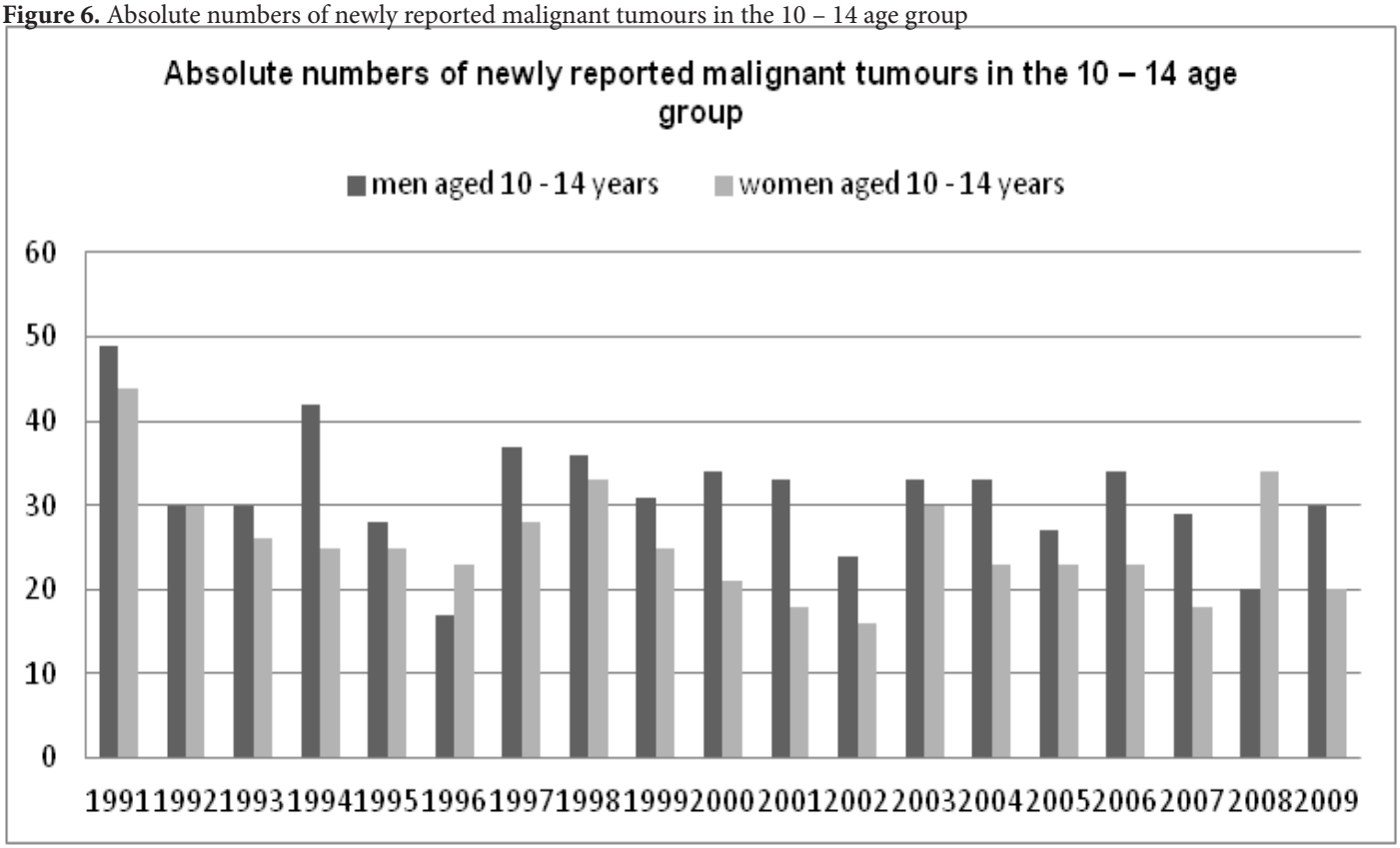


Figure 7. Absolute numbers of newly reported malignant tumours in the 15 – 19 age group

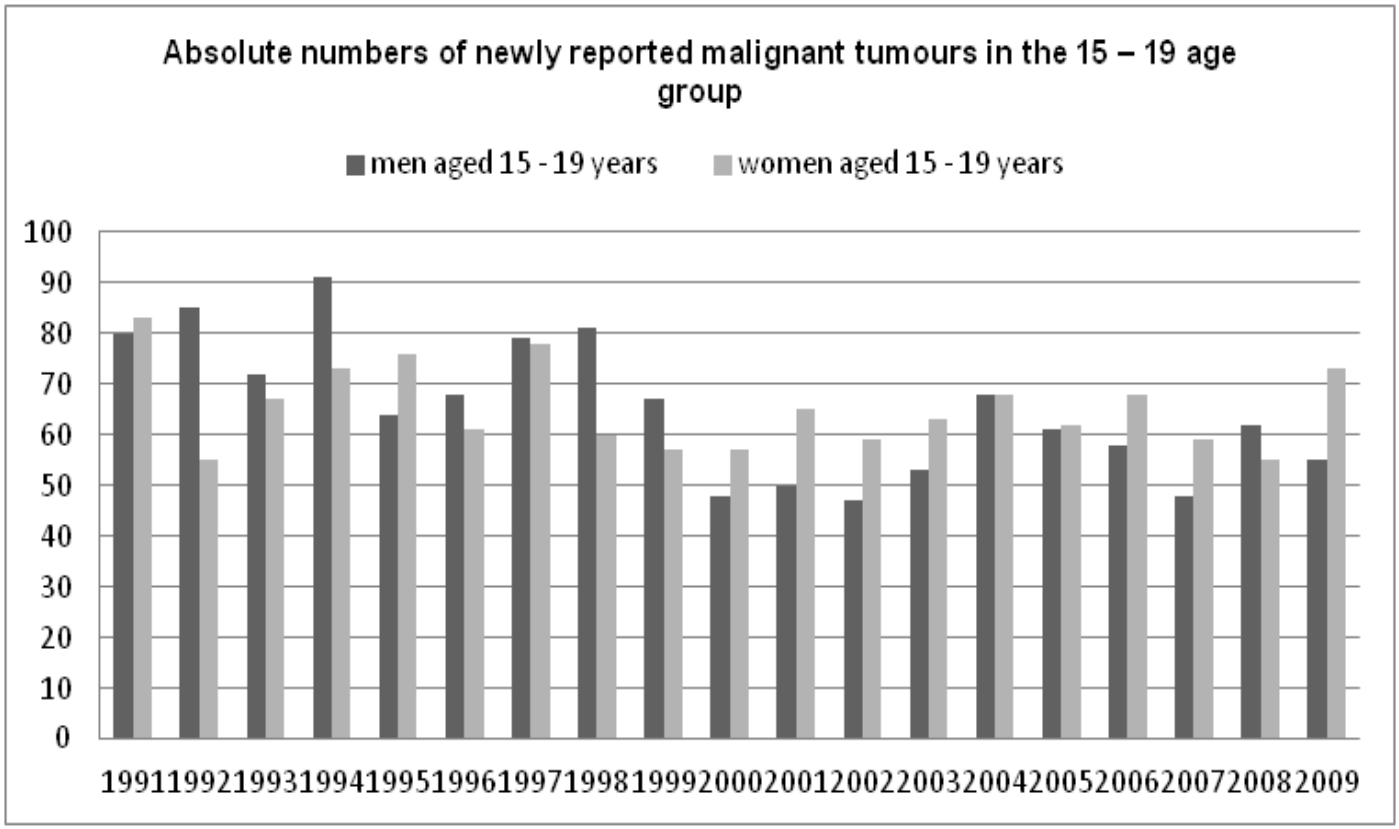
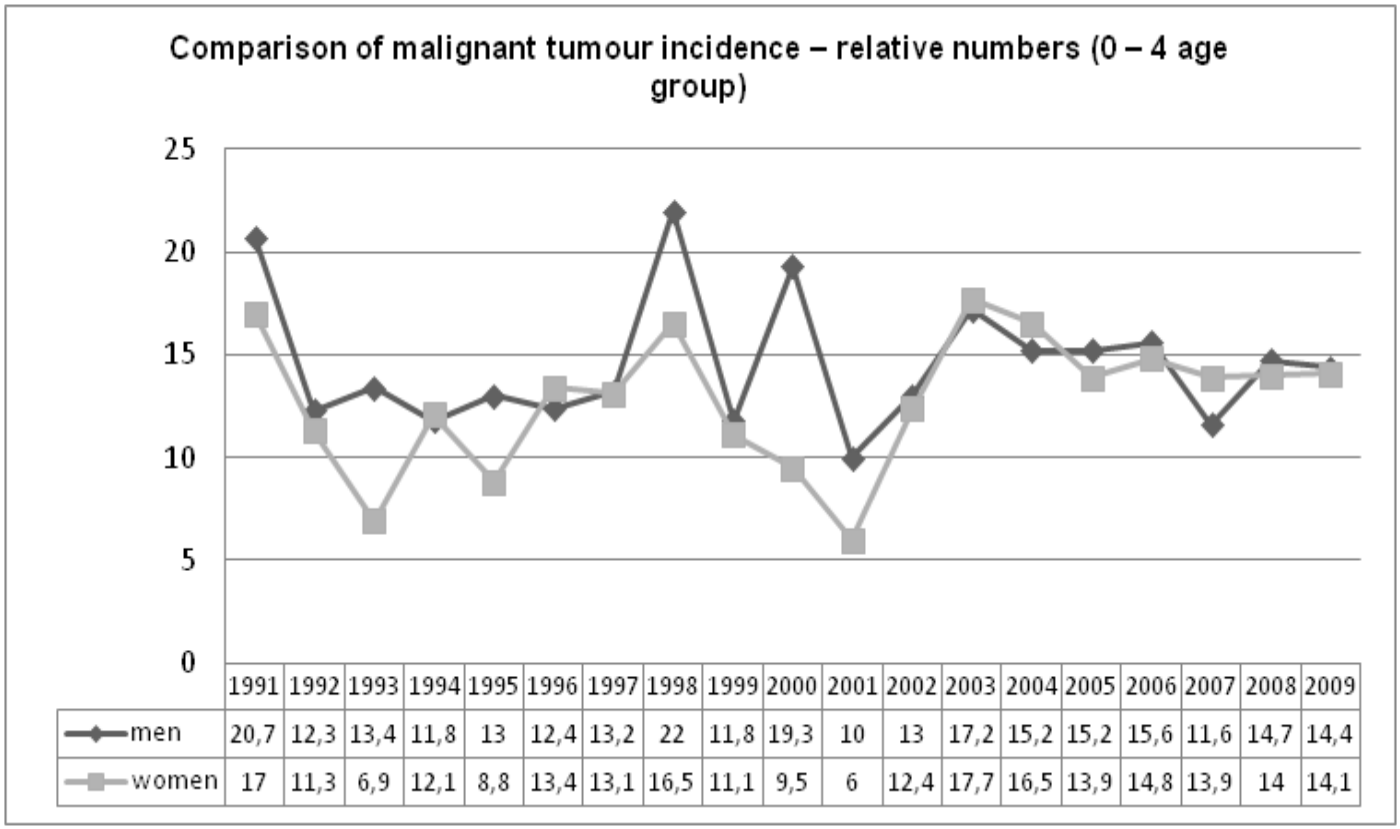


Figure 4 through 7 show that the higher absolute numbers of newly reported malignant tumors in the 0–14 age group concern boys in contrast to the 15–19 age group where, since 2000 (with the exception of 2004 and 2008) the higher number of newly reported malignant tumors concerns girls. Closer comparison 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 tumor diagnosis in this age group was malignant tumor of the thyroid gland (C73), particularly in girls and women. Malignant thyroid tumors are a disease with increasing incidence in childhood and adolescence. Thyroid gland tumors are more frequent in girls and young women; in children under 10 years of age the incidence is balanced for both sexes.

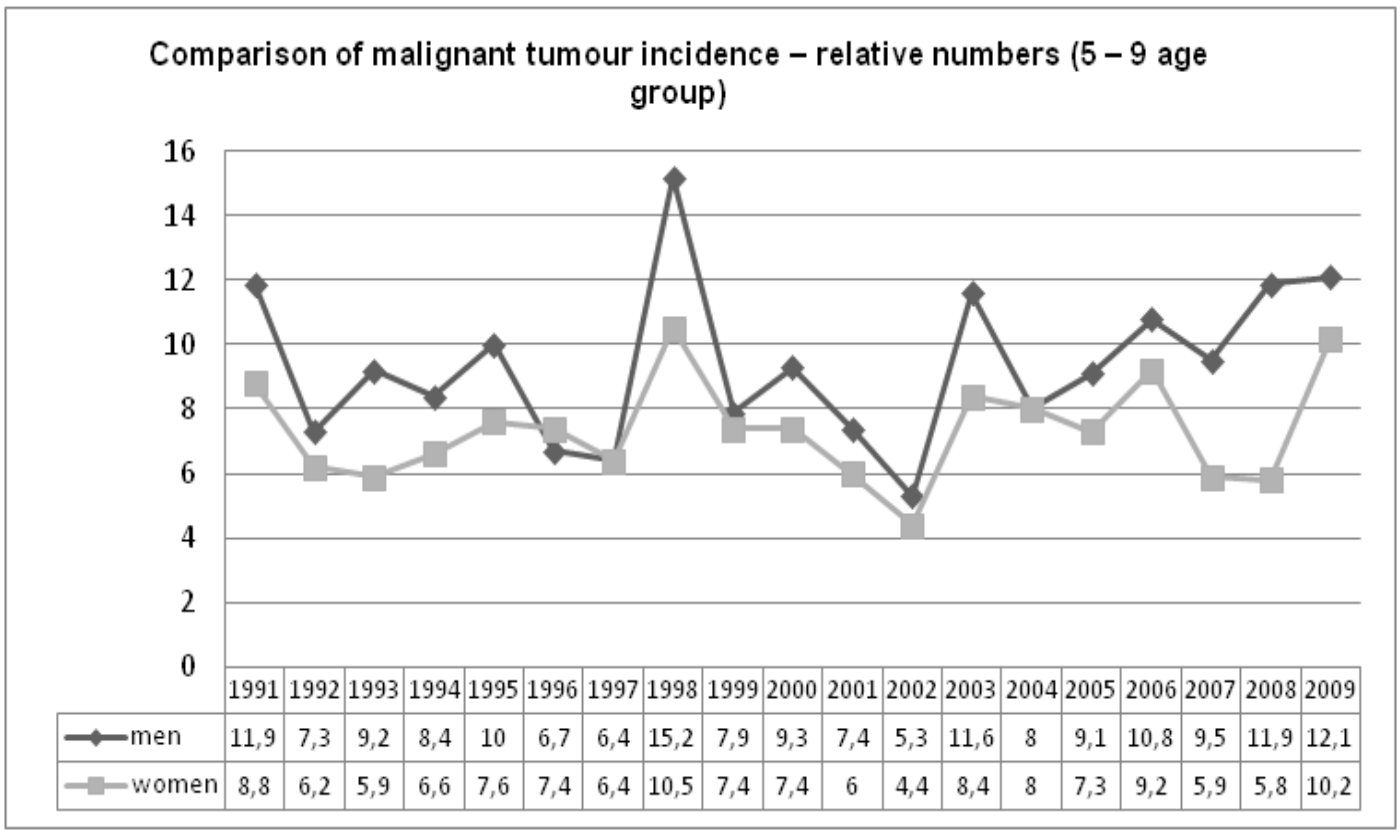
The group of four graphs below (Figure 8 through 11) depicts the gross malignant tumor incidence in children and adolescents in the CR defined as a share in the number of newly discovered cases of the diseases in the particular population in the particular period of time and the number of individuals 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)



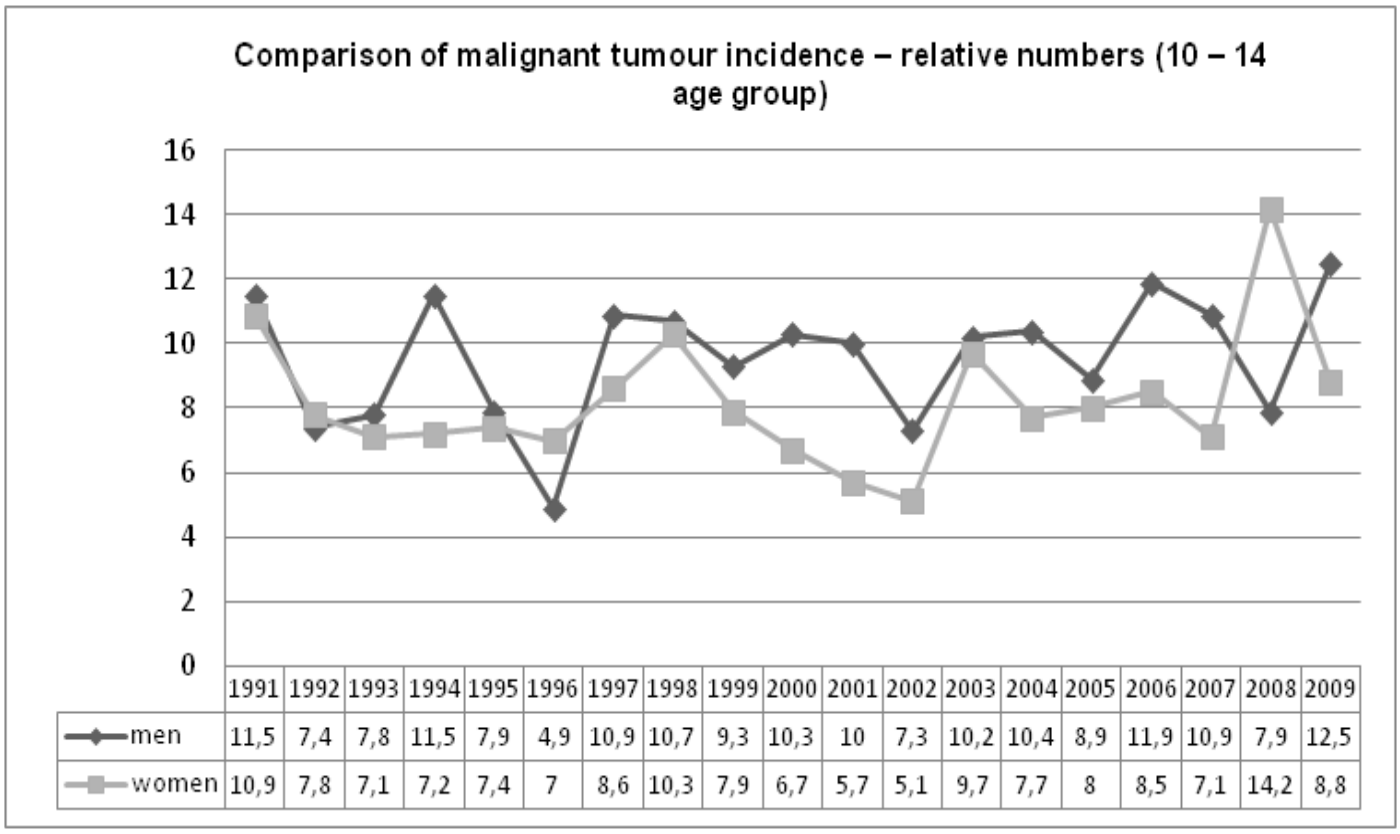
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
men	20,7	12,3	13,4	11,8	13	12,4	13,2	22	11,8	19,3	10	13	17,2	15,2	15,2	15,6	11,6	14,7	14,4
women	17	11,3	6,9	12,1	8,8	13,4	13,1	16,5	11,1	9,5	6	12,4	17,7	16,5	13,9	14,8	13,9	14	14,1

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



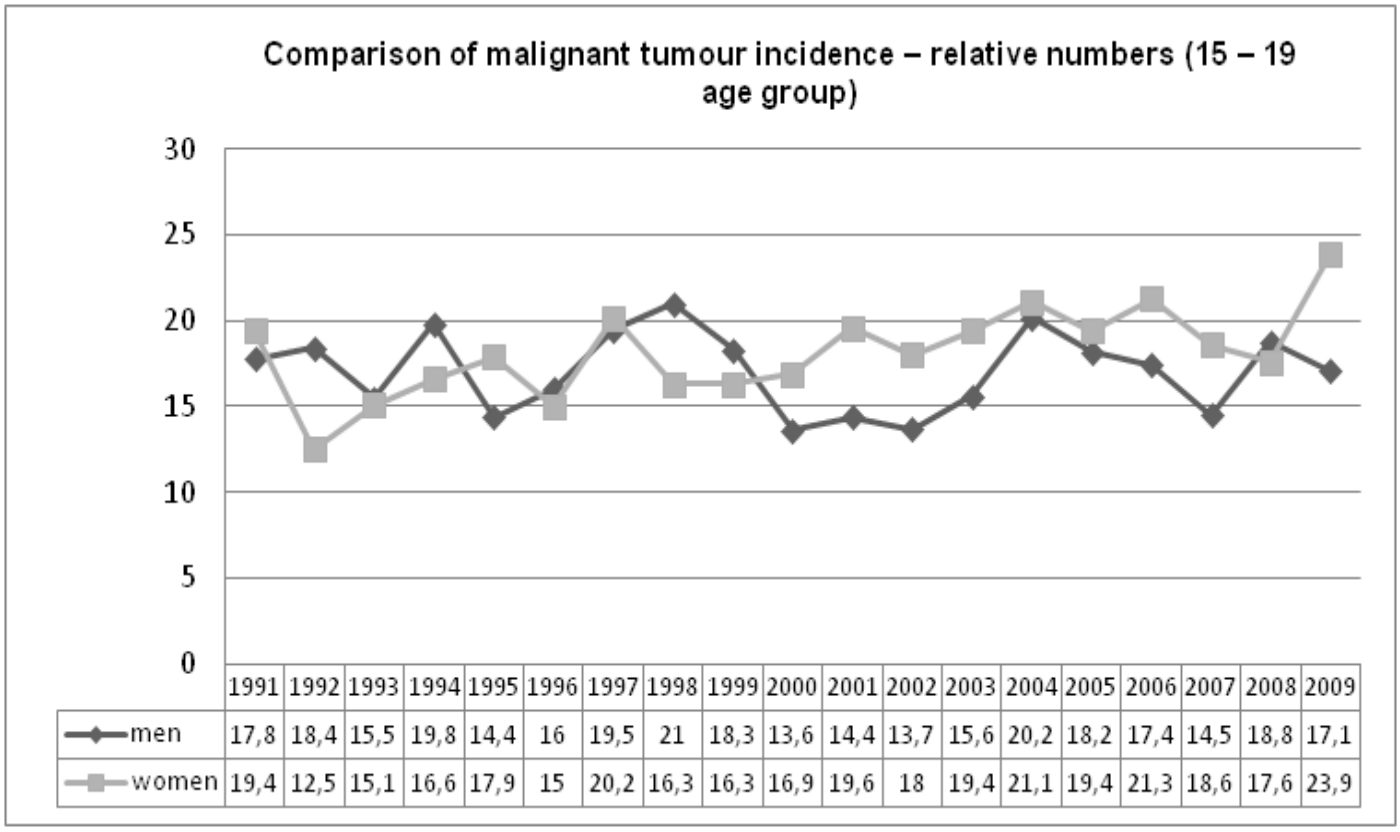
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
men	11,9	7,3	9,2	8,4	10	6,7	6,4	15,2	7,9	9,3	7,4	5,3	11,6	8	9,1	10,8	9,5	11,9	12,1
women	8,8	6,2	5,9	6,6	7,6	7,4	6,4	10,5	7,4	7,4	6	4,4	8,4	8	7,3	9,2	5,9	5,8	10,2

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



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
men	11,5	7,4	7,8	11,5	7,9	4,9	10,9	10,7	9,3	10,3	10	7,3	10,2	10,4	8,9	11,9	10,9	7,9	12,5
women	10,9	7,8	7,1	7,2	7,4	7	8,6	10,3	7,9	6,7	5,7	5,1	9,7	7,7	8	8,5	7,1	14,2	8,8

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



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
men	17,8	18,4	15,5	19,8	14,4	16	19,5	21	18,3	13,6	14,4	13,7	15,6	20,2	18,2	17,4	14,5	18,8	17,1
women	19,4	12,5	15,1	16,6	17,9	15	20,2	16,3	16,3	16,9	19,6	18	19,4	21,1	19,4	21,3	18,6	17,6	23,9

Not only do the individual gross incidence values for the CR set of persons studied depicted in graphs (Figure 8 through 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 - 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

he results confirm that the incidence of tumors 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 - 2009), according to the recalculation per 100,000 men 'and women in the particular age group monitored, malignant tumor incidence has increased for both sexes in the 0–19 age group in the CR and the total time trend of malignant tumor incidence in children and adolescents is instead growing. This growth trend in the incidence may be seen particularly in the 15–19 age group where the risk for tumor 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 tumor 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 tumor disease resulting in timely treatment in specialized oncological centers. Stabilization and further education of medical staff support for clinical studies and sufficient financial resources for anti-tumor and support treatment are also of key importance.

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

an elementary epidemiological handbook. The world, European and African standards are used as the principal standards. These standards vary especially in the 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 the increase in the incidence of cancer among children and adolescents is a Europe-wide trend.
Some contribution on this increased trend can be due to the improvement in the efficiency of registration of eligible cancer cases. A large part of the increase is due to the rise in leukemia in young children and lymphomas (especially for Hodgkin's disease) in adolescents. Etiological studies show that not only traditional risk factors, but also changes of birth weight and exposure to infection might be good candidates [23].

When comparing the results with the study by the AIRTUM Working Group, it is clear, that between 1988 and 2008 there was a significant increase in the incidence rates observed for all malignant neoplasms in Italian adolescents (15–19 years); in the dominating incidence of non-Hodgkin's lymphoma, thyroid cancer and melanoma. Conversely, lymphoid leukemia is showing a long-term decrease in adolescents. Similarly, as in Czech Republic, there is an apparent increasing trend in thyroid cancer in adolescent girls [24].
Repeated CT scan exposure in childhood and adolescence significantly increases the risk for many types of cancer, especially lymphoid cancers, thyroid cancer, melanoma and leukemia. That is why CT scan in childhood should be strictly an indicator and with the lowest possible dose of radiation [25].

An Italian multi-centric epidemiological study on risk factors for childhood leukemia and non-Hodgkin's lymphoma (SETIL), investigated the risk of childhood cancer in relation to parental occupational exposures. The increased risk for childhood leukemia is associated with maternal occupational exposure to aromatic and aliphatic hydrocarbons, particularly in the preconception period. The 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 do not underestimate and underplay 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 tumors reported in the CR population over the past 19 years, i.e., from1991 to the 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 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 lives. The help provided is based on the most basic requirements for people's co-existence, and it is the respect for the dignity of each individual. To mitigate 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 them 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 that minority population.

COMMENTARY

INTRODUCTION

Discriminated, underestimated and forsaken by the majority, the Romanies are looked upon 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.

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 in the job market, which is closely connected with his attained qualification. The insufficient level of Romanies' education lowers their chance of becoming employed; increases the probability of becoming dependent on the state's social support; the impossibility of escaping their state of social exclusion.

THE RISKS OF THE SOCIAL EXCLUSION OF ROMANIES

The term "social exclusion" first appeared in the literature of the 1970'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 studies by 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)
- in families with children (higher number of children in household without work; lower birth weight; higher child mortality; low school attendance; worse school results; higher birthrate in lower age groups; higher number of children in offenders institutions). (Navrátil 2003, p. 35)

As to the economic indicators, the two greatest risks for Romany social exclusion are long-term unemployment and poverty; the three social indicators being 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 a 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 factors triggering social exclusion is lack of education. Its level predetermines one's position in the job market. The vicious cycle starting with poor education becomes apparent here as it is commonly maintained that the higher the level of education, the better the chances are for employment. Lack of 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. Their choice in 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 various character closely interconnected, it is impossible solve them 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: 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 off 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. Černakova also draws 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 an unqualified workforce; 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 later has a strong influence on all other aspects of their lives whether it is the inability to become employed; the consequent dependency on social support; unexcused absenting from school; school-related failures; growing range of delinquency, crime, drug abuse and other socio-pathological phenomena. These often result in weak cultural development; poor hygiene; poor health conditions.

TThe contemporary Romany family is in a poor socio-economic situation connected with poor housing conditions. The strong dependency on social benefits often makes it impossible for them to cover their 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; 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 populations. 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; thus 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 EU economy 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 in 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 non-governmental organizations, they invest significant amounts of money into their education; improving their living standards; increasing the employment rates; 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; 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; building of infrastructure; through the support of education; requalification and increased employment rate through supporting business in particular settlements; 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 specific local

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

Receiver's activity	• active regulations • passive regulations
Provider	• civil service (state institutions and organizations) • autonomy (villages, towns, autonomies) • non-state sector (associations, funds, the church)
Forms of aid – realized activities	• 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	• housing policy • social policy • education policy • healthcare policy
Demographical classification	• age limit • sex • place of residence • status
Place of activities	• natural family environment • community centers • institutions, residential establishments
Type of work	• individual – case work • group work • community work
Localization of the Romany minority	• intravillan areas • extravillan areas
Way of life(Rosinský 2006, p. 26)	• settled Romanies • semi-settled Romanies • socially most regressive Romanies

conditions as well.

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:

Receiver's activity. This aspect includes active and passive regulations which should prevent social exclusion. In the case of active regulations, the receiver participates in activities and does not just passively receive the programs. The counterpart of this 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 degree of support.

The receiving of an 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 reveals how much willingness the unemployed has 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 only a problem of the state and the civil service. Therefore, it is necessary that more parties participate in providing help. Through legislation, 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 non-governmental and non-profit sectors 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 at one point; 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. (Lešková 2008b, p. 83; Lešková 2008d, p. 81 - 92)

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 projects realized in them 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 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; 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. (Klepochová 2006; Uháľ 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 cycle 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 continuality 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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Key words: **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 a paternalistic concept of services from the era of communism and puts the quality of life of their users to the forefront. 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 a misunderstanding of the meaning of SQSS that endeavors to guarantee the optimal adjustment of the service for the users; to maintain the dignity of clients; 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 the way of processing of the conceptual apparatus of Social Work for practice; the attitude to the profession of Social Work; as well as in the confusion of the position, institutionalization and perspectives of Social Work. The 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 the fact that the threats and risks in the post industrial modern world 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. Now, the service is 'purchased by the client from his/her care allowance, and also the requirements for service provider; which by changing the cost base meant a departure from a paternalistic conception of Social Services (Sládek, 2010: 110) the residues of the former communist regime, when the state was an exclusive provider and donator of social care (Šiklová, 2001); when the life quality of care receivers falls 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 Labor and Social Affairs which tries to guarantee an 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 the 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

COMMENTARY

the definition of SQSS criteria (Čermáková, Johnová, 2002) and often produce written materials (requirement of many SQSS criteria for written methodologies) that are not effective: i.e., do not correspond with theoretical bases used in daily practice of an organization. But, Social Workers understand them as a way to fulfill SQSS. There are also many cases when some organizations copy methodologies of other organizations that have passed inspection without actually 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 the 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 toward the Social Work profession or in a broader context which then affects the function 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 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 subsequent 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 distraints 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 the Social Worker and the influence of the Social Work Concept on the public in terms of good practice. In the 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, not only the public but also Social Workers view the Social Work Profession only as an administrative duty, 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 a 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; Social Worker 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 modern-ization, 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 a 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 competitively towards the social field. 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 (see the list of typical roles of Social Worker: counselor, services provider, case manager, agent of social changes and others (Rezníček, 1994)). Because it is the practice of having multi-disciplinary bases and typical of synthesizing features (Květenská, 2007), the position of workers in multi-disciplinary 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 base of Social Work does not go beyond industrial modernism and still linger in its schema - 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, because 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 in the market of services and like other services it is profit-oriented. So we can view the law categorizing Social Services as an 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

The Social Worker is the one that determines the final form of Social Work. As stated by Elichová (2011: 30), generally speaking, helping the organization is shaped by workers who give it a body, both by formulating its mission and by establishing methodizing 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; who indirectly shape the awareness of social problems. Therefore, it is necessary to find out how Social Work, now when facing an identity crisis, is viewed in its live form by Social Workers themselves; who according to Musil (2011) just in this 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 center of a research project implemented by the University of South Bohemia in České Budějovice called The Concept of Quality of Social Work in Relation to Self-definition of Social Worker and the 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 within which it arose. Its theory and practice are in fact reactions to how real people perceive social problems in a certain time period and in a specific location (region, country). Practical Social Workers are also a product of the context within which they occurred.

During the 20th Century Social Work established in stable market democracies 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 with the Velvet Revolution in 1989, when a non- profit sector began to develop; there occurred new social problems such as homelessness; or unconcealed prostitution; 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 Labor and Social Affairs for Social Work. This council tries to support passing and implementation of the Principle of Law on Social Workers and self-governing professional organization of the Social Workers which was unfortunately removed from the legislative agenda of the government. According to the Scientific Council the vague identity of the Social Work Concept is reduced (Musil, 2013).

The purpose of the Law is to support and regulate the professional quality of the 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 the Social Work Concept in Czech Society in order to secure an availability of professional help by 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 of the 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; support of Social Work in disputes related to the performance Social Work Profession; 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 described in more detail in Navrátil (1998: 44): In society there is a circular process underway, 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; Růžičková, 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 influencing 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, E.J. (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, the Society for Spirituality and Social Work, the Canadian Society for Spirituality and Social Work, and the Center for Spirituality and Integral Social Work at 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 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 religion 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 Southeastern 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, Practitioner's 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 who 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 spiritual 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 a 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 reli-

gious 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 programs 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 may 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 21st 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 20th 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 favor 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 meager 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 analyze 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 neighbor group; to his altar of worship; to the products of his labor 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 environment shall remain in harmony with the funda-

mental 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 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 behavioral 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 beyond 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; that 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, then 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 favor of vested interests; to others 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 behavioral 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 inter-personal 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 defense 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 w firmly believe that, before all else, it is an age of metaphysical anxiety.

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 proportion-ately 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 harbor 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; at the same time finds access to new reserves of confidence and worthwhileness in his/her labors.

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 counselor. 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 super-

natural outcomes. Social Work, as a professional discipline, 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 pathways. 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 skepticism cease to encumber our collaboration; only thus will the mechanisms of defense 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 programs 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 address 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 irreplaceable component of a 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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Key words: **home nursing care; patients' satisfaction; nurses**

Abstract

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

INTRODUCTION

Home nursing care contributes to making the trend of health and nursing care in Slovakia move towards the provision of treatment and nursing care in the home environment. An important factor in increasing the level of quality of health and nursing care is the subjective perception of satisfaction by patients and their families with treatment and home nursing care. So, in our survey, we decided to pay attention for the determining of the level of satisfaction of patients and of the level of satisfaction of family members with care provided by nurses working in 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 patient's and their families' satisfaction through the provision of home nursing care.

PARTIAL OBJECTIVES

O1: to determine the level of communication skills of nurses working in ADOS
O2: to determine whether the expectations of patients and families with the provision of nursing care through ADOS were met
O3: to determine the sources from which patients and their families learned about the possibility of the of ADOS services
O4: to determine whether the care provided to ADOS patients - recipients of nursing care - through ADOS was sufficient
O5: 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 in more than 50% of nurses are encouraging for patients and their family members.
H3: We assume that satisfaction with care provided by ADOS Nurses will be evaluated posi-

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tively by more than 50% of the patients and their family members.

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

RESEARCH SAMPLE AND SURVEY METHODOLOGY

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

The main method was a 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 the questions. The core of the questionnaire consisted of 9 surveyed questions.

The questionnaire items (Q) were formulated in closed form, one item was formulated as opened. In the closed Q respondents labeled only one alternative response. In the open item respondents were provided with the opportunity for free expression. The questionnaire was anonymous in keeping with 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%

All 600 respondents answered this item: 220 patients (74%) and 260 family members (87%) rated communication skills as stimulating and only 10 of the patients evaluated the 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%

All 600 respondents answered this item: 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%

All 600 respondents answered this item: (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%

All 300 respondents answered this item: 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%

All 300 respondents answered this item: 180 family members (60%) indicated that cooperation of the 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%

All 300 respondents answered this item: 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 tested with questionnaire Q1. 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% of their relatives in hospital during inpatient care; 7% of patients and 17% of their relatives from people who used them before; 7% respectively both using of ADOS Services learned about it from relatives of respondents; only 3% of both respondents and relatives from the mass media, radio, television or internet. 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 our working hypothesis H1 was not confirmed.

In working hypothesis H2, we assumed that communication skills of Nurses are assessed as stimulating in more than 50% of respondent's answers by patients and family members. This working hypothesis was examined with Q2. Patients rated the communication skills of the Nurses working in ADOS as encouraging in 74% and family members in 87%; 23% of patients and 13% of families reported as average; 3% of patients rated them with disinterest. Based on the above, we can conclude that working hypothesis H2 was confirmed.

In the working hypothesis H3, we hypothesized that satisfaction with the care by the ADOS Nurses will show more than 50% of the patients and their family members as positive. The working hypothesis H3 was verified with Q5, Q6, Q7 and Q8. In the survey, we focused on the evaluation of the care for biological needs; on the cooperation by the Nurse in the care of a patient; if patients encountered difficulties in working with their Nurse. 70% of patients and 60% of family members rated the cooperation of Nurses as excellent in patient care; a 3% above average rating was achieved in both respondent samples; a below average or an unsatisfactory was not mentioned by any of the respondents. These Qs aimed at determining the level of satisfaction of patients and family members were prepared in tabular form in which respondents had a single Q to express their satisfaction, or respectively, dissatisfaction. This was subsequently evaluated using the Likert Scale. This assessment

showed that all answers of both patients and family members were positive. Patient satisfaction (Q4. Q5) and family member's satisfaction (Q4. Q5) were high. Qs, whether the respondents faced difficulties in collaboration with the Nurses working in ADOS were 93% of patients and 97% of family members answered never met; rarely reported 7% of patients and 3% of family members; often was not mentioned by any respondent. On this basis, we concluded that working hypothesis H3 was confirmed.

In the working hypothesis H4, we assumed that the time an ADOS Nurse devotes to working with a patient will be evaluated by patients and relatives as completely sufficient. The working hypothesis was examined by Q3. We found that the time a Nurse pays to the patient was assessed by 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 by 3% of patients and family members. On this basis, we can conclude that working hypothesis H4 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 by 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 between 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 there exists positive interaction and communication between them which is good. Home nursing agencies during the transformation of healthcare laws passed since its inception show 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; fighting the 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 Nurses who work in 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 healthcare facilities in legislation; help to resolve financing of ADOS; extend training in community nursing; inform the general public through information brochures, leaflets; the professional medical community with organizing conferences, lectures, seminars, discussions; 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 Society.

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OPINIONS OF STUDENTS AND GRADUATES ON A WORK CAREER IN THE SOCIAL SECTOR

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Key words: **students; graduates; employment; social sector; Slovakia**

Abstract

This survey on the employment potential of students and graduates in the Social Sector in Slovakia has been accomplished as part of a joint international project. Youth unemployment is a serious problem. Young graduates face considerable problems in making the transition from education into employment mainly due to shortage of job offers. The survey discovered general satisfaction with University Education, but also the necessity to have better capacity in some areas appeared. This study analyzed strengths and weaknesses in aspects of education and issues of transfer from study to work. Generally, Society is not giving priority to development of the Social Sector. There are sources for higher employment due to rapid social changes within Slovak Society.

COMMENTARY

INTRODUCTION

A relatively low proportion of the Slovak working force is engaged in social investment activities in comparison with other EU member countries. Both entrepreneurship and self-employment in the Social Sector represent suitable pathways for young graduates to escape from unemployment.

Slovakia has begun to experience aging similarly to other European States, but still there is low engagement of young people caring for older people. Young graduates may find job possibility in it.

Feminization in a Sector with a high proportion of night shifts composes problems in the framework of living and working condition harmonization. Changing roles of men and women in families and its own rapid changes has to be reflected in future plans for the Social Sector.

Diminishing changes in financial resources of clients and growing or stagnated unemployment are main factors behind the rise of poverty. Slovakia faces an urgency to develop the social capacity in solving ageing problems; deteriorating employment for older people participation; 'return' of the long-term unemployed to work; humanization and ethnic 'Roma question. Many other new challenges lie ahead. Some of them: missing elderly education; family services; work with youth; community centers; human capacity building.

Rather modern and elaborated schema for social protection suffer from steep 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 a social economy; social cooperatives; social enterprises are very sparse as well. A relatively low proportion of the working force is engaged in social investment activities compared with other EU member countries. In the so called white collar professions there are many unfilled job possibilities. Slovakia is giving a relatively smaller proportion from its budget to Social Sector activities (health and social protection) than is standard within EU average. (Hetteš, 2013a, p 47, p 157)

Social Workers have to fulfill certain qualification requirements based on the law on public employment service, employment and Social Services. Slovakia is missing a professional organization of Social Workers. This organization could protect and help in promotion of a professional Social Sector.

Social work and social policy are interconnected by a system of human rights, social and economic rights, which is the basis for human dignity. Slovakia has reached relatively high GDP (Gross Domestic Product) per capita with very low labor cost. Long-term unemployment; unemployment of young people;

generational discrepancies; regional differences are among the most important obstacles for inclusive growth.

The OECD December 2012 report on Slovakia urged it to do more to tackle problems of the labor 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 the EU average). From the point of view of the labor market school leavers belong among a marginalized group. In some regions over 40 % of them are unemployed. Young people are more often at risk of poverty than retired people. (Hetteš, 2013b)

As in Slovakia, youth unemployment remains a serious problem in many countries. This situation reflects the mismatch between their skills and labor market needs; a lack of demand for labor as well as insufficient development strategies for youth employment in the past. According to the National Social Report from the year 2012, the main measures to increase the employment of people up to 29 years of age will include improvement of the training of school leavers entering the labor market and reallocation of resources. Through active labor market measures, the 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 substantial numbers remain active. The 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 potential in the Social Sector activity for young people.

Slovakia has to develop labor market demand skills by encouraging and enabling people to learn throughout life; foster international mobility of skilled people to fill skills gaps; promote 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 an international project of five EU member countries (Italy, Czech Republic, Slovakia, Slovenia and Romania) focused on young graduate's job possibilities within the Social Sector. The survey in Slovakia has been taken among of Social Work graduates, active Social Workers (operators) and managers (decision making persons) in the Social Sector Organizations in Nitra Region and the western part of Slovakia during the first half of the year 2013.

A national sample was identified according to the objectives 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; their professional profiles.

There were a relatively large number of respondents – 425. Individuals were questioned or interviewed by the Slovak research team from February – May, 2013. Altogether 131 Social Workers, 250 current students and 43 managers took part in the survey. It is important for a 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 the then Czecho-Slovakia reflected in the country of the respondent's origin: 95.3% were from Slovakia and 4.7% from the Czech Republic. Slovaks still have strong ties with the Czechs and vice versa. Slovak young people used to prefer to study in the Czech Republic than in other countries; to a lesser extent Czechs study in 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; the second part focuses on their expectations and perceptions.

There is common female preference in favor of Social Work Study in Slovakia and a respectable female majority in Social Sector employment. The number of foreign students is slowly growing and some Slovak Universities actively offer their educational services abroad as well.

Students mostly live with a partner and less often with their parents. Marital habits have been rapidly changed during the last decades. Living together out of wedlock for a longer time is a frequent way of sharing life especially during the time of studies. Dormitories are not available all the time. Joint living is less expensive when it is going on rent accommodation. The survey has been done among students of Universities oriented mostly on Social Work Study

programs in Nitra and Bratislava.

Overwhelming, the majority of respondents were of the opinion that high level education is a necessity for work in the Social Sector. This outcome is in correlation with a generally accepted position that a highly skilled labor force requires both health and Social Sectors.

The majority of students obtained specific work experience during their studies (Figure 2). From Slovak practice, we know that after finalizing their studies many former internship/ placement participants were offered work in this area. This kind of work practice offered an advantage for later work careers. Daily, students also were using the opportunity to work as volunteers within this possibility.

As for the main social needs which the Social Sector should face today, there were many different answers (Figure 2). The first position concerned the issues of employment/ unemployment. This problem is commonly accepted as the most serious problem among the population of Slovakia. The 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. A low fertility rate is threatening future sustainability not only of the Slovak Society, but also its neighbor countries.

What are the adequate competencies to deal with current needs? Results show the importance of humanistic and social ("soft") skills within the framework of Social Sector activities. Employers give preference to the potenetial employee with suitable skills. Management and project planning skills are important for successful economic and financial institutions performance of many social institutions. Students are not always are very well prepared to deal with these latter tasks.

A study program provides competencies for work in the Social Sector and there was common satisfaction with the obtained information. Despite satisfaction with an completed education, respondents spoke of the need for more technical skills and to a lesser extent management skills (Figure 3). Knowledge and ability to work with computers has a higher role than is required in the opinion of respondents. Digital literacy is at a satisfactory level according to students.

Students feel that they are good at acquiring new knowledge; that they are open minded; able to work in a team. The weakest point among strong points is low knowledge of a foreign language. Unfortunately, many Social Workers want to work abroad, due to the shortage of job possibilities and high labor cost in Slovakia especially within Social Sector, compared with nearby Austria, Czech Republic, Germany, etc. This could be behind their feeling.

A study program is good starting point mainly for personal development, to a lesser degree for a future career and for further learning. Life-long learning is expected also in the field of the social economy. There is surely disappointment with a future career which reflects the national situation in the labor market, particularly in the Social Sector.The importance of work autonomy is accepted as very high. 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.

Figure 1.

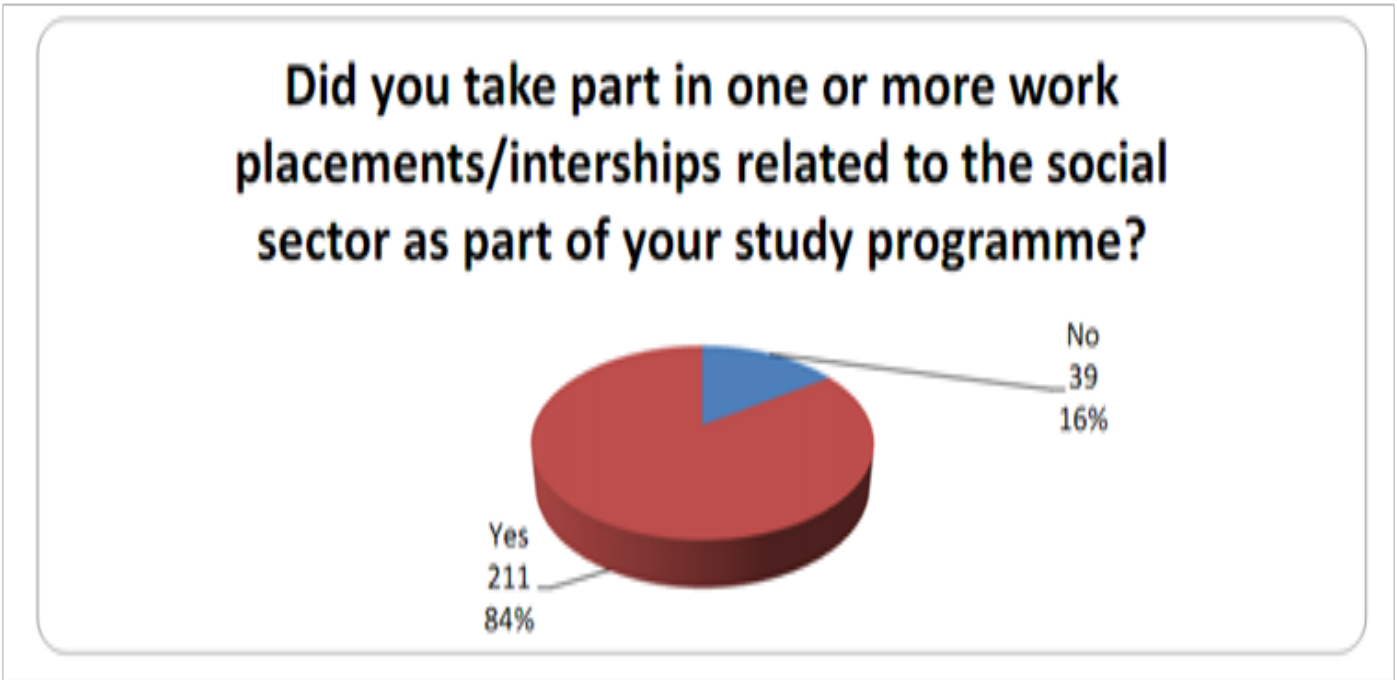
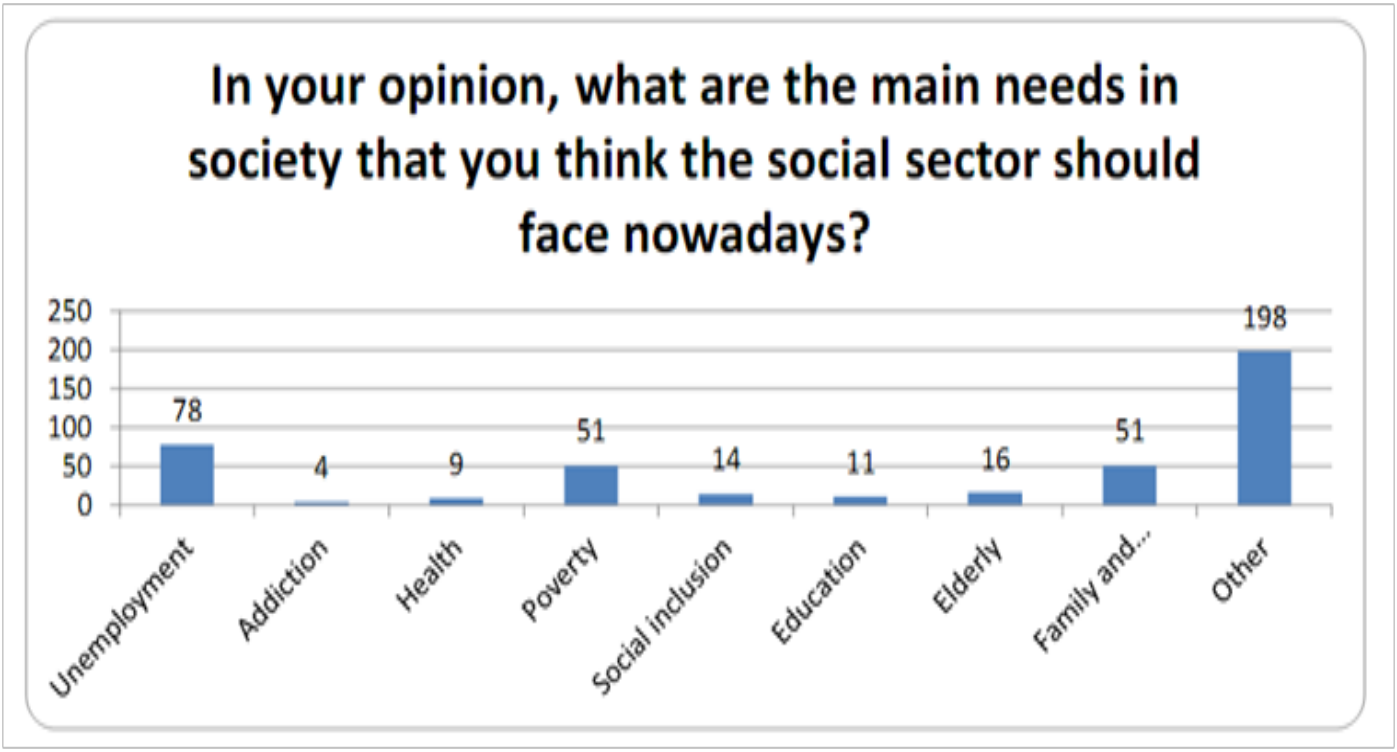


Figure 2.



The importance of job security has the highest importance for Slovaks in general public opinion pools. The importance of job security could be even more serious in the Social Sector. Students of social programs are very eager to obtain new knowledge and to acquire new skills. The Slovak labor force earns generally only 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 sector was more important than simply a 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 underestimation 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 a less important position.

Figure 3.

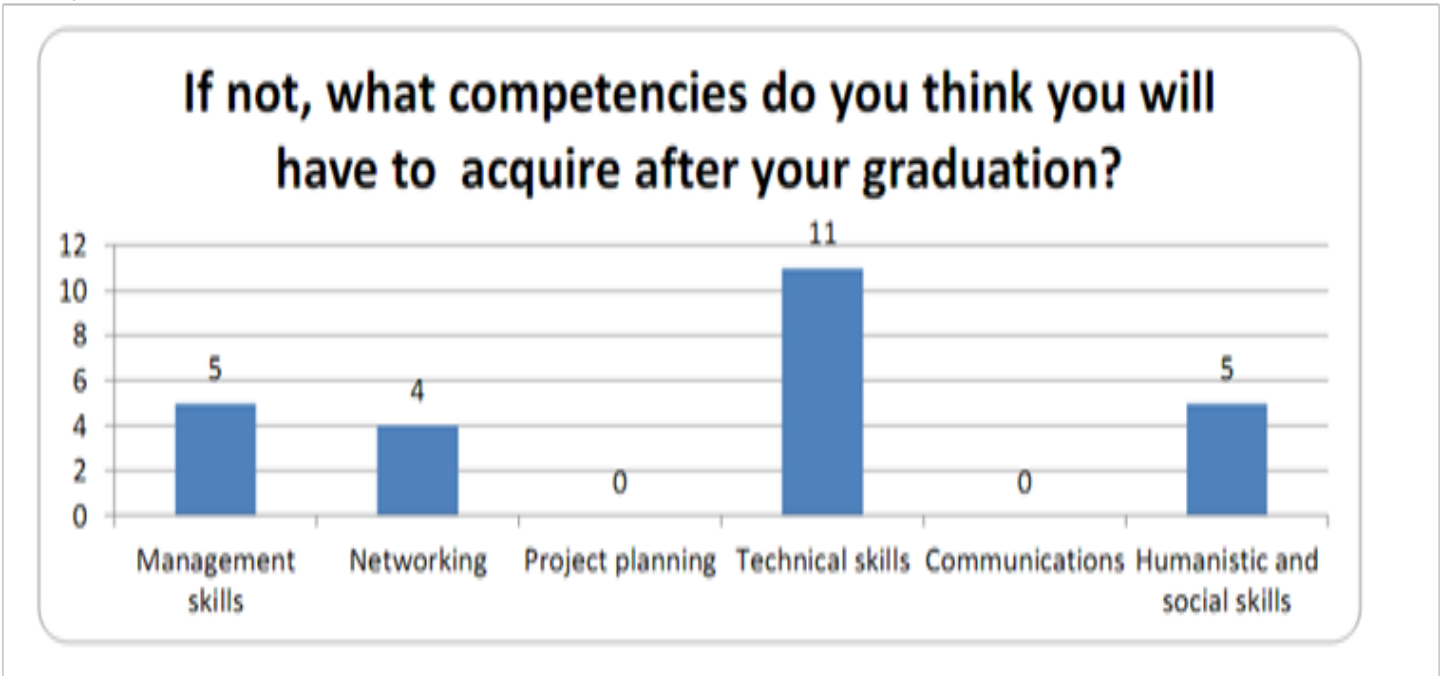
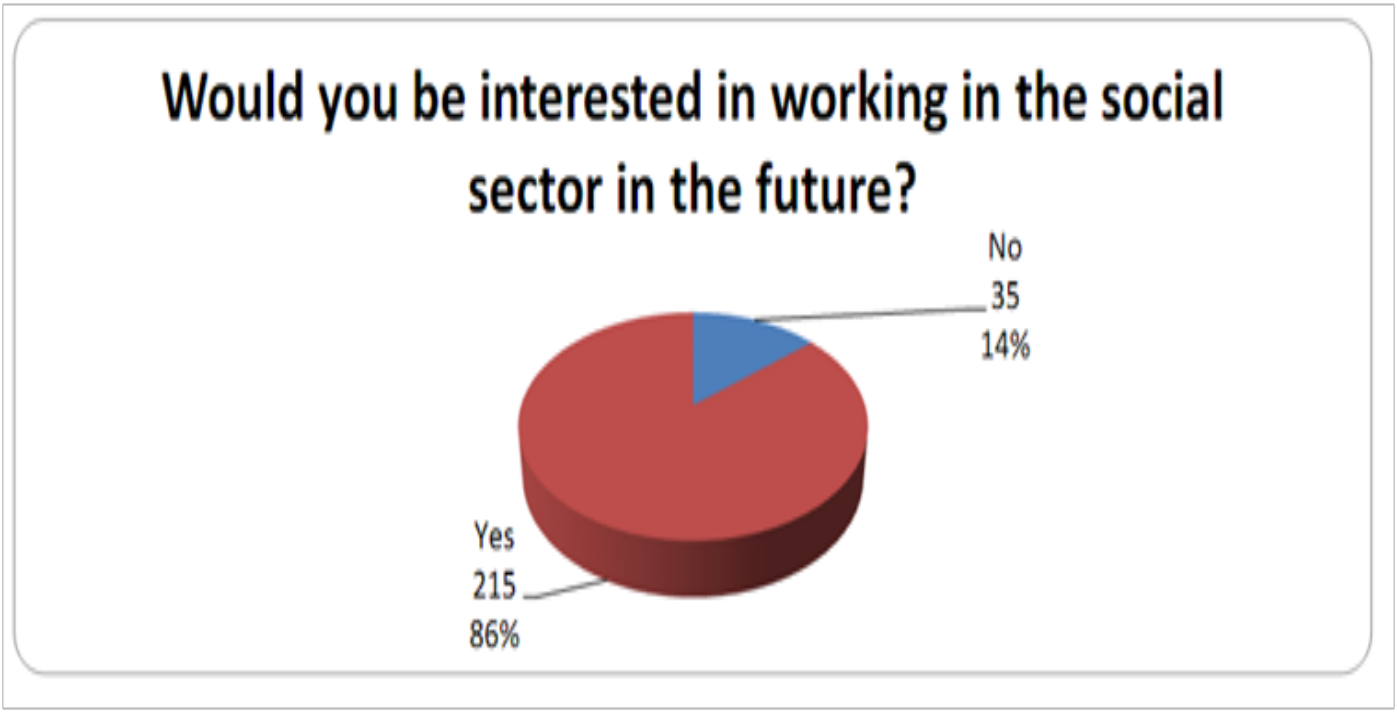


Figure 4.



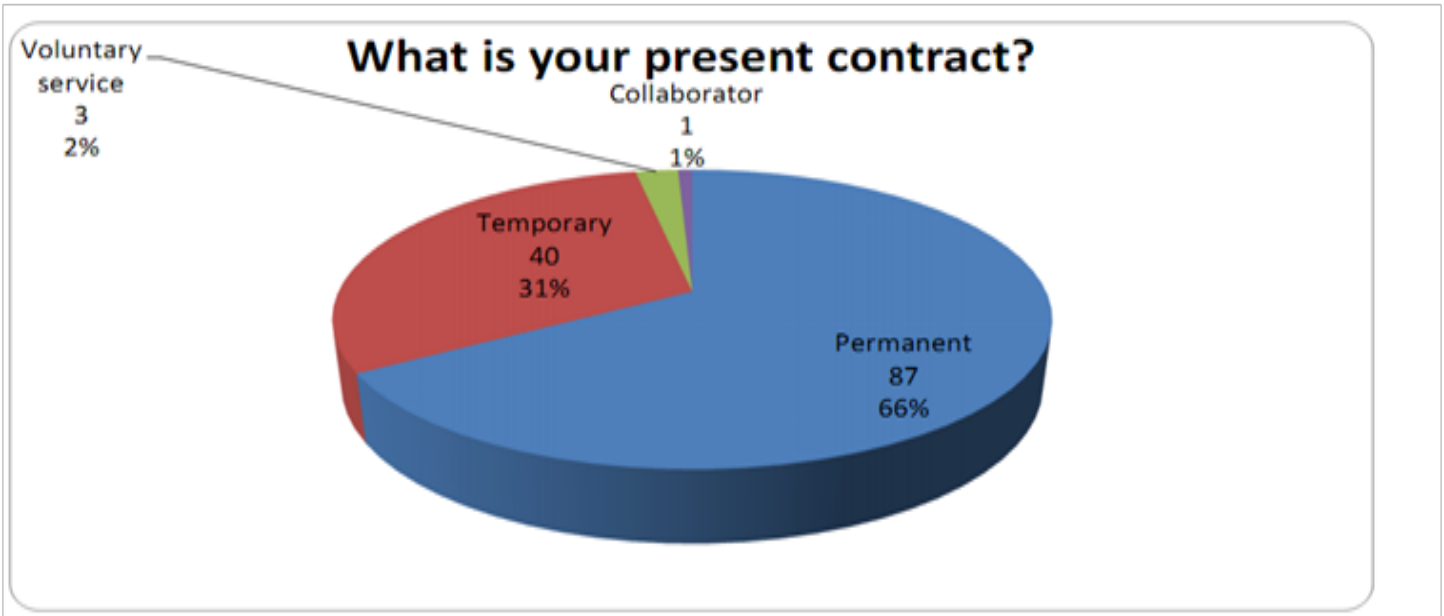
Good career, better income and new knowledge are more desired. A possible interpretation is that students want to help others without publicity. A feeling of importance of balanced living and working conditions is positive for future family policy in the country. Overwhelming majority of students do not hesitate in 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 new society needs. In the first place, the questionnaire focused on collecting data useful to understanding the characteristics of people working in the Social Sector; in the second place, to ask them to list what they believe to be the new needs; thirdly, what kind of profiles are presently not working in the Social Sector but would be suitable; in the fourth place what kind of skills and competence these new profiles should possess and if they consider the University study program comprehensive enough.

Prevalence of female respondents 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

Figure 5.



sample have some experience with work abroad. Success in finding a job depends on one's own initiative; family and friends help, as well, in approaching an employer. Some former interns have been selected by employers to join their staff after finishing the school. A permanent job contract is decreasing in favor of temporary job possibility. The current job contract is still mostly full time and permanent (Figure 5). Generally, in Slovakia part-time jobs have approximately 5% share of overall employment. The result of part-time jobs in this survey was 5 times higher than the national average.

Prevailing opinion for the education prerequisite for working in the Social Sector is a University degree. The result correlates with the present practice in this sector. Similarly, as in the case of students, preference is given to socio-pedagogical orientation and humanistic study programs by workers.

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

The main reasons for changes within employing organizations were mostly from reorganization and changes in personal tasks. Another important problem are massive lay-offs that destabilizes the Social Sector and its workers. Interviewed workers were from various organizations ranging up to 59 employees which represented 41% of all. Vacancy filling with suitable/proper employee takes a relatively a short time. Acclimating to working conditions could take longer. Generally, organizations do not have the financial resources to employ more staff.

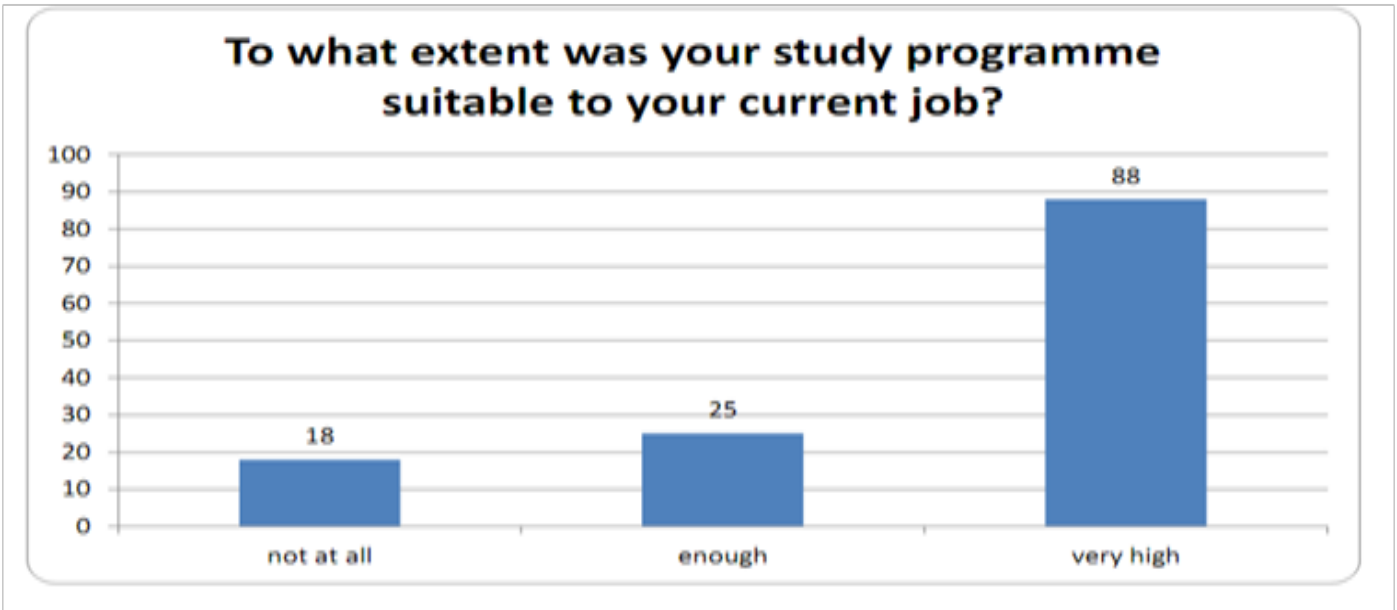
Social Workers admitted the necessity to have skills mainly in project planning and to a lesser extent in networking. Among the strong points of Social Workers, we can add abilities to perform under pressure and coordination of activities. Weak points are connected with foreign languages; with asserting their own authority; surprisingly, they still have low competency in digital technology. Among Social Workers there was a prevailing opinion of favorable satisfaction with study programs for starting jobs. For a future career, the majority of workers in this sample still seem quite positive as a result of study program. Interviewed Social Workers admit the high importance of study programs for their personal development.Still, such study programs are not giving enough knowledge for entrepreneurship.

Even after a time of internship practice, there is a wish to repeat the same study program. The conclusions are similar among students. The personal importance of work autonomy is very high under all circumstances. Opportunity to learn is perceived as personally very high and also within the framework of the current job.

Overall, the importance of income is high, but in current job climate, it is not hottest issue for workers. New challenges are important in a personal career and also significant in a current job with less wage differential than was previously the case. Also, favorable career prospects are highly appreciated in personal life, but not the main challenge in a current job.

Social Workers evaluated the importance of using leisure time higher than students. Proper usage

Figure 6.



of free time and the need to have enough time for family and rehabilitation is important for Social Workers (burnout danger).

Social status is equally important in private and public life. We see differences between the importance of income and status. Status and the opportunity to do good for Society is very important for workers in the Social Sector; equally in private and working life. Working and life harmony are very important for Social Workers. A social responsibility policy is important to be developed and has to be enforced by employers.

There was a high interconnection between a current job and a study program (Figure 6). Workers did not use placements/internship at the level as is now common among current students. 17% of interviewed workers took part as volunteers during their studies.

The number is growing now among students. Volunteering is a good step leading to possible later employment at the same venue. Only 32% of workers took part in a Social Sector Training Course. Respondents admitted a certain gap between school knowledge and employment requirements. That reveals the necessity for more post-graduate studies. Main subjects of these training courses were focused on supervision, caring, socio-psychological skills and community planning.

In the connection with the survey there were dozens of interviews with managers in the Social Work Sector. Their opinions and answers are very different and sometimes broad and not specific. It is not easy to summarize their positions and statements.
How can Social Work Managers describe competencies of their employees/staff? In the first place, the majority of the Managers appreciate ability to work under the pressure; mastery of their field or discipline; ability to coordinate activities; digital literacy. The weakest points are inability to write and speak in foreign languages and missing ability to assert their authority. Personal awareness was a weak point in other answers as well in this survey.

CONCLUSIONS

In a practical way, Slovakia is missing a social economy, social cooperatives and even rarer social enterprises. Development of the Social Sector also has high potential for improvement for the employment of young graduates.

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

Young graduates face considerable problems in making the transition from education into employment due to the overwhelming shortage of job opportunities. Finding employment is not easy requiring many interviews and extended time. Within the active inclusion into the labor market, emphasis has to be particularly directed to disadvantaged groups, especially on young graduates.

Despite the general satisfaction with University Education, respondents articulated the need for more technical skills. Social Workers admitted the necessity to develop better talents mainly in project planning. Employers (Managers) give preference to potential employees with soft-ware skills. In many social institutions, management and project planning skills are important for successful performance in economic and financial institutions.

Study programs accepted as a good starting point mainly for personal development; to a lesser degree for a future career work. Life-long learning also is expected in the field of social economy. Specific disappointment regarding a future career for young graduates reflects a national situation in the labor market, particularly in the Social Sector segment.

Preference is given to socio-pedagogical orientation and humanistic study programs by Social Workers. Generally, managers accept the current schema of study, but recommend a 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. The opposite weak ability is in foreign languages literacy. Asserting of own authority within workers is low and surprisingly, there is still a competency gap in IT.

New services require improving of software skills, a better ethical approach to clients and standards. The importance of humanistic and social (soft) skills within the Social Sector framework activities continues to grow.

Social organizations have limited capacity to hire more staff-members, even where there is demand for more social services in Society. This decreases capacity to solve poverty and social inclusion problems in Slovak Society. It is crucial to improve the position, remuneration and awareness of Social Workers in Slovakia, otherwise the 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 the possibility of continual development.

REFLECTION

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 a 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 immediate 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 an influence on the historical context of the Social Work Organization

and current legislative background.

Real vision of management systems in Social Work is focused 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 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 methodology 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 that the quality of employee relations 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).

Improving employee relations is now heavily involved in the process of collective bargaining through compromise in 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).

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

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 delimiting problems in inter-personal interactions and greater motivation to address specific problematic situations 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 others.

Brounsteina (2001) says that 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 opposing. Conflict is a natural part of working life (Porvaznik, 1999).

Vruzek (1999) states that conflict in the interests of the company are 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 within the working groups (Adamkova, 2006).

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

1. Mobilizing conflicts - leading to development activities such as promotion of new working methods or reorganization of the workplace;
2. Destructive conflicts - are the diminishing effects in the workplace which 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 opposing interests or values (Plaminek, 2006). If the parties (employees and managers) looking only to their own interests inevitably results in labor conflict (Harvard Business School Press, 2007). When creating a positive working relationship, it 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 isolate the individual from the collective;
2. In confusion - may be caused by poor communication or lack of qualifications 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 paying 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. Adverse working conditions for employees often results in dissatisfaction and staff leaving the organization (Kulková, 2012-07-20).

Michel (2010, p. 90) points out that "for people occupation (job) is a 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 creates space for self-expression and self-esteem."

The role of managers (management) is primarily prevention of conflict situations their important measures should include preventive deployment of staff in their profession and skills (Bohumel, 2012-07-29).

According to Spiess and Fading (2008), 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 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: In conflicts between employees and senior staff of the employees in industrial undertakings, which is related to a compromise deal.
C2: What strategy managers and employees prefer in industrial enterprises to resolve conflicts.

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 in conflicts with employees in the surveyed entities in industrial plants.

SURVEY SAMPLE

Our research was conducted by questionnaire from 09. 08. 2012 to 27. 01. 2013.
The core set were randomly approached staff and managers in industrial plants where 113 questionnaires were distributed. This basic set was chosen because this was in line with defined objectives and research hypotheses. Of the 113 questionnaires in the research 98 questionnaires were properly filled and returned, representing an 86.7% return of usable questionnaires. These 98 respondents composed the exploratory 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.

The subjects studied: we have chosen industrial enterprises because they present the most frequent participants 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 two-stage sorting of acquired data (two-dimensional contingency table) were applied which established absolute and relative frequencies for the observed category.

Two-stage (two-dimensional) separation is oriented to describe the relationship between the 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 correlation research in which we focused on relationships between pairs of variables in the research hypotheses.

SURVEY RESULTS

We have used the statistical program SPSS to verify hypotheses results.

The data in Table 1 show that of the category of employees working in the industry, the largest percentage, t. j. 35.4 % of respondents perceived importance for 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 category of working managers in industry, in the largest percentage, t. j. 46.2 % considered cooperation to resolve conflicts the preferred strategy when employees fail to agree on a common solution. In the strategy of confrontation 'Strategy adjustment' and 'Enforcement strategy is an avoidance strategy' did not have any respondents.

DISCUSSION AND RECOMMENDATIONS FOR PRACTICE

The aim of our research was to determine whether a compromise conflict resolution improves relationships between research subjects employees and senior officials from the perspective of Social Work.

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 Svidnik, in Bardejov and Presov. Of the 113 questionnaires properly filled and returned 98 questionnaires were used in the research, representing a 86.7 % return of usable questionnaires.

We found that in the category of employees working in the industry, the largest percentage, t. j. 35.4 % of respondents perceived the importance of 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, 46.2 % considered the preferred strategy of cooperation in resolving conflicts when employees fail to agree on a common solution. The 'Strategy of confrontation' "Strategy adjustment', 'Enforcement strategy' and 'Avoidance strategy' did not have any 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 work place are very negative situation involved in employee relations and effective mutual cooperation between employees and employers (senior staff).

Hard labor, wages, working conditions, health and safety, employee training at work are common causes of conflict in the work place. If in the process of collective bargaining, the employee's interests are not accepted by the employer (Senior Staff), employees can exercise their right to strike as a last resort in settlement of labor disputes with the employer (Senior Staff).

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

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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.

REFLECTION

Current and future demands of Social Work Services require many changes. Research and reviews forecast that working in the same ways will not deliver what is required in the future. Demands and expectations are high; the focus of Social Services will be on what improves outcomes for service users and ensure these are done consistently (Moynaugh, Worsley, 2005).

Social Work is at a very important stage of development, and is currently facing challenges and more critical reflection as well as more highly skilled approaches to Practice are needed. A major challenge for management across Social Work Services is one of 'change management'. To provide what Social Work in the 21st Century requires, we first need to transform the whole thinking about services
establishing the right culture and climate for change (NHS Scotland 2005).

Every Social Worker at every level should know something about the discipline called Management. There are however, lots of questions if the same should apply the other way around; whether every Manager should have a Social Work Practice background. Although, it does have to be acknowledged that today's Managers of Social Work are employed not for their Social Work skills from practice only, but mainly their Managerial skills that are of 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 a Practice whatever services are provided, and no matter how senior one rises within the organization.

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 or delivered (Coulshed, Mullender, 2001). The Social Work Manager is not only responsible for recruitment of the best staff, but also for the essential development of those staff. Without proper training and further follow up, top quality service cannot be provided.

Supervision is a key by which Managers can assure quality Social Work practice. It is crucial for Social Work Managers to build networks with the people they work within their own organization and with people from 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 a person first begins as a Manager, but probably will have picked up key skills as a Social Worker.

Professional leaders should have clear vision as to their role, especially when comes to developing and maintaining practice (Rosenberg, 1995). A good Manager should be actively involved and inspire their staff. Being able to take an action and deal with conflicts also goes hand in hand with the Managerial role. Social Work Services have been built on values such as choice and self-determination to help to develop a practice that is person orientated; emphasizes social inclusion; trust; engagement; partnership with service users. It is based on interventions from skills in assessment; planning; review; supporting independent living; alternative care; networking; communication; 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; gain the rewards of the competent leadership; but they may also feel losing touch with direct practice; in certain ways perhaps becoming deskilled. There is a stereotype of the Manager who has sacrificed Social Work values to the importance of filling in forms; gathering data on computer; giving priority to what her/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; sociability of each and every person. Most people, however, prefer the theory of 'healthy balance' explaining that good leadership may well be a combination of both traits and behaviors (Lambley, 2009).

Whether you are a born leader or a 'made leader', leadership style should reflect your style of work and should be within the context of the services you provide.

We are aware that Social Work Managers are working in a sometimes 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 in Social Work belongs to very important tasks in a Social Work Manager's role. People are the most important and greatest assets and without good staff, quality services cannot be provided or delivered. Supervision is the key and with its help, a skilled Manager easily can be involved in quality measurements of provided services; monitor the staff; 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 the role; the task; the role and relationship with the team; situations being faced (Payne, 2001). Leaders who are trusted by their group are able to encourage people to participate highly, and be well placed to delegate with confidence. However, a new leader or the one with poor relationship with the team, as well as no real influence, can be in a 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 the work of others in behalf of the wider organization. This can be quite an unfamiliar term for 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. Uncontrolled conflict is often a sign of poor management. A Manager of Social Work should first seek to understand and then be understood. She/he should be able to understand people she/he works with and find ways to compromise and negotiate.

In Social Work, Management and leadership, are evolving. Alongside professional Social Work, 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 adopt the best ways of working (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. Ethics are very closely connected to the Social Work Manager's role. Ethical issues in Social Work arise for Managers because of the decisions they are taking which have implications for others; because Managers are taking responsibility to ensure that the quality services and organization activities are in line with public interest and standards.

Every Social Work Manager should represent and develop a personal ethic. An ethically based

Management is supposed to inform us about a particular service provider or organization and how they will proceed to achieve effectiveness. Four principles which lead to healthy and no conflict management are: Autonomy, beneficence, non-malfeasance, and justice (Hugman, Smith, 2001). Those four principles, depending on the situation and circumstances, can carry different weights concerning a particular ethical issue or problem. However,
the principles are the basic standards of Management practice across disciplines.

A Manager's most obvious concern is the Management of people. Whether this is service users; careers; the general public; 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; 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 confirm 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 great deal 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 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.

IIn recent decades, researchers have concentrated more on the physical world than on non-physical human dimensions. Physics and Chemistry have made great progress in recognition of reality regulators. However, at the same time, Science about people was developing quite slowly. Even at the time of Sigmund Freud and Ivan Petrovič Pavlov,
the Pioneer's dialogues were seen as merely important artifacts of thoughts, ideas, and information about human ways of thinking, action and emotional responses/reactions.

Today, Psychology is a system including more than 60 Psychological Sciences, which are dynamically evolving and compose Humanistic Science. The main aims of Psychology Science are to describe, explain and predict human behavior and living to increase human satisfaction (Plháková, 2003).

Study of information encompassing Social Work and Psychology allows people to glean some idea about our own psychic life; to understand our own living and behavior, feelings and motivations so that we can manage, plan and predict our lives. This can help us to understand the behavior of others; create good human relations; discern potential conflicts and solve them effectively. It assists us in our own and other's life enhancement and by negotiating around possible traps. Even, just in this last aspect, we are able to see the value of acquiring knowledge through these Sciences.

It is very difficult to define Social Work because it is a never-ending process during which the Practice attempts to analyze and resolve a constantly changing Society. (Matoušek and col., 2001). Defining Social Work, (In: Matoušek and col., 2001), he speaks about Social Work as about a '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 ".

In early 1920, N. Hartmann (In: Hašto, 2005), in his concept of teaching about segments provided a philosophic-ideological model according to which the human is 'layered':

- the lowest layer is inorganic which is studied by Physics and Chemistry;
- right above it is the vital layer that is studied in Biology with all its disciplines;
- following is the psychic layer which is an aspect of the Psychological Sciences;
- the last layer, a Social-Spiritual within Social Sciences and Clerical Studies.

„In the Biology layer, we may also find physical-chemical laws of the lower layer, but with respect to some laws which are unknown within the inorganic stage, e.g. aimed adaptation. A higher layer - over Biological - is Psychological, as a thinking and performing human. There are many expressed individual specialties which are clearer in final sight (in which are some complex of causal processes). The Social-Spiritual layer is over the individual determinations and it has a merit to all human society: sphere of social communications, spiritual, ethical and religious values. It transcend individual awareness. Each of layers has its own rules and specifications, and the higher layer is dependent on the lower layers. The lower layer is the base for higher ones and therefore 'stronger' than those. The higher layers cannot exist without the lower layers. However, lower ones can exist without the higher" (Hašto, 2005, p.87).

A wide consensus of the professional community and its use in practice, has already gained a bio-psycho-social role which was first introduced by George Engel in 1977 which integrates biological, psychological, and social aspects of the human being. Nowadays, this role is accepted by the Humanities and it is a resource to holistic, systematic, multi-variable approaches to the client. Acknowledgment of biological, psychological, and social factors as cooperating aspects in etiology and treatment to sickness, as well as a solution to social

and psychological crises in human lives, implicates needs for an 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, well-being and personal growth.

In the spectra of the Humanities, Social Work and Psychology are situated quite close to each other. Despite specifics, we find a great many conjunctions and similarities in many parts of their theories and practices concerning the relationships of psychological scopes, ethical principals, terminology as well as work methods and research procedures.

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 disciplines are characterized by a high rate of multidisciplinary Sciences, because they link up with other disciplines, including Sociology, Pedagogy, Law, Philosophy, Psychiatry as well as Economics, 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, to know that the client expects advice, help and solutions to his situation, from his Consultant. Presently, in the social sphere, the preferred approach is based on the help and supporting of the client as an assumption of his motivation for mobilization and involvement in solving his problems.

The elevation of the connection between Socio-therapy, Psychotherapy, and Social Work by L. Lozsi (2011) is very interesting in 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 which attempt to arrive at 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 centered area (Lozsi, 2011, s. 2).

Therefore, the client centered area may be considered as one other great intersection between Psychology and Social Work. She concurs with Haštova's (2005) theory about the plurality of methods, according to which, it is obvious, that Professional - Social Work and Psychologist, are 'moving' within the client's layer whether he/she realizes that or not. It is true that she considers some different levels - levels of Sociology, Pedagogy, Law, Philosophy, Psychiatry, Economics, Somatology and Medicine, as well. Needless to say, we have to consider a Social level, too. If we had ignored it, we would not be able to ask some very important questions nor look for their answers.

We would have to resign to risky social and protective factors in formation, a possibility of aimed work with the public and socially focused prevention. Strictly considered, we would have to resign to Psychotherapy, too, because it is a social interaction, as well (Hašto, 2005, p.88).

On a 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 cooperation 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 clinical experience of Social Workers following the solution or alleviation of a client's problems. Psychology assists the Social Worker in better understanding of her/his client, and at the same time it gives her/him a better idea of self-knowing and self-developing.

Social Workers, as a professional helper, perform their Profession in close contact with
their clients and other Specialists. Therefore, it is necessary for them to have knowledge and skills in areas 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 Work are not substitutable. These may help the Social Worker to understand the individuality of a client's way of thinking, living and needs which are the basis for their individual and optimal approach to that client; help to understand the client's life situation and his motivation to change. A valuable support for the Social Worker may be knowledge of communication including the understanding of the communication process itself and handling of specifications of communication with different types of clients and especially cooperating Specialists. Areas of handling pressure and stress cannot be neglected, so Psychology can help to identify factors that influence managing and organizing solutions for social situations and problems including their basic requirements for everyday living. It is obvious, that this information can be (and should be) used by Social Workers not for just for a client's benefit only, but for preserving her/his own health as well.

Competence and a wide view of specialized working activities provided by Social Workers on a daily basis require many details and demands. These refer to special preparation and experience as well as personable maturity and ability to respect ethical norms and values while in practice. It is necessary 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 the individuality of each person, we can suppose and expect that the Social Worker will be equipped with 'a package' of qualities, attributes and skills. These may not only be reasons for his quality interaction with a client, but also for many more aspects in this professional 'package' must be an ability to self-reflect, self-understand 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 evolutionary Psychology, Psychology of Personality and Social Psychology together with a foundation in Psycho-pathology are as important as practical preparation and placation 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, offer help, support, accompaniment; a net as a system of support, where the center is client-individual, family, group, community and ambition to implement human values into interventional processes. 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 cannot remain detached when some individuals are in a collision, danger or even sometimes reject practical offers of help. They have to respect ethical principles, client's right for self-evaluation and help a client with identifying and clarifying his objectives.

Psychology clarifies some controversial questions for Social Workers, for example: How far can a client employ self-destructive activities by the Law? What should be the reaction of a Social Worker be when an oppressed woman decides to go back to her violator or she does not want to leave him? With a psychiatric client who decides to discontinue his/her psychiatric treatment? With the safest approach to a suicidal client?

Help a homeless person who prefers to sleep

in the street rather than in refuge. Balance between these professions can be seen in the commitment of clients for self-determination and in protection of clients from harm. On behalf of a client's protection, they help a client to solve and cope with everyday problems and heal mental, behavioral and emotional problems.

Social Work and Psychology study people's behavior and living laws together with external and internal variables which regulate them. Both of them can be described as Science Disciplines thanks to which we possess enough 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 the Law of Gravity. It brings not only intuitive but also experimental approaches for obtaining information while they are interested in a wide context of human existence and complex phenomenon as well as in connection with other science disciplines.

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INSTRUCTIONS FOR AUTHORS

We would like to offer you an opportunity to contribute to CSW Journal content as we would like to aspire to create a collection of real experiences of social workers, doctors, missionaries, teachers, etc. CWS Journal is published by the International Scientific Group of Applied Preventive Medicine I-GAP in Vienna, Austria.

The journal is to be published quarterly and only in English language as it will be distributed in various foreign countries.

We prefer to use the term 'clinical social work' rather than social work even though it is less common. In the profession of clinical social work, there clearly is some tension coming from unclear definitions of competence of social workers and their role in the lives of the clients; the position of social work in the structures of scientific disciplines especially in cases where people declare themselves to be professionals even though they have no professional educational background. These are only few of the topics we would like to discuss in the CWS Journal.

Your contribution should fit into **the following structure**:

1. Editorial
2. Interview, Case Reports
3. Review
4. Original article
5. Letters

Instructions for contributors:

All articles must be in accordance with the current language standards in English, current ISO and the law on copyrights and rights related to copyrights.

Your contributions are to be sent via e-mail (addressed to: michalolah@gmail.com) as an attachment or on a CD via regular postal service. In both cases written and saved in MS Word (no older version than year 2000).

Style Sheet Requirements:

Maximum length: 3500 words
Letter type: Times New Roman
Letter size: 12
Lining: 1

All **articles must include**:

1. Name of the article and author's address in English
2. Article abstract of 150 words in English
3. Brief professional CV of the author (100 words)
4. Text of the article consisting of at most 3500 words

Publishing languages: English, German

Each article must be an original never published before. When using references, parts of other articles or publications it is inevitable to quote them and provide information about the source.

We reserve the right to formally edit and reduce the text if needed. Academic articles undergo an anonymous critique. Each author will receive a prior statement of publishing his/her article.

When writing a review it is necessary to attach a copy of the cover of the book.

Thank you for your cooperation.

Yours sincerely,

Michal Olah, Ph.D.
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