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2/2014 - Social Work and Poverty of Families with Children (czech only)
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4/2014 - Social Justice (czech only)
The editor of this issue is Dr. Alois Kristan.

5/2014 - Special English Issue 2014
The editor of this issue is prof. Peter Erath.

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Editorial

Positive boundary-crossing in social work

Welcome to the annual edition of *Sociální Práce/ Sociálna Práca*, the *Czech and Slovak Journal of Social Work* in English. Each year, the Journal publishes a number of papers in English in a special edition like this, and in its quarterly editions. If you want to propose a paper for this edition in 2014, you send an abstract to the editors by 30th June. Most of the papers report research and scholarship by Czech and Slovak writers about social work practice and research in their countries, and by writers from other countries discussing material of interest to Czech and Slovak social workers and researchers.

In doing so, the authors are communicating across cultural, linguistic and national boundaries affecting social work, but they are also crossing boundaries in other ways. In doing so, their work symbolises the need to think flexibly in social work practice and policy. In this editorial, I explore the purpose and role of positive boundary-crossing in social work, illustrated by the contribution that papers in this edition make to our thinking.

Most contributions to professional and academic journals are written in a particular administrative, legal and social context and within particular cultural and professional traditions. A reader outside those contexts and traditions makes a cultural transfer to their own context and tradition, and writers may facilitate or hinder that transfer (Payne and Askeland, 2008). Writers can specify the particular cultural, professional and social factors characteristics that colour the particular forms of social work and social provision in their setting. In doing this, they alert readers to think: how is that different from experience in the cultural and social setting where I practise?

Aware of the requirement to make translations, readers can seek out in papers potential restrictions in cultural transfer to alert them to the need to translate a paper to their own context. The wise writer and reader will approach material from a different cultural and national context with caution, recognising that limitations may be hidden. It is considered good research practice to explain how the limitations of the methods used in a piece of research will affect the extent to which we may generalise from their findings. In the same way, since social work is a field of research and practice that depends strongly on cultural and social setting, it should be considered good practice to describe the limitations of that setting on the findings.

The analysis by Horák, Horáková and Sirovátka of *recent trends and changes in Czech social services in the European context* using comparative material on social care services for children and older people is an explicitly cross-national comparison. Its comparative focus suggests that social workers need to look in the provision of other nations to understand potential alternatives in social provision in their own. But wider boundary-crossing is also an important possibility. The message to practitioners is that they must cross the boundary from their

everyday practice with children or older people to incorporate awareness and responsiveness to the funding and management of their services. It is easy to say that another country provides more resources for a particular client group and press for change to level up to that standard of provision. Or we can say that it organises services in a different way, allowing us to assert the need for new priorities. But we can also ask how funding and management interact, and whether they need to. How far do expenditure trends and policy pressures support each other? Or are they in tension? And is there a further tension with practice needs?

Positive boundary-crossing can increase our opportunities to draw implications and guidance from the papers presented here to extend our thinking. In dealing with two usually separated client groups, this paper raises further questions. How far does our society set children and older people against each other in a battle for resources? Or can improved practice or policies for children's services generate ideas that may be transferred to improve practice and services for older people too?

We can seek opportunities for positive boundary-crossing in other papers presented in this special edition. Vontorová's paper on the *self-sufficiency of older people* on discharge from hospital identifies several boundaries. One is the professional boundary between a healthcare speciality, geriatrics, and social work. It also refers to the institutional boundary between hospital and social care; different but perhaps related. Another issue arises as people move away from self-sufficiency towards dependence of public services. This movement is solidified by shifts in the use of services: from family or community support to formal services, from healthcare to social care provision, from the particular of medical diagnosis and treatment to the generality of social responsiveness.

One way of understanding this has been the development of integrated care pathways as part of our services (Schrijvers, van Hoorn, and Huiskes, 2012) In this model of interagency practice, a typical journey of a client through the care system is identified, and the role of agencies at each point specified. We can see clients as progressing through a series of gateways, with a particular professional or agency responsible for assessing and deciding on access to the next element of the service. But is such an arrangement too linear? It neglects the reality that frail older people usually have multiple health conditions, so that seeing their needs as following one pathway may mean that we do not see them as whole people, whose differing health and social care needs interact. It also assumes that the older person will only experience decline in their lives, rather than improvement and development. Are all our pathways for older people assumed to be towards frailty?

On the other hand, do we value self-sufficiency too much? And why is this? Perhaps the focus on maintaining self-sufficiency does not value mutual dependence between mothers and daughters or between spouses. Or perhaps we focus on self-sufficiency because we do not want to pay the full social costs of the health and social decline that older people may experience. And perhaps our rejection of decline reflects our own ambivalence about aging. In adult life, we want to remain independent and avoid dependence on others, so we demand that older people should struggle for independence, rather than allow us to value supportive and caring relationships in our society.

Seeing related papers from different sources emphasises that concerns may be shared across boundaries and also helps us to look at the same topic through different cultural lenses. Two papers, one from the USA and one from Ružomberok in northern Slovakia, explore different aspects of 'moral work' in social work. Many social workers do not consider 'moral work' as part of their professional function, yet making moral decisions is often seen as integral to social work actions in public perception and social policy. This is because social work decisions that do not connect with wider social perceptions of moral appropriateness may lead to social work being seen as misguided (Payne, 1999). Bibus, an American social work teacher, reviews the relevance of ideas from virtue ethics in *Applying approaches from moral philosophy, especially virtue ethics, when facing ethical dilemmas in social work*. He shows how striking ideas can be relevant to social workers in different nations, and his case study demonstrates how commonplace experiences as we practise social work can speak to us from a distant country. Lajčiaková's

research into 'moral competence' reported in her paper *Social work students' moral judgement competence* draws out the relevance of moral judgment to competent social work practice and demonstrates both the possibility and the need to explore this in social work education and practice, when perhaps doing moral work would have been outside readers' assumptions about the role of social work.

Pešáková, in her paper on *Violence against Men* also challenges an assumptive boundary: when looking at intimate partner violence, we take it for granted that it is men who are the violent ones, and women the oppressed. There is evidence, which perhaps has been underplayed, that men are subjected to violence, too. And if this happens when everyone assumes that it is usually men who are violent, Pešáková asks what this may mean for them. Is it harder to believe that men are oppressed in intimate relationships because they are often physically bigger and more muscular than women? If men are assumed to be more prone to an aggressive temperament, what does this mean for men whose temperament is otherwise? More broadly, do we focus only on some forms of violence, neglecting others? What are assumptions about the way intimate relationships should be?

Matulayová and Pešatová, writing about *Social Workers in Schools* also raise questions more widely than their apparently restricted focus. Social workers in schools are working in a secondary setting, that is, social work is not the leading profession and its objectives are not the main purpose of a school; it contributes in the support of educational objectives. This is true of social work in many other settings, in hospitals, clinics, prisons, housing services and social security, and working with many other professions. It may even be true of social work more generally. Is social provision secondary to the main roles of government services? Is social work secondary to providing broader social services, such as housing or social security? Is social provision secondary to private sector services that people pay for in the market?

Social work practitioners can therefore ask themselves: what can we learn in our secondary setting from how school social workers deal with their secondary position in schools? And we can ask about schools (and other secondary settings): are the apparently clear main educational objectives hiding social aims such as promoting social cohesion and social justice which should be drawn out and made clear? A school that creates social divisions and conflicts among its students in the cause of academic achievement does not contribute to wider educational aims of encouraging social cooperation and respect. Social workers in secondary settings often personify hidden social objectives and their engagement in the life of a secondary agency signifies a commitment to those aims. A healthcare service contributes to an unhealthy society if it treats illness in isolation from the social needs of the sick person's family and community. Employing social workers accepts the responsibility of specialist services to have a concern for the social. If social work accepts such roles, it is important to understand and make real this aspect of carrying out its role through exploration of the implications of social work practice in every practice setting.

Positive boundary-crossing, as well as comparative material, then shows how contributions to knowledge that are apparently specialist can stimulate us to think more widely and inform a more flexible and critical practice and knowledge base in social work.

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Recent Trends and Changes in Czech Social Services in the European Context: the Case of Childcare and Elderly Care[1]

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Abstract
Due to contemporary societal trends, social services are becoming more important in welfare state architecture than in the past. In the proposed article we deal with the question as to whether the development of selected Czech social services is following (dis)similar trends when compared to other EU countries. Two areas of social services (childcare and elderly care) will be analysed with a focus on the key aspects of governance in child care and elderly care: financing, regulation and service delivery, how they have developed over the past ten years in the Czech Republic in

comparison with other states which represent different welfare policies (liberal United Kingdom, conservative Germany and social-democratic Denmark).

Keywords
social services, governance, childcare, elderly care, financing, regulation, service delivery

Introduction

The worldwide wave of reforms in welfare states which has gradually taken place since the 1980s has significantly affected social services. Although the welfare policies of individual countries bear certain specific traits, available studies focusing specifically on the development of social services, document certain similar trends across countries (cf. Ahonen, 2006; Jensen, 2008, 2009; Seeleib-Kaiser, 2008; Dingeldey et al., 2009; Wollman and Marcou, 2010; van Berkel et al., 2011; Sirovátka and de Graaf, 2012).

Most EU countries have implemented government reforms in order to make their welfare services more effective. The key changes brought by such reforms primarily include centralization (recentralization) of decision-making, marketization and contractualization of delivered services, coordination and control through new public management methods, involvement and activation of clients, individualization of services, networking of state and non-state organizations, inter-agency cooperation, organizational innovation at the local level, etc. (cf. van Berkel, de Graaf, Sirovátka, 2012). These changes have importantly brought about specific changes leading to a split in the functions of regulation, financing and delivery of services (Seeleib-Kaiser et al, 2008, Simonazzi and Ranci, 2008).

In the current article we deliberately focus on a comparison of developments within childcare and elderly care in order to examine to what extent similarities in the trends in governance have emerged in these different policy fields in the Czech Republic in comparison with other EU countries. The central question is whether the development of these social services in the Czech Republic is following (dis)similar trends when compared to other EU countries (liberal United Kingdom, conservative Germany and social-democratic Denmark). We specifically attempt to identify the key trends which occurred over the last decade in financing, regulation and service delivery, and consequently in the accessibility and quality of childcare and elderly care in the Czech Republic in comparison with the United Kingdom, Germany and Denmark.

We draw upon a dynamic version of the governance concept (new governance, local governance) which is briefly discussed in the first section of this article. We subsequently use a wide range of available quantitative and qualitative data sources, particularly OECD and Eurostat databases, empirical studies, ministerial reports and academic papers dealing with the governance of childcare and elderly care in the observed countries. Particular trends in these services are presented in the second section. In conclusion, we summarize key trends in Czech social services and the factors behind this.

1. Governance as financing, regulation and delivery of social services

The governance concept is closely linked with the ideology of new governance, which is gradually permeating the welfare reforms taking place in almost all European countries as of the 1990s. This ideology reflects the shift from "government" of public policies and programmes by the State at the national level to "governance" by state and non-state organizations in the profit and non-profit sector at the regional and local level. In other words, the policy is no longer in the hands of the state, but instead the original sovereign authority of the state is dispersed among self-organizing autonomous networks of interdependent organizations using different sources and following different rules of the game (Rhodes, 1996, 2007).

The principles of the new governance are specifically based on attempts at introducing market principles into governmental operations, moderating pervasive control over state departments newly laid out into small pieces, making management more flexible, measuring

and stimulating the performance of public servants, giving contracts to service providers from the private sector and privatizing certain services. The aim is to increase the efficiency, effectiveness and quality of organizations, instruments and programmes of the welfare state and of social services delivered by governmental and non-governmental organizations (cf. Clark and Newman, 1997; Harris, 1998; Hoós et al, 2005; Salamon, 2002, 2005; Brodkin, 2005, 2011). Activities associated with the government represent an area of management of programmes and services by regional and local organizations that may or may not fit together and create dyadic relationships or more or less complex networks. In this context, Anglo-Saxon literature uses the label "local governance" which represents the way in which various types of local [non-governmental] organizations interact and shape along with governmental organization partnerships and networks at the local level (cf, Stoker, 1991, 1999; Goss, 2000).

The practical application of the (new, local) governance concept is relatively complicated due to its complexity. On the one hand, we can identify the rather comprehensive approach of mostly theoretically thinking authors in the literature who try to make clear what the new "governance" is but who do not put so much emphasis on the exploration of specific conditions of delivered public policies and social programmes. Instead, they consider what the political and institutional capacity of the state to govern is, and how interactions of actors, in particular in political networks *at the state level*, are coordinated (cf. Rhodes, 1996, 2007; Pierre, 2000; Pierre a Peters, 2000; Kjaer, 2004; Zelenková, 2013). On the other hand, there is the more straightforward approach of primarily empirically oriented authors (policy analysts and representatives of governmental organizations) who try to describe governance. These publications focus exclusively on identifying ways and quality of governance (outputs and resulting effects), i.e. whether the government governs well or poorly and thus whether the problems of poverty or social inequality are solved successfully or unsuccessfully; regarding the label of governance as "good" governance, "strategic" governance (World Bank, 1989; UNDP, 2007; Williams a Young, 1994) or "progressive" governance for example (UNDP, 2005) (cf. Nekola, 2007).

Both theorists and empiricists ignore, however, the empirical exploration of specific structures and processes associated with the (new) governance, which usually involves the process of planning, administration and implementation of particular public policies at different levels of the state, market and society. At most, they examine one of the predominant factors affecting governance, this being law, new public management, political system, government, corporations, market, marketization, etc. (cf. Casey a Gold, 2000; Ahonen et al, 2006; Ehrler, 2011; Sirovátka and Winkler, 2011).

Our participation in the 7th Framework for the European Commission in the years 2012-14 enabled made it possible to devote ourselves more intensively to the operationalization of the (new, local) governance concept (see Sirovátka et al, 2012). Based on the available literature, we created our own concept of governance in order to identify four "areas" (dimensions) of governance *(financing; regulation; delivery; and effects)* and six "sub-areas" (sub-dimensions) of governance *(the kind and method of financing rules; management, coordination and control; level of governance; partnership and networks of actors; delivered programmes and services; and delivery effects)*. Particular elements of governance can be identified within the particular sub-areas (for more details see Horák, 2012).

Of importance is the fact that a knowledge of all areas of governance enables us to compare the governance of social programmes and services (and public policies as well) not only between countries but also between the regions of the particular countries surveyed. It is actually firstly necessary to identify and evaluate key dimension of financing, regulation and delivery and subsequently to assess and label the resulting effects as a specific type of governance.

Moreover, the multidimensional model of governance used here enables us to understand that the change in any area or sub-area of governance affects other areas of governance (for example, changes in the area of financing or regulation of public policy affects not only the process of service delivery but also the resulted effects of services in the form of their accessibility and quality).

2. Development of social services in the Czech Republic in a comparative perspective

In the following text we focus on governance of childcare and elderly care in the Czech Republic compared to countries representing different welfare policies (Denmark, the United Kingdom and Denmark). After a short presentation of the development of these social services over recent years, we present our key findings in an attempt to identify specific trends and changes in the key areas of governance: financing, regulation and delivery and accessibility and quality (representing the results of the services provided).

Childcare

Family policy in the Czech Republic represents a rather conservative model with elements of universalism and liberalism (Saxonberg and Sirovatka, 2009). Certain trends can be observed in the post-communist era since 1989. Specifically, pre-school facilities for the youngest children and the number of kindergartens for children aged three to six years gradually declined in numbers over the last two decades in the Czech Republic which is the opposite trend compared with the other countries (Denmark, Germany and Great Britain). The reasons are twofold: the gradual demographical reduction of the population of Czech children since the mid-90s up to 2007 and the commitment of the post-communist Czech governments to replace the model of two working parents with the model of working men and women staying at home with children (the male-breadwinner model) (Szelewa and Polakowski, 2008).

As a result, the state and municipal authorities closed many of existing childcare facilities (particularly nurseries for children up to three years of age), and cut financial support for parents (Saxonberg and Sirovatka, 2006, 2009). Nurseries practically ceased to exist and are inaccessible for most current Czech women with the youngest children due to their small number and high financial costs.

Conversely, kindergartens in certain Czech regions are forced to enrol children under two years of age who were previously placed directly into nurseries. Subsequently, the number of places in kindergartens (particularly in large cities) is inadequate and does not meet the total demand of parents for these services.

The Czech government recognised this problem and has submitted a draft law for child groups (nurseries) in August 2012, which should increase the number of facilities for the youngest children in the Czech Republic. Nevertheless, the services provided by the Czech public kindergartens are of high quality (concerning child-to-staff ratio and the qualification requirements of the staff). This corresponds to public expenditure on these facilities which attained the average spending level of other EU countries (see below). While parental contributions to public kindergartens are low, private facilities (nurseries, corporate kindergartens, babysitting, etc.) are expensive and therefore primarily accessible only for wealthy parents from large cities.

Czech childcare services are mostly ***financed*** from the state, municipal budgets and various national and supranational grants. The extent of public expenditure on childcare services, however, is extremely low over the long-term and has permanently reached about half of the average costs of EU member states (0.14% of GDP in 2005, 0.12% of GDP in 2008; OECD 2012 – see Table 1). While the governments of a number of EU countries actually financially support facilities for children less than three years of age, the funding of day nurseries is fully in the hands of municipalities in the Czech Republic. The enrolment fees for nurseries are therefore extremely high and the payments by parents have to cover more than half their costs (Kuchařová et al., 2009).

Table 1 Public expenditure on childcare services as a percentage of GDP in selected countries in 2005 and 2008

	2005		2008	
	pre-primary	childcare	pre-primary	childcare
Czech Republic	0.34	0.14	0.33	0.12
Denmark	0.51	0.66	0.47	0.85
Germany	0.31	0.07	0.33	0.06
United Kingdom	0.21	0.37	0.65	0.44
EU (27)	0.38	0.25	0.39	0.25
OECD	0.35	0.25	0.38	0.25

Source: OECD (2012)

Notes: Childcare expenditure covers children under three years of age enrolled in pre-school. Childcare refers to formal day-care services, such as day care centres and family day care; pre-school includes kindergarten and day-care centres which usually ensure educational and social care activities.

As Table 1 shows, the expenditure on pre-school care for children 0-2 is extremely low not only in the Czech Republic but also in Germany compared to the EU average (EU 0.25% of GDP, CR 0.12%, GER 0.06%, UK 0.45%, DK 0.85% in 2008). The highest spending is in Denmark and relatively high in the United Kingdom.

In contrast, the expenditures on services for children of pre-school age (3-5/6) is almost at the same level in the Czech Republic as the EU average (0.33% of GDP in 2008, when the average of EU countries was 0.39% of GDP; OECD 2012). This kind of services is fully supported by the state and parents contribute at only a minimal level (between 3-5% of the average wage in the economy). This fact is confirmed by Table 2 which shows that expenditures for pre-primary education were almost completely publicly covered in the Czech Republic as well as in Denmark in 2009 (while in other countries these services are also paid privately – 10% in United Kingdom and 40.4% in Germany; OECD, 2013).

The costs of non-state institutions caring for pre-school children differ based on the type of services provided. Although private kindergartens receive state subsidies for educational activities, they require quite high tuition fees from parents *(about 44% of the average wage in the economy)*. Similarly, the enrolment fees in private kindergartens are significantly higher when compared to public kindergartens *(from 21% to 83% of the average wage in the economy)* – see Table 3 (Vláda, 2011; Novotná, 2012; Jak do školy, 2013; Jesle-jesličky, 2013).

Childcare services in the Czech Republic are ***regulated*** by the Ministry of Labour and Social Affairs and by the Ministry of Education. A role is also played by the departments of Finance and the Interior which set the policy for the operations of local and regional governments. Municipalities, which are the main founders of nurseries and kindergartens, predominate in the current Czech system. The situation is similar to the other countries surveyed (with the exception of Great Britain where the private sector predominates).

Table 2 Public-private expenditure for pre-primary education in selected countries and years

Country	2000		2005		2009	
	public	private	public	private	public	private
CR	100%	0.0%	98.5%	1.5%	99.5%	0.5%
DK	99.3%	0.7%	99.3%	0.7%	99.5%	0.5%
GER	65.9%	34.1%	64.7%	5.3%	59.6%	40.4%
UK	95.9%	4.1%	92.2%	7.8%	89.9%	10.1%

Source: OECD (2013)

Table 3 Parents' fees as percentage of average wage in selected countries

Country	Nurseries	Kindergarten	Private child minding	Total net cost
CR	6-22% (public) 44% (private)	3-5% (public) 21-83% (private)	3-7 EUR per hour (100- 180 CZK)	10.6
DK	25% (public)	33% (public)	-	11.2
GER	3.7% (public)	7% (public)	3-6 EUR per hour	14.1
UK	-	-	4-5 EUR per hour (£3.5-£4.50)	40.9
OECD, all	-	-	-	18.4

Source: Maminka (2010); Vláda ČR (2012); Echo (2007); Jesle-jesličky (2013); Jak do školky (2013); Langrová (2009), Rodina (2013); Emimino (2013); NWCI (2005); CCCABC (2007); EC (2009); Wrohlich 2005); Chefkoch (2013); Netmums (2013)

The Czech government has begun to consider alternative forms of childcare (particularly services provided at home by private child-minders or neighbours and children's groups and enterprise facilities) as of 2007. The Ministry of Labour and Social Affairs did not respond, however, to the increase in the number of births and the lack of nurseries until July 2013 when it passed the Act on Child Groups (nurseries) valid as of January 2014.

In summary, one long-term trend and one recent change can be identified in Czech childcare in the field of regulation and delivery during recent decades. In the first case, a large number of publicly provided childcare facilities *(nurseries and kindergartens)* have gradually disappeared over the last two decades due to low birth rates. In the second case, the growing birth rate in recent years has increased the commitment of the Czech government to childcare services. The current trend in childcare in the Czech Republic reveals, however, that the Czech system falls behind the other countries observed, particularly in the area of regulation and delivery of care for children younger than 3 years of age (cf. Box 1).

Box 1. Key characteristics (governance) of childcare in the area of regulation and delivery in DK, GER and the UK

- *DK: A well-developed system of day-care for children at an early age (to be legitimately claimed by and available to all children aged between six months and six years). A predominance of public services supervised by local authorities and funded from local taxes and central government grants.*
- *GER: A mixed-market model supporting the work-family life balance where the predominant providers are religious groups, public centres and not-for-profit centres. Childcare is traditionally funded by the state from local public funds at the discretion of local governments*
- *UK: A significant role of the market, public childcare services traditionally set and financed by central government (through general taxation) and organized by local authorities. Significant cuts within the local authority budgets as of 2010 has resulted in a reduction in the level of services in certain areas. A few large providers, the private, voluntary and independent childcare market is comprised of a mosaic of small businesses of various sizes.*

Source: Compiled by the authors

Concerning the ***accessibility and quality*** of childcare services, three key changes have occurred in the Czech Republic over recent years. Firstly, although the gaps in the capacity and accessibility of childcare facilities is a key issue in scholarly debates, governmental papers, research studies and media debates (cf. Kuchařová et al., 2009; Mejstřík et al., 2011; Vláda, 2011), only a small number of extremely costly private and public services for children under three years of age (nurseries and child minding) are available (there were 46 nurseries in 2010 – Sokačová, 2010; ÚZIS, 2011). For these reasons the enrolment rate of Czech children attending nurseries has been extremely small and has only increased a little compared to the other countries surveyed (in 2009, 6.4% CR; 28.2% EU, 66% DK)- OECD (2011).

Although the number of children attending Czech kindergartens is at a solid level compared with nurseries, there was a decline in these facilities over the years 2005-2010 (from 85% to 72% which is about 6 percentage points below the EU average - OECD 2011a). The result of this was a more than four-fold increase in the number of Czech children who were unable to enrol in kindergarten over the last ten years (Vláda, 2011; ÚIV, 2012). The enrolment rate of children between 3 and school age was close to the EU average in the CR in 2010, although it was the lowest from the countries surveyed (EU 71.9%, CR 72.5%, other countries about 90% in 2010) (OECD, 2011b).

Thirdly, despite the low accessibility of nurseries and high demand for kindergartens, the quality of childcare services is at a good level in terms of the care provided, staff training, psycho-social development of children, pedagogical and hygienic standards (Kolářová, 2007; OECD, 2011a). Moreover, whereas employees with a secondary school education have been predominate in Czech pre-school services over the long-term, the share of university graduate employees has increased in recent years *(from 4.4% in 2006 to 7.8% in 2009 – ÚIV 2011)*. The survey is carried out by a special body "Czech

School Inspection". Kindergarten teachers are required by decree to receive additional training in order to expand their professional qualifications.

The key characteristics for accessibility and quality of childcare services in the other countries surveyed are shown in Box 2.

Box 2. Key characteristics (governance) of childcare in the area of effects (accessibility and quality) in DK, GER and the UK

- *DK: Parents pay for childcare services on an average of 11.2 percent of average wages which is much less than the OECD average 18.4 percent. The quality of services is higher than in most of the other countries and the coverage is extraordinary high, particularly with children below 3 years of age.*
- *GER: Financing out-of-pocket by parents is relatively low. One-fifth of children under three years of age use religious groups, public centres and not-for-profit centres (which is double the number ten years ago). The services are on a good quality level and differ from region to region.*
- *UK: The high costs of private services and the small scale of public funding provision lead parents with children aged under three to use informal childcare in particular. There is a trend in governmental provision towards more early-years educational provisions and longer opening hours (focused on disadvantaged areas). The supply and the quality of the childcare services vary according to the individual providers.*

Source: Compiled by the authors

Elderly care

The Czech Republic ranks among those countries which represent a rather conservative model of social policy where family care is preferred to institutional care. Additionally, the limited public funding for Czech institutional services entails that the capacity of these facilities has remained insufficient for a number of years (although there are more serious problems in regions with smaller communities which are characterized by limited local resources and political support).

New expectations in elderly care have been connected in recent years with the Social Services Act of 2007 which brought three crucial changes, which can be considered innovative. First, active participation of service users was introduced, which is reflected in the possibility that users can participate in decisions on planning of social services at the community level and in the establishing of individual services (individual plans).

Users can also receive a care allowance which enables them to purchase a home or professional workers. Another innovation is related to the introduction of quality standards, the categorization of different types of social services and the possibility of sharing them with different groups of clients. While the quality of residential social services and home care services is improving, the quality, however, of long-term health facilities is not sufficient due to outdated legislation from the 1990s (the result is an insufficient number of poorly paid nurses and social workers).

The current Czech social care system is ***financed*** by the state and from contributions from the founders (regions and municipalities), health insurance companies, the care allowance and pensions (Průša, 2011). The available statistics indicate that the extent of expenditures on long-term care is extremely low over the long-term and amounted to less than half of the average costs of the EU member states in 2010 (0.81% of the GDP in CR in 2010 compared to 1.43% of the GDP in Ger, 1.97% of the GDP in the UK and 4.50% of the GDP in DK, CS 2012 – see Table 4).

Table 4 Public expenditure on LTC as % of the GDP in 2010 by kind of care

Country	Total	at home	in institutions	cash benefits
CZ	0.81	0.06	0.23	0.53
DK	4.50	1.33	1.14	2.04
GER	1.43	0.40	0.58	0.45
UK	1.97	0.86	0.56	0.56
EU27	1.84	0.53	0.80	0.52

Source: Lipszyc et al (2012)

Health and social care services have different sources of funding, however. Specifically, social

services are financed by a mix of general taxes, regional budgets and individual contributions. While retirement homes are paid by the region, nursing homes are funded by municipalities *(state budgets and local authorities cover in a similar proportion over half of all costs)*. Whereas the financial participation of service users on care at home is often only a fraction of the total cost *(e.g. 25% for outpatient care services and 20% for personal assistance)* costs for stays in residential care institutions are extremely high *(usually 50% for retirement homes and approximately 33% of total costs in the case of the special regime house) (all data for 2008, APSS, 2010)*.

The present system for financing social and health care services has been criticised as ineffective (APSS, 2010; Průša and Horecký, 2012). Financial resources are allocated in a manner which is random, voluntary, non-transparent, non-systematic and discretionary. Service providers do not know the amount of state subsidy for a subsequent year, the funding is not tied to service performance or optimal cost performance and the amount of reimbursement for publicly provided social services often does not reflect the specific users' needs.

In terms of ***regulation and delivery*** of elderly care, one trend and one important change can be observed over the last decade. This trend may be partly attributed to the conservative legacy of the Czech welfare state, partly to the trend of making elderly care more efficient and effective, similarly as in many other countries: home care for the elderly prevails over elderly care in the institutions in the CR. In order to enforce this approach, the introduction of new legislation on social services in 2007 *(Act 108/2006 Coll. on Social Services and Decree No. 505/2006 Coll)* brought numerous significant changes.

The responsibilities for elderly care in the Czech Republic are divided across social services, the health-care sector and various levels of government (local, regional, national). While the health sector (including long-term care) has remained largely centralized, responsibilities in providing and funding of social services have been increasingly shifted towards regional and local levels (Österle et al, 2010). While in other European countries, the welfare mix of delivered services has been promoted extensively in recent years, it only occurs fairly rarely in the Czech Republic and the founders of institutional care are mostly regional and local government bodies (90%) and municipalities.

Caring for the elderly is provided in three ways, which differ in terms of whether the care is provided within social services, health care facilities or other facilities. Social services, coordinated by the Ministry of Labour and Social Affairs, include residential services ("retirement homes" and "special regime homes"), field-based services (community care service at home users or "nursing homes") and out-patient services (including day centres of various types). Health care facilities, managed by the Ministry of Health, include "hospitals for the chronically ill" and "geriatric departments (centres)" at hospitals). Other facilities include community care services which are built and managed by municipalities with the financial contribution of the Ministry of Regional Development. While social services are governed by the Act on Social Services and include care services performed by social workers, health services are governed by the Act on Health and are provided by nurses who perform nursing services. All of these services can be publicly or privately provided. NGOs can operate, however, at the interface between social and health services and can therefore provide both day care services provided by social workers and nursing services provided by medical professionals.

As mentioned above, the key regulator of Czech social services for the elderly is the *Act 108/2006 Coll. on Social Services* which defines various kinds of social services and delivery methods, including service quality standards. Compared with the period prior to 2007, seniors have a new opportunity to participate in the community and personal planning of delivered services and choose a wider range of social services which can be combined. The newly introduced care allowance, may be used for the purchase of professional services or informal care delivered by relatives. Experience has shown, however, that the majority of seniors do not use it for the purchase of services because the care allowance is low *(the maximum amount is slightly less than half the average wage in the economy)* and it is therefore considered more of a supplement to their pensions *(for example in 2012, 18.4 billion CZK was paid for care allowance and only 6.4*

billion CZK was used for purchase of professional services). This allowance is additionally associated with time-consuming administrative procedures (see Musil et al, 2008, 2011; Kubalčíková, 2009, 2012).

For a comparison, the regulation and delivery of elderly care services in Denmark, Germany and the United Kingdom are included in Box 3.

Box 3. Key characteristics (governance) of elderly care in the area of regulation and delivery in DK, GER and the UK

- *DK: A universal system which is primarily financed from local taxes (the highest proportion of people over 65 who are granted long-term care). The municipality has the responsibility for providing and paying for care.*
- *GER: A universal, non-means-tested contribution-financed social insurance model grounded on a wide range of tools making possible predominantly informal care at home and professional care through a network of private and public providers. The organisation of elderly care based on the self-administration of health and social insurance funds.*
- *UK: A residual system of long-term care supporting publicly only those with severe needs who are unable to meet the costs of their care (92% of elderly people received private services in 2013). There is a predominance of domiciliary care provided in the client's home by professionals and financed through a combination of public and private spending and residential care run by local authorities and in the private and voluntary sector.*

Source: Compiled by the authors

Care at home delivered by family female members predominates in the Czech Republic over the long-term *(80% of all care delivered – see Jeřábek, 2005; APSS, 2010; OECD, 2011a; cf. Table 5).* In the case of other social services (i.e. residential care, field- and out-patient services), there are differences in ***the scope and quality*** of the provided services between the regions and municipalities. Whereas care services in small communities are often not established due to insufficient political support or insolvency of municipalities (which rely on retirement homes paid by the regional authority), large municipalities often provide well-funded social services at a good quality level (cf. Habart, 2007; APSS, 2010; Průša, 2010, 2011; Průša a Horecký, 2012).

Table 5 Population aged 65 years and over receiving long-term care in 2010 (or the nearest year) in selected countries

Country	Institutions	Home	Total
Czech Republic	2.2	10.9	13.1
Denmark	4.5	12.4	16.9
Germany	3.8	7.6	11.4
United Kingdom	4.2	6.9	11.1
OECD (21)	4.0	8.2	12.2

Source: OECD Health data (2012)
Note: data for the Czech Republic and OECD from 2009, data for the UK from 2004.

The quality of social services is supervised by the State by social services inspectors composed of employees of regional offices and the Ministry of Labour and Social Affairs. As of June 2010 till November 2011, the European E-Qalin Management quality system has also been introduced in many Czech public facilities for elderly people (APSS, 2013). The trend towards gradual improvements in service quality can be seen in particular in residential social care facilities. EU subsidies in 2007 made possible the new construction or reconstruction of buildings and the introduction of quality standards which influenced the increase in individual care for seniors by care workers. In contrast, however, health care facilities focused on long-term care ("hospitals for the chronically ill") have often been criticized in recent years due to the poor condition of the buildings and the lack of staff and resources needed for adequate treatment, rehabilitation and care (Princová, 2009; MLSA, 2010a).

Accessibility of social and health institutions delivering long-term care in the Czech Republic is at a high level: the ratio of long-term care beds in social institutions and hospitals per 1,000 population aged 65 years and over is close to the OECD average over the long term period *(f.e. in 2010, 42 beds in institutions in the Czech Republic compared to 50 beds in OECD countries*

on average and 7 beds in hospitals in the Czech Republic compared to 5.8 beds in OECD countries (OECD, 2011b).

The above-mentioned information along with data in Box 4 below enable a comparison of the governance of elderly care in the area of accessibility and quality of services provided in the Czech Republic with Denmark, Germany and the United Kingdom.

Box 4. Key trends and changes in elderly care in the area of effects (accessibility and quality) in DK, GER and the UK

- *DK: Only a small percentage of the total long-term care expenses is paid by the user while the public provided domiciliary elderly care is free of charge (tax financed). Innovative changes focused both on the quality and the efficiency of elderly care (client's choose from a wide range of services, use of new public management instruments, the implementation of welfare technologies)*
- *GER: Although there are many public and private providers delivering services of high quality, long-term care is often criticised for not being sufficiently networked or coordinated.*
- *UK: The UK government focuses on improving the quality of provision and making the long-term care system more client-friendly through the implementation of government funds available for the training of social care staff, strategies to combat high staff turnover and the wider involvement of volunteers in long-term care.*

Source: Compiled by the authors

Summary

The presented mosaic of information on the gradual development of childcare and elderly care over the last ten years indicate that the Czech welfare state is financially undersized. When measuring the share of expenditure on social protection of various kinds in GDP (which indicates the amount of social services expenditure), it was more than twice as high in Denmark in 2010 compared to the Czech Republic *(13.3% of the GDP in DK compared with 6.4% of the GDP in the CR)*; in the UK and in Germany the differences were not as great, although considerable *(11.3% of the GDP in the UK and 10.6% of the GDP in Germany) (Eurostat, 2012).*

In the field of childcare, the population decline in the mid 1990s and the subsequent increase in the number of children born in the first half of the new millennium was accompanied by the closing of the majority of the nursery schools for children from one to three years of age and in a reduction in the number of kindergartens. Minimal interest on the part of the government and the media and insufficient pressure on the part of parents has meant that the nursery schools have not been restored or substantially replaced with private facilities (they are currently accessible only to rich parents in large cities), nor was the number of kindergartens increased, due to the high financial costs of their construction. The increase in the number of births in the first half of 2000 was solved by increasing the number of teachers in existing kindergartens and reducing the threshold for enrolment of children in kindergartens from three to two years. The wages for preschool teachers increased slightly between 2000 and 2006, from almost 80% to 90% of the average wage in the economy (MLSA 2006, 2007, 2008, 2009, 2010b, 2011, own computation). While private childcare services (primarily kindergarten and babysitting) and public nurseries built by municipalities, the number of which is low in the Czech Republic, are fully covered by parents, public childcare services (kindergartens) are fully funded by the state, with parents' contributions being fairly symbolic. For this reason, expenditure on Czech services for preschool children have reached the average spending level of EU countries. Increases in the number of nursery school teachers in 2007-2009 has meant that the ratio of child-to-staff is at an extremely high level in childcare services. The requirements of the Department of Education for the quality of education of pre-school employees also provides evidence that the services are provided at a high quality level. The current Czech government is currently considering a long-term deal with the small number of nursery schools, particularly as a result of the low employment rate of women-mothers or their high unemployment rate.

In the field of social and health services related to elderly care, a significant decrease in pedagogical and health care workers and simultaneously a significant increase in social care workers (who are the lowest paid workers in the social and

health sector) occurred in the Czech Republic over the years 2005-2010. There is noticeable pressure both on service delivery due to the growing number of senior population and in consequence an attempt to make public health services more effective by reducing the number of health-care staff. Most of the Czech elderly use, on the one hand, social services which are provided directly in the home of the seniors (and administered by the Ministry of Labour and Social Affairs) and, on the other hand, long-term institutionalised health services (administered by the Ministry of Health). There is a discrepancy between these types of services. The actual capacity of both kinds of facilities, which are public provided (private services do not exist), has been insufficient for many years. The problem is partly in the undersized public funding, which is to a large extent co-financed by the elderly in the case of social services, or symbolic in the case of health services. Another problem is related to the centralization of financial flows, causing a rigidity of the institutional facilities which provide health and social services to seniors. Heath care services are often targeted at self-sufficient clients who solve their housing problems and block access to other clients who need professional help to a greater extent. While the quality of social services (accommodation and direct care work) has increased in recent years (particularly through the introduction of quality standards under the Social Services Act in 2007), the quality of services provided in health facilities is at a low level (legislation from 1990s led to the degradation of education of care staff working particularly in long-term care facilities).

In summary, in contrast to changes and innovations implemented in childcare in other EU countries, care for children under three years of age has been fatally neglected in the Czech Republic and the situation in kindergartens has also worsened over the last ten years. A similar problem can be seen in elderly care where efforts to introduce a quasi-market system have met with limited investments for service users (a low care allowance) and the weak regulation of the direction of their use. These failures are related to the underestimation of these areas and to failures in governance during the implementation of welfare reforms in the Czech Republic.

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Endnotes

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The Issue of Senior Self-sufficiency after Hospitalization – a Field for Geriatrics or Social Work

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Abstract

Demographic aging of population brings a range of threats, which can acquire the character of a life crisis primarily in the elderly. These threats include limitation or loss of self-sufficiency. Illness and limitations of self-sufficiency often require hospitalization of a senior, to provide him/her with geriatric care. But this is also a social event requiring the presence of a social worker. Complex care of elderly is impeded in the Czech Republic by the division of activity between the Ministry of Health and the Ministry of Social Affairs. Seniors suffering from a lack of self-sufficiency appear to be the most vulnerable to the effects of departmentalism because strict separation affects both the termination of the hospitalization of the elderly as well as the aftercare. Sustainability of the quality and appropriateness of health and social services delivered require a dedicated long-term care, such as the implementation of empirical research.

The present article describes the current state of system of the care of seniors with loss of self-sufficiency and dependent seniors in the Czech Republic. The text includes theoretical background of selected terms and focuses on the key issues within the state, which led to the formulation of the research objectives of the dissertation thesis by the author of the text.

Keywords

elderly, demographic aging, loss of self-sufficiency, departmentalism, hospitalization, geriatrics, social work in health care, long term care, empirical research

Introduction

The issue of ageing and old age is nowadays becoming more topical than ever. The growing number of elderly people in society also proportionally increases the need for help, care and services intended for seniors who will have to cope with a number of varied problems in the future. Old age is a period of life in which biological, psychological and social consequences of ageing frequently intertwine with effects of a life crises. Crisis situations in seniors' life occur in connection with various aspects of their lives, in fact often in response to a worsened health situation and lack or loss of self-sufficiency. If the senior is not able to solve it by themselves with the help of family and close friends, then it comes the time for assistance from formal care providers. But according to Přehnal (2005), the current situation in the care of the elderly and the long-term ill in the Czech Republic is definitely not ideal. Individual activities in the care of seniors are divided between the Ministry of Health and the Ministry of Social Affairs. This strict division disrupts the desired links between the two departments and is a fundamental obstacle to the effort of establishing comprehensive, integrated care, which proves to be adequate and the only possible if the aim is to maintain dignity, autonomy and quality of seniors' life.

Senior within a health care facility becomes a patient of geriatric care. But lack or loss of self-sufficiency is a social event requiring social intervention; therefore he/she becomes a client of social work in health care. Social-worker presence in hospital has become necessary and social work in the field of health care has been increasingly important. The growth in the population over 80 years of age implies a higher need for social workers who help seniors cope with a current crisis situation, adapting to new, changed conditions and planning of health and social care and services (Hrozenská et al., 2008). The social worker also plays a crucial role in the termination of hospitalization of seniors which appears to be problematic in the Czech hospital care system. Social work in health care is an integral part of comprehensive geriatric care of seniors at high risk, incorporating principles of demedicinalization, deinstitutionalization, desectoralization and deprofessionalization[2] (Weber, 2005; Tallis, Fillit, 2003).

System of the care of the elderly suffering from a lack of self-sufficiency is unsatisfactory and requires certain changes. Given the current demographic changes, the priority of the Czech Republic, but also of other European countries, is to focus on linking health and social systems, as well as the formal care system with the informal system. Social work is important in this effort but crucial role is played by the families of seniors. It is probable that in the future the implementation of an integrated and long-term care of the elderly will be more substantial. Thus, current society can seek the answer to the question of how to provide the best medical and social care of seniors; how to keep their self-sufficiency as long as possible; and how to ensure the highest possible quality of life through research surveys.

The present article describes the current state of system of the care of ill seniors, of seniors with limited self-sufficiency and dependent seniors, and seniors facing a life crisis in the Czech Republic. The text includes theoretical bases of selected terms and focuses on the key issues of the current state which led to formulating the research objective in the dissertation of the author of this text, entitled: "*Between Hospital and Home. Solutions to Care for Seniors after Hospitalization*".

Demographic aging as a threat to seniors

Demographic aging of the population, characterized by the growth of relative and absolute share of the population over 65 years of age, has accelerated rapidly within Europe in past years. Life expectancy has grown, its quality has been improved, on the other hand there is a decrease in birth rates that together with the growing number of seniors in the population significantly affects and will affect not only the social and health sectors, but also the economic sphere. Therefore population aging has become a major challenge within all the EU countries in recent decades, which is more and more relevant. The population over 65 years of age will represent 29.5% of the EU population in 2060 (Europa, 2007 [on-line]).

In the Czech Republic, this process has increased in intensity since 2011, due to the transition of a large post-war age-group (65+ years of age). According to a prognosis by the Czech Statistical Office, the number of people aged 65 and over will have increased by more than 2.1 times by the year 2065 compared with 2010. Whereas the number of people aged 80 and over will increase by more than 4.3 times in the same period. Even nowadays, it is estimated that despite the promising trend in the development of population health, roughly a quarter of people aged 65 and over require a certain form of help as a result of their disability[3] (Výzkumný ústav práce a sociálních věcí, 2010). Therefore, the assumption is that with increasing age in the ageing population, there will be more chronic diseases with disability potential and tendency to comorbidity[4]. This will be accompanied by an intensified need for specific services and care of seniors (Jarošová, 2006).

Demographic aging of population thus enables people to live to an increasingly higher age, on the other hand the phenomenon of ageing poses a real threat of lack or loss of self-sufficiency especially to the elderly. We begin to use the concept of lack of self-sufficiency as a result of disability, chronic illness, trauma or acute disease causing an impaired ability to manage self-care activities. Lack of self-sufficiency is regarded as a social event which is at one of the top places of an imaginary "ladder" of risks connected with the advanced age, it may even have the nature of a life crisis (Špatenková, 2003). Solving

a crisis requires self-help and mutual help. Social network plays an important role in crisis management. If a person cannot find assistance mechanisms in their environment, this is the time for help from formal care providers (Vodáčková, 2007; Cowles, 2003). The need to pay attention to seniors who are facing a crisis situation connected with a lack or loss of self-sufficiency is considerable. A worsened health situation and loss of self-sufficiency or autonomy belong to the greatest threats in old age (Sýkorová, et al., 2003). Factors such as the health situation and level of self-sufficiency significantly determine the way of life in old age and the degree of integration of seniors in the society.

Although to be self-sufficient is considered a social event, it is a phenomenon inseparably linked with the current health status of the elderly person. The old age is characterized by the inseparability of health and social issues. On the one hand, almost every change in the state of health may significantly affect the social situation of the elderly, on the other hand the changes in the social field may deteriorate their health (Přehnal, 2005). The result is usually the need for different health and social services. Presently, services in the Czech Republic are not provided systematically and on a subsidiary basis, they are fragmented between the Ministry of Health and the Ministry of Social Affairs and within them among various providers (Jurášková, 2008). In my opinion, this is the main reason why there is the problem of solving and fulfilling needs of older persons suffering from a lack of self-sufficiency in the Czech Republic. The current existence of the two departments often creates completely impermeable barriers. These barriers make it practically impossible to form medico-, social- or social-health bonds, and ultimately give rise to all the negative situations and consequentially lead only to expensive solutions (Přehnal, 2005).

Departmentalism as an urgent problem of the care of seniors

With increasing age of the population and a growing number of seniors in the society, the unresolved issue of providing for needs of those who require intensive medical care and social care at the same time is becoming a priority (Weber, 2005). The care should be based on these seniors' needs. Inadequate provision and distribution of social and health care which cannot adequately and efficiently meet seniors' needs, have a negative impact on the lives of these seniors. An old, ill and self-insufficient person remains to be a "burden" for the Ministry of Health as well as for the Ministry of Social Affairs. Both departments rather define themselves against each other instead of cooperating, clearly stating their goals and working towards achieving them (Janečková, Malina, 2007). Sufficient information for seniors and continuity of individual types of services are missing. Simple things are often arranged for in an overly complicated way (Jurášková, 2008).

The unclear definition of the care results in situations when patients are often non-systematically relocated from health care or social facilities to homes, from homes to facilities, between facilities, etc. Geriatricians note that even physicians in charge frequently do not have a clear idea of where to place seniors with a health and social handicap. Holmerová adds: *"Separate systems of health and social care make representatives of health care feel that transferring a patient to the area of competence of the Ministry of Social Affairs means savings."* (Holmerová, et al., 2007:36). Relocation of patients who need long-term care from one facility to another can be considered as a very specific form of maltreatment of seniors. There are also many conditions on the border of health and social care; there is a lack of continuity in the follow-up care. A patient may be perfectly treated and controlled as for their acute condition, but then they are released to home treatment and there is nobody to care for them (Holmerová, et al., 2007). Lack of connection within health and social system then causes the overuse of institutional care, despite expert's estimation that the number of seniors who need this type of care to only 2%. So, seniors are threatened by unnecessary institutionalization (Jeřábek, 2005).

In my opinion it is departmentalism what puts the boundary between health and social sphere and causes significant problems in the system of the care of the elderly. The mere fact that

both departments have separate budgets is one of these problems. When money is involved borders are tightened. However, health and social care of the elderly mutually influence each other so it would be more logical to break down mutual boundaries than to try to tighten them. Holmerová (2003) mentions that in some cases medico-social care exists at the interface of the two sectors. In this case we cannot even determine exactly what a health care is and what a social care is. But in practice, a senior suffering from a lack of self-sufficiency is viewed primarily as a patient of geriatric health care, or only as a client of social care. What if a senior with limited self-sufficiency is both the patient and the client? Can the different perception of seniors influence them already in their hospitalization?

Geriatric versus social work or senior as a patient or client?

Seniors come to terms with a progressive loss of self-sufficiency due to physiological changes in old age better than in a situation where due to illness or injury one of the highest values is lost suddenly. In consequence of acutely worsened state of health, the senior involuntarily comes into interaction with medical environment – arrives at the health care facility, comes into contact with the doctor and other staff, is examined, treated (Špatenková, 2003). Senior hospitalized with illness or injury, suffering from a lack of self-sufficiency, obtains the status of the recipient of geriatric care.

Knowledge of at least the general particularities and specific features of the geriatric medicine will be of crucial practical importance in view of the fact that as of 2050 the Czech Republic will belong to the oldest countries of the world (Weber, 2005). To mention at least basic definitions: Geriatrics provides specialized health care to ill people of advanced age, usually patients aged between 70 and 75, because problems in the somatic sphere (diseases), mental (dementia, depression) as well as social sphere (loneliness) start to come to the fore especially after the 75th year of life (Weber, 2005). Geriatrics differs from other fields of medicine by its extent and comprehensive approach, blending the health and social issue in geriatric patients. Geriatrics works with the fact that social factors (loss of self-sufficiency, loneliness, maltreatment, failure of caregivers, death of a spouse) may significantly affect the senior's health situation. This requires coordinated team-based medical, nursing, rehabilitation and social care (Topinková, 2005; Přehnal, 2001). The aim of geriatric medicine is to use this team care in improving the health care of patients – seniors, to improve the health situation, self-sufficiency, quality of life and along with proposals and implementation of further measures necessary to reduce need for long-term institutional care. General characteristic of geriatrics is therefore an interdisciplinary approach[5] to treatment of diseases and team-based solution to the problems of advanced age (Weber, 2005), which should provide a basis for effective health and social services and the patient should benefit from higher efficiency and safety of the care with a better understanding of their needs (Kalvach, Onderková, 2006). We learn from experience that despite the efforts of holistic approach and indisputable need for interdisciplinary collaboration, medical devices remains primarily focused only on treatment. But working with seniors requires differentiated approach. It is necessary to show them understanding, politeness, respect, empathy and esteem. The most important element is a comprehensive view of seniors – ensuring access which, apart from somatic aspects of the health situation, also emphasizes the mental and social aspect. This approach should be ensured by applying the principles of social work.

Social work in health care rests on understanding of health as a state of complete physical, mental and social well-being of a human[6]. It is an integral part of medical and preventive care of human health. Its essential aim is *"to use a positive influence of the psychosocial sector to adapt to the disease better, to overcome difficulties, to motivate for treatment, cooperation, and a better life quality. An emphasis is laid on comprehensive care of the client in accordance with the mission of the social work profession and mission of the given organization"* (Kuzníková, Malík-Holasová, 2012:14). The sense of social work in health care consists mainly in helping the client and their family to reduce or to eliminate completely the negative social consequences of the disease

(Kuzníková, 2011). Although senior-oriented social work can take place outside the health care facilities, it is specifically hospital where seniors, in addition to losing their health, also faces stress, anxiety and fear of future changes and impacts on their social life. Help for seniors in such situations is unconditional and the role of social work in health care increases. In the future, we can expect that work with seniors with limited self-sufficiency will inevitably need social work in health care.

Social workers have a wide range of target groups (families with children, homeless people, people disadvantaged in terms of health) in a health care facility, but seniors with significantly reduced self-sufficiency represent their most numerous clientele. Not every senior who finds themselves in hospital due to acutely worsened health situation is a client of social work at the same time. Seniors in hospital are considered by social worker as clients especially if they are: living alone, socially and geographically isolated, long-term and repeatedly hospitalized, with a significant decrease in functional abilities and self-sufficiency, etc. (Janečková, 2005).

Social workers in a health care facility recognize, reflect and solve problems affecting the health and social situation of individual seniors. They rehabilitate the negative consequences and help prevent their (re)occurrence, which has a positive impact on the patient. The task of social workers is to seek support and development of the client's abilities to activate resources which will enable maintaining and developing their autonomy (Nečasová, 2004). Thanks to their communication skills and abilities, socials workers establish contacts with the senior's family, provide psychosocial support, facilitate the process of adapting to a new environment and cooperate with members of a multidisciplinary team with a view to assisting their client in satisfying their specific needs.

Although the social worker is made aware by the medical staff of the seniors at risk, the following question remains: How can medical staff identify and assess adequately which patient necessarily needs consultation with a social worker? The problem arises in situations where on the basis of such an assessment those who need help or advice are excluded from the social worker's care. But it is not the only problem that may occur in hospitals in the care of the elderly. The process of discharge from hospital appears to be very problematic for seniors suffering from a lack of self-sufficiency.

Termination of hospital care – (un)solved problem

The process of termination of hospitalization in the Czech Republic is practised contrary to the international efforts to apply positive and holistic approaches of interdisciplinary blending of social and health spheres (Vurm, et al., 2007). Discharge of a senior from hospital is subject to the state of health and the decision by the physician in charge. Yet a comprehensive assessment of the health and abilities of the patient, environmental conditions, presence of primary caregivers and outreach services in the place of residence, needs for and availability of rehabilitation and assistive devices are often omitted. This, however, increases the risk of re-hospitalization or institutionalization of the person concerned and their secondary disability (Janečková, Malina, 2007). Unfortunately *"the studies conducted recently shows that hospitals do not have a standard procedure for discharging the patient and that the cooperation between hospitals and community care is significantly different."* (Přehnal, 2005:161). The fact that the information about discharging is not given to the patient and their family well in advance appears to be another problem (Fries, et al., 1994).

In order to discharge the elderly from hospital successfully, the discharging must be understood as a process of teamwork, where a part of this team should include doctor, nurse, physiotherapist, social worker and other specialists as necessary, who will evaluate the health and abilities of the patient, always in relation to the conditions and resources available in their local environment (Janečková, 2005). The social worker plays a unique role of the so-called "discharge manager"[7] in the process of termination of hospitalization. Social workers know how the environment of a health care facility and subsequent impacts of hospitalization determine the clients, their experience and behaviour, and also how to help eliminate these negative effects and enhance

the resocialization of seniors (Přehnal, 2001).
The planned discharge made as a concerted effort of the medical team and a social worker attenuates the patient's feeling of insecurity and distress by helping them understand what will follow. It also reduces the possibility of fragmented care. Unfortunately, it is necessary to state that this role is neither required nor covered by health insurance companies, and consequently in recent years, social workers have disappeared from many hospitals (Weber, 2005). Therefore I agree with opinion of Špatenková suggesting that: *"the use of social workers in health care is still very limited and their administrative application clearly prevails. Employment of social workers in health care facilities depends entirely on the decision by the management of the respective institution. The Ministry of Health only recommends employing a social worker per a certain number of beds"* (Špatenková, 2003:74). Nedělníková states that the number of social workers in health care is not satisfactory and the question arises whether the number and status of social workers in health care facilities is only connected with a lack of financial resources, or whether it is a sign of dominance of scientific medicine *"rigidly insisting on the assumption of an organic cause of all troubles, ... which only very reluctantly accepts knowledge from the humanities"* (Nedělníková, 2005:24). However, the role of a social worker is in my opinion irreplaceable in terms of its outreach to the patient's home environment and inclusion of family and community. Thanks to its comprehensive approach, abilities to combine perspectives of different disciplines and to coordinate activities of the individual participants, it can significantly contribute to ensuring quality care of an old person, using all the resources related to the existing life of the old person, as well as to their activation (Janečková, 2005). Even when the patient's condition has been medically stabilized and acute medical care cannot contribute to improvement of health at that stage, it is necessary to ensure sufficient health and social care of the patient, suitable environment and adequate social support so that they could cope with the convalescence process and return to their natural environment or to another institution.

Integrated system of the care of seniors after hospitalization

The optimal method of the care of the elderly after the hospitalization in a medical facility is seen in the possibility of returning an old person to his/her home while maintaining the highest possible level of health, self-sufficiency and autonomy. This aim can be achieved through the existence of flexible and continuously provided services (also across borders of the departments) which will respond to the current seniors' needs, in the community where the senior lives (Holmerová, 2003).
As mentioned above, the continuity and smoothness of the care is problematic due to departmentalism. In the Czech Republic of these days, there are virtually all types of care, from family to institutional care, which are known and commonly implemented around the world, but for various reasons, many of them do not actually work as they should (Přehnal, 2001). The use of diverse services is subject to many aspects. It is not only a reflection of seniors' needs but it also depends on knowledge, ability, willingness to cover the required costs and on the availability on the part of the providers (Kuchařová, Rabušic, Ehrenbergerová, 2002). As regards provision of combined health and social services, no changes have been implemented as yet to support these services. Although the law does not reject these combined services, in practice it assumes a double registration of services with different entities. Subsequent administration in accounting for these services is then overly difficult and complicated (Jarošová, 2006).
In addition, the urgent problem at the present time is that in practical situations it is common that seniors are often too ill for social services to be sufficient, but the issue of their health situation and self-sufficiency is of a long-term nature, health care is often unaffordable for them (Holmerová, 2003). Dealing with this problem, the above-mentioned holistic perspective is of the key importance. Health care professionals must understand a person in the context of their life experience, environment and bonds, *"which is a completely different view of the patient than that perceiving the patient as 'the one with a non-functioning kidney'"* (Úlehla, 1999:106). A professional (either medical or social worker)

directed in this way has the ability and the required knowledge/tools for overcoming even a possible crisis situation, in cooperation with the client, which in everyday work with geriatric patients unfortunately cannot be completely avoided. It is also important to bear in mind that work with seniors facing hospitalization due to a limited self-sufficiency is based on the creation of a relationship of trust, confidence and safety, being one of the primary needs of old people.

In order to meet the specific needs of the elderly for services provided and care system, the continuity and coordination of services with the need to strengthen health and social concepts are considered as a necessary condition.

Increased system flexibility, breaking the barriers between professions, specializations, institutional and outreach services and especially between the ministries is required for the system of the care of the elderly by a number of Czech professionals in the field of both gerontology and social work, for example Kalvach et al. (2011), Holmerová (2010), Čevela et. al. (2012), Haškovcová (2002), Špatenková (2004), Kuzníková (2011), Jarošová (2006), Přehnal (2005) and others.

With a view to solving seniors' needs comprehensively, cooperation between health services and services of social care[8] and the field of primary integrated community care, is very important (Špatenková, 2003). A key element in the comprehensive health and social care of seniors is family[9]. In Czech society, the model of providing care to seniors suffering from a lack of self-sufficiency is based on the traditional approach, which assumes that satisfying of seniors' needs is primarily the responsibility of their families, while formal or more specifically the state services are used in a situation where informal care providers are missing or cannot cope (Demografie, 2010). The families should be supported in their activities by a functioning system of community services, such as home nursing care, rehabilitation, social work, respite care, support for families providing care, personal assistance, day care centres to ensure that this system operates successfully (Sýkorová, 2004). The absence of this assistance leads to both unnecessary hospitalization and early placement in an institution (Holmerová, et al., 2008). However, it is obvious from past experience that the area of cooperation between the family and the institution is not free of problems. The knowledge of aspects and conditions to support informal caregivers becomes increasingly important. It is possible that this particular impaired area is a major obstacle in implementing the principles of the so-called "long-term care" in the Czech Republic. The long-term care is common in the European context and is currently considered as optimal and the best way of taking care of the elderly suffering from a lack of self-sufficiency.

Long Term Care – view of the future?

The non-existence of the long-term care (LTC)[10] which would meet the needs of the health and social situation of patients requiring long-term provision of assistance can be regarded as one of the gravest situations in the field of health and social services in the Czech Republic (Holmerová, et al., 2008).

With regard to the current demographic changes, addressing the issue of long-term care as an important condition for sustainability of health services and quality of social services, and of health and social services should be considered as appropriate – or at least as satisfactory. According to the OECD, the aim of the long-term care is to compensate for a lasting self-insufficiency which is perceived as a result of a worsened state of health. The long-term care system is currently using and is sure to use in the future the findings of modern medicine, but still needs a lot more findings, expertise and research, which applies particularly to social gerontology, social work, psychology, and a whole spectrum of different therapeutic methods, especially with regard to the issue of specific illnesses (OECD, 2010).

What are the needs of clients/patients of the long-term care? If it is not possible for them to remain in their home environment, it is necessary to ensure a long-term or permanent stay in an institution which will be able to solve their situation of reduced self-sufficiency due to a worsened state of health and will respect their bio-psycho-social and spiritual needs. In other words, they need assistance in basic self-care activities, other individualized services and qualified medical supervision with regard

to their worsened state of health which is relatively stable but still causes self-insufficiency. Institutions of this type are unfortunately the exception rather than the rule in the Czech Republic these days. Conventional institutional facilities with their regime, equipment and approach are a source of anxiety and fear for seniors. Often the patients' relocation to a place which reminds them of home only remotely ends up in developing a maladaptation syndrome[11] (Špatenková, 2003). Paradoxically, long waiting times and constantly growing interest in placement are the reasons why these institutions do not hurry with any change for the better.

According to Kalvach: *"Modern societies developed the LTC (long-term care) systems as means of suppressing social exclusion due to disability or illness as a manifestation of the high degree of humanity and respect for dignity as one of human rights."* (Kalvach, et al., 2011:152). The formation of the LTC concept is perceived as a so-called "third sector" between health and social affairs, and it mainly rests on the outreach services, on health and social integration and on supporting the meaning of life and quality of life. This coordination is still missing in the Czech Republic, mainly owing to the aforementioned inter-departmental nature of services which are both social and medical, professional and charitable and with their extent, they do not fit fully into competencies or training of any expertise. On the one hand, we could say that in the institutional sphere of the social field, the most necessary amendments to legislative conditions were carried out, which should also lead to some improvements in practice. However, there has been no expected improvement in practice, or at least it does not occur quickly enough (Holmerová, et al., 2007). The Czech Republic can benefit and learn from experience of many Western countries, including the entire EU. Old people are facing the same problems in terms of their need for care and help. Moreover, an example from Norway shows that the need for LTC poses a constantly growing problem and it is therefore necessary to adopt measures within the whole society reaching beyond the Ministry of Health and the Ministry of Social Affairs (OECD, 2010).

Solution to problems could be found in research

The above mentioned problems in the care of the elderly after hospitalization are the reason of many professional debates not only in the Czech Republic but also in Western countries. Experts from the environment of the health and social sciences try to find solutions, often through empirical investigation.

Empirical research is carried out by professional experts including sociologists, social workers, health care workers, psychologists and others who are aware of the seriousness of the current demographic trends and changes which will be reflected exactly in the target group of seniors, with the aim of informing both the professional and general public in the Czech Republic about conditions and quality of life in old age. Although the intention of this article is not to summarize the results of the conducted research, following are some interesting findings related to problems mentioned above.

A project focused on the strategies used by seniors to maintain personal independence and solidarity, i.e. managing everyday life, coping with life-cycle events and life crises, involvement of seniors in social interaction and individual experience of integration was implemented by Sýkorová et al. (2003) under the title "*Seniors in the Society. Strategies for Maintaining Personal Autonomy*". Among others, the research data revealed that adaptation to old age rests on three pillars: optimism, getting on top of things, and keeping social relations as a source of support and activity.

The need to address the issue of seniors facing crisis situations also appeared in research data by Kuzníková and Malík-Holasová in the research of "*Conditions for Performing Social Work in the Health Sector in the Czech Republic*" conducted in 2011. Although it was a project which was not aimed at seniors but social workers working in health care facilities, it was shown that social workers most often work exactly with the group of seniors with reduced self-sufficiency. The most common problems of these clients are those concerning care and activities of daily life, illness resulting in reduction or loss of self-sufficiency, changes in the financial situation, needs of suitable housing, psychological problems (e.g. conflict and death in the family)

or changes in mental activity, particularly the risk of social isolation (Kuzníková, Malík-Holasová, 2012).

Urgent problem related to the process of discharging the elderly from medical facilities has been studied at international level within the International Association COHEHRE in 1997 - 2000. The project entitled "*Discharging patients over 80 years of age from acute-care beds to home care*" has been realized in several European countries including the Czech Republic. Comparative study has brought forth some interesting results. The results were unfortunately rather negative for the Czech Republic (Šimek, Chlumecká, Kolínová, 2003). Šimek, Chlumecká, Holubová, Kolínová carried out research entitled "*Discharging elderly patients from hospital – professional and organizational problem*" in 2004 directly in Czech conditions. This research showed that health professionals tend to underestimate the risks of returning home and rely on support from family and partner, without further investigation of their availability and abilities. Research also showed that very few of the interviewed seniors use formal social and health services. For the majority the key person to help is someone from family. Due to the current problem of the process of termination of hospitalization, the authors tabled a question as to what extent the family is ready to take care of the discharged patient (Šimek, Chlumecká, Holubová, Kolínová, 2004). Staňková and Walter in their research entitled "*Continuity of hospital care and care after hospitalization for the elderly*" (2000) also dealt with the issue of discharging. Based on the results of the study authors tried to create a standard framework for the transfer of the elderly from hospital to community care, which would adequately meet the needs of these patients (Staňková, Walter, 2000).

The process of termination of hospitalization of seniors is discussed and researched especially by the medical and health care professionals. But it has become a serious topic in the sphere of social services too. As mentioned above, it is after all a social worker who has the major share in the process of termination of hospital care. The article deals with selected aspects of the problem of the care of the elderly suffering from a lack of self-sufficiency that led author of the article to formulate research objective within the dissertation entitled "*Between Hospital and Home. Solutions to Care for Seniors after Hospitalization*". This is meant to provide interpretation of seniors and their ways to adapt to the stay in hospital as described from the perspective of selected seniors, how they cope with the state of limited self-sufficiency, what implications their changed state of health will have for their future lives and whether the presence of a social worker in a health care facility presents desirable aid for them. These topics were chosen with respect to the fact that despite numerous research outcomes, the field of transition between health and social care is still a subject of debates, while lacking a proper analysis based on empirical data, especially in social services sphere. The intention to respond to seniors and to conclude on their answers comes from the belief that the criteria for assessing the quality of care should be the seniors themselves, their satisfaction and benefit. By asking seniors we can find the answer how to effectively solve the mentioned problems in the system of services for seniors.

Conclusion

Ageing can be viewed negatively because old age brings a person closer to death. Although ageing is inevitable for humans, illness, physical self-insufficiency and dependence are not inevitable in old age. Yet, we encounter a relatively strong stereotype that old age is synonymous with disease (Atchley, 2000) and that old people are ill. It may be caused by the fact that due to present ageist thinking in the population, we tend to exaggerate the negative aspects of ageing. In everyday life, we fail to notice healthy and vital seniors; on the other hand, however, we pay a lot of attention to ill and self-insufficient seniors. This is probably the reason why the state of health was established as one of the most important factors for defining old age in the Czech public opinion (Vidovićová, Rabušic, 2003).

Age itself is not a reason for increased care demands. The need for social work with old people occurs only in extraordinary situations caused by health or social factors. Social work therefore concentrates on the care of those seniors whose state of health is associated

with a decrease in functional abilities and self-sufficiency (Matoušek, Koldinská, 2007). The clientele of social workers represented by seniors with limited self-sufficiency, the severely ill and families of hospitalized patients, is typically the most common in health care and is closely linked with the issue of long-term and follow-up care. Unfortunately, it appears that the issue of long-term care is an undervalued and non-established area in the Czech Republic (Kuzníková, Malík-Holasová, 2012). Hrozenská et al. (2008) believes that to improve the situation in this country, it is necessary to find a way of combining the care provided by family and the state, which will not impair seniors' autonomy, and simultaneously will enable the use of family as a possible source of assistance. In developed countries, interconnecting health and social services with family care has been proved the most successful long-term model of the care of seniors with limited self-sufficiency. In this country, the model is hindered by departmentalism resulting in the absence of satisfactory links between health and social services, which in turn gives rise to a number of negative situations and consequently to very expensive solutions. "*As time went by, the separation of social and health care of old people has been indisputably proved to be to the detriment of things. Therefore, it is necessary to build a wide range of coordinated services so that all old persons could choose the type of care which best covers their actual needs*" (Haškovcová, 2002:30).

In the present article, the author tries to point out the fact that solving the issue of seniors separately, i.e. as health and social care, is unfortunate, presenting an immensely complicated solution for the future. Social work will have to make an effort to emphasize its crucial inevitability in the field of the care of seniors and to highlight its role in the field of health care.

This paper points out the key problems which emerge particularly in situations where a senior faces the life crisis of self-sufficiency loss due to illness and hospitalization. In the future, it will be necessary to fully respect patients' rights, their human dignity and autonomy (particularly neglected by health care professionals, the task of social workers in this context is to assert and defend these rights), strengthening the role of patients and family members in decision-making process concerning the provision of care, expanding the range and availability of community services with support of multidisciplinary teamwork in cooperation with the Ministry of Social Affairs. Improvement of cooperation between the departments of the health and social care should become a priority. It is necessary to initiate negotiations on establishing a functional system of cooperation and joint responsibility of these two departments, to present arguments for creating a legal basis for the concept of health and social care, and developing proposals for multisource financing of the care. Last but not least, provision of health care in social facilities for the elderly must be improved and enshrined in the legislation (Přehnal, 2001).

Arranging for close cooperation between the health care and social work will be an extremely important tool for a successful solution to a variety of problems and risky situations of senior age. Integrated care should be enhanced especially in the field of long-term care (LTC) through the development of community services (social, health and nursing ones) provided at home. As exemplified in the international context, this type of care seems to be of the greatest importance in ensuring the dignity and quality of life for seniors.

Social work with seniors, as a wide and very heterogeneous target group, does not need to focus only on solving the problems related to health. On the other hand, we must admit that old age is exactly the period when illnesses, injuries or disorders occur more often and elderly people are also more frequent clients of health services. Thus, social work with seniors must respond to demographic trends and try to cooperate with medicine actively; not to act as its opponent, but using its knowledge of, for example, the nature of disability and morbidity in older age, in planning and implementation of the senior-oriented programmes. The task of social work is to contribute to humanization of health care so that services within the basic provision as well as professional medical services are performed with regard to autonomy, meaningfulness and dignity of seniors, with regard to the factors which should be of the highest priority for the care-providing system.

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Endnotes

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2 **Demedicinalization, deinstitutionalization, desectoralization and deprofessionalization** - four principles of social and health care. The first principle of *demedicinalization* seeks to make aspects of medicine take into account the individual's quality of life, dignity and autonomy. Attention should be paid to preserving a natural character of the environment for the client. *Deinstitutionalization* shifts the focus of providing care into home environment of the ill person using outreach services. It is necessary to establish such environment in institutional facilities which will allow client's privacy and prevention of possible social deprivation. The *desectoralization* principle consists in interconnecting the health and social system or removing barriers between the professional and non-professional expertise. Comprehensiveness and continuity of the provided services comes to the fore, with the use of available capacities and resources. The *deprofessionalization* principle lays emphasis on cooperation with clients' family members and support of voluntary activities. It is necessary to develop respite care, for example in the form of daily stays of the ill in specialized centres (Kalvach, et al., 2004).

3 **Disability:** any reduction in or lack of ability (in consequence of a disorder, an illness, an injury) to perform an activity in the usual way, or to the extent which is considered normal for humans. Disability is in some cases equated with self-insufficiency or used as its synonym (Phillips, 2003).

4 **Comorbidity** – typical of advanced age. With increasing age, the number of diseases, which often have atypical clinical progress, chronic tendency and complications, rises; one disease induces

the emergence of others, diseases are combined (Phillips, 2003).

5 **Interdisciplinary approach:** *"In interdisciplinary research, individual disciplines are used to solve problems in an integrated manner; yet in addition to this, it is necessary to develop understanding of each discipline in terms of their methodological assumptions and limitations. This means recognizing the extent and limits of each integrated field, their possible contribution to the given issue and scope."* (Envigogika, 2011 [on-line]).

6 **Definition of health by the World Health Organization (WHO)**: *"a state of complete physical, mental, social and spiritual well-being."* The definition thus expresses a bio-psychosocial-spiritual unity (Špatenková, 2003).

7 **Discharge manager**: (= a person who discharges) a coordinator of planning the discharge of seniors at a higher risk. The discharge manager has a good grasp of the patient's actual condition, knows all sources of outpatient care in the patient's natural home environment, their admission criteria and capacity. A discharge coordinator should be able to evaluate the patient's support system and to make sure the environment to which the patient return is able to ensure the necessary care, to what extent and under what conditions. Finally, the coordinator should provide informed consent by the geriatric patient and their family with implementation of each consecutive stage of treatment and care. This task is best to be fulfilled by a social worker, and in facilities where social workers are not employed, this role is most often substituted by a chief nurse (Intermed, 2013 [on-line]).

8 The importance of social services lies in their integrative effect which enables a better and dignified life to people who would otherwise have serious problems or would be excluded from the society. They increase their independence and autonomy in decision-making about life. Social services should also help to develop relations in the community.

Social care services provide assistance to ensure physical and psychological self-sufficiency by arranging for people's basic life needs. The aim of social intervention services is to integrate the client in their home environment and to facilitate their integration into the society (Holmerová, 2003).

9 In the Czech Republic, up to 80% of the care of dependent persons of advanced age is provided by family (Kuchařová, Rabušic, Ehrenbergerová, 2002).

10 **Long-term care** (LTC): It is a care provided to people whose self-sufficiency is limited on a long-term basis and who are dependent ("dependent for an extended period of time") and their ability to perform daily self-care activities is reduced by chronic diseases or possibly as a consequence of disability, whether physical or mental. Long-term care is understood as care in home environment as well as care in institutions (MPSV, 2010).

11 **Maladaptation syndrome**: is a manifestation of failed adaptation typical of old age which occurs as a result of chronic stress induced by a severe psychosocial stimulus, which – in case of seniors – may be represented specifically by the fact of hospitalization. In the clinical context, GMS is most commonly manifested in the cardiovascular or immune system and by a mental disorder, which can result in a life-threatening situation or even death (Špatenková, 2003).

Applying Approaches from Moral Philosophy, Especially Virtue Ethics, When Facing Ethical Dilemmas in Social Work

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Abstract

This article introduces readers to the application of three approaches from moral philosophy to ethical decision-making in social work. The *Statement of Ethical Principles* of the International Federation of Social Workers points out that social workers often encounter moral quandaries, some due to our function as both helpers and controllers. In addressing these ethical dilemmas, we are obliged to "take responsibility for making ethically informed decisions" and "be prepared to state the reasons" (IFSW, 2012: 5.10 and 5.11). In the United States (US), literature on ethics has relied primarily on two approaches from moral philosophy: deontology (based on principles, rules, and duties) and teleology (based on ultimate ends and consequences, e.g., utilitarian calculations). Social workers internationally have added the perspective of virtue ethics. Thus, discourse among social workers internationally is vital for a balanced strategy to address ethical dilemmas.

With a child welfare example, the article demonstrates how these three theoretical perspectives help in determining an ethical course of action. While principle/duty-based and utilitarian approaches keenly focus on an *act's* morality, virtue ethics first focuses on the *actor's* motivation and characteristics. The article concludes with suggestions on how virtue ethics can inform social workers' professional development and personal growth.

Keywords

child welfare, ethical decision-making, ethics, moral philosophy, social work, virtue ethics

"Human flourishing requires a recognition of the need for all of us to make others' good our own, to give with just generosity and receive with gratitude, courtesy, and forbearance" (Adams, 2009: 94).

"Because of the difficulty of applying ethical demands to actual situations and the difficulty of evaluating real situations, the questions raised can never be altogether satisfactorily answered. Neither social work nor philosophy will ever be able to establish rules of conduct applicable to every case. What must be done is to clarify general philosophy and make a constant awareness of his value system a habit of mind for every social worker" (Konopka, 1958: 9).

Introduction

We will begin with a brief conceptual overview of three perspectives from the western tradition of moral philosophy that I have found useful in developing the "habit of mind" required for ethical practice according to the esteemed German-American social work scholar Gisela Konopka (1910-2003). The first two perspectives, often categorized as deontological and teleological, have influenced many frameworks of analysis for addressing ethical dilemmas and have dominated the teaching of social work ethics in the United States (US). The third perspective, virtue ethics, has recently emerged as an alternative or complementary approach to the first two. Using the "ethics triangle" (Svara, 2007: 68), we will see how these three perspectives can be used together in thinking through ethical quandaries that social workers often face. As the *Statement of Ethical Principles* of the International Federation of Social Workers (IFSW, 2012) suggests, some of these typical dilemmas are due to our function as both helpers and controllers. (Interestingly, the Swedish statement of social work ethics lists as first among eleven common dilemmas: "Care, support and assistance versus control and demands" [Akadelmikerförbundet SSR, 2008: 6]). I offer here one such example from my practice in child welfare when I faced a decision regarding whether to become party to deception in the interests of a youth's well-being. Finally, I suggest implications for ethical decision-making, in particular elaborations on professional development and international discourse from the point of view of virtue ethics.

Conceptual Overview: Three Perspectives for Addressing Ethical Dilemmas

Ethical dilemmas are those difficult situations when we have to choose between courses of action that may at first appear equally good or bad, between ethical standards that conflict, or between competing interests. "An ethical dilemma is a situation in which professional duties and obligations, rooted in core values, clash" (Reamer, 1999: 4).

Typical examples include those when we are forced to choose between duties, for example the duty to maintain confidentiality and the duty to make a mandatory child protection report, or between the interests of children and their parents. In child welfare, dilemmas tend to hinge on duties to protect the freedom of parents and children on the one hand or their well-being on the other hand. If it is easy to decide on the right course of action, such as when there is a clear legal and ethical prohibition against a particular action, we are not facing a dilemma. Rather, dilemmas arise when we must decide what course of action is ethically most right (or sometimes what is least wrong). Such ethical dilemmas are usually best sorted through using systematic and rational decision making processes to arrive at what appears to be the right action given the circumstances. Reasonable practitioners might disagree on whether that course of action was ethical, and we might ourselves in hindsight question whether we made the right decision. "Having made the choice, the impact of the dilemma does not go away, for even the least unwelcome alternative is still unwelcome" (Banks, 2012: 12). But if we have followed an ethical decision-making process, including using theoretical perspectives from moral philosophy to help both decide and evaluate the decision, we have proceeded as reasonably as possible.

Deontological or Principle/ Duty-Based Approaches

Deontological theories are among the foremost perspectives to which social work scholars, educators, professional associations, and practitioners have turned in establishing ethical duties and addressing dilemmas. Leading American social work ethics scholar Frederick Reamer writes: "Deontological theories (from the Greek *deontos*, "of the obligatory") are those that claim that certain actions are inherently right or wrong, or good and bad, without regard to their consequences" (1999: 65). These are also referred to as principle or rule-based approaches (often associated with the 18th century philosopher Immanuel Kant). If we are justifying an action because it is abiding by a principle or rule, doing our duty (*deon*), or advocating for rights, we are thinking deontologically. "For deontologists, rules, rights, and principles are sacred and inviolable. The ends do not necessarily justify the means, particularly if they require violating some important rule, right, principle, or law"

(Reamer, 2008: 148).

Deontological approaches based on principles and rules that lead to moral duties have influenced the development of ethical standards, codes of conduct and regulations. British social work ethics scholar Sarah Banks writes that "….the principle of respect for persons...has been the most influential in social work ethics" and that it underpins "a set of general principles relating to the relationship between individual social workers and service users" (Banks, 2012: 43, 45). Many social work scholars have included *autonomy* (protect liberty and privacy) along with three additional principles as fundamental to social work ethics: *beneficence* (do good), *non-maleficence* (first do no harm), and *justice* (be fair). Banks identifies these four principles as elements of our "common morality" (2012: 57) and then adds respecting *human dignity*, promoting *well-being*, and especially promoting *social justice* as core principles for social work ethics (2012: 60). American social work ethics scholar Kim Strom-Gottfried includes *fidelity* (be trustworthy and honest) among social work's basic ethical principles (2007: 39).

Aligning with international conventions such as the United Nations Declaration of Human Rights, the IFSW's Statement of Ethical Principles for social workers sets forth two fundamental principles: *human rights* and *dignity and social justice*: 4.1 and 4.2). More specific elaborations and implications follow as guides for social workers' conduct in compliance with those principles, such as 5.3: "Social workers should act with integrity". In another example of a specific standard, the *Code of Ethics* established by the US National Association of Social Workers contains a rule prohibiting social workers from using deception: "Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception" (NASW, 2008: 4.04).

Generally, deontologists argue that there are no exceptions to fundamental, impartial moral rules that apply universally, such as to tell the truth, keep promises, and be fair. However, it is possible to make a deontological, principle- and rule-based argument that in certain cases, higher principles override the rule prohibiting deception. For example, there could be a rule that in those situations when deception is required to save another's life, then it is ethical to lie as a way to comply with the principles of human rights, dignity, beneficence, well-being and social justice; this would be a universal rule to apply in all such situations.

One limitation of deontological thinking is that principles are often abstract and general rather than sensitive to specific cultural norms or practices; principles also tend to presume the point of view of individual actors rather than that of families or communities (Banks, 2012: 69; Boss, 2014: 334). In addition, many "real world" dilemmas do not seem readily resolvable if we are to strictly abide by one ideal principle above all others. Few principles in social work ethics are universally applicable or absolute. Even self-determination, arising from one of the historic core values in social work – respect for the dignity and worth of the person – is modified in the current US NASW code as it should be applied in practice: "Social workers promote clients' *socially responsible* self-determination" (NASW, 2008: 5, *italics added*). The modifying phrase "socially responsible" was not present in earlier iterations of the NASW *Code of Ethics*, and its addition in 1996 highlighted the understanding that there are occasions when social workers may ethically be required to intrude into the autonomy of a client when there is potential danger to the client or others. Finally, with a keen focus on doing one's duty as the essence of morality, some versions of deontology provide little direction for those situations when we might consider going beyond the call of duty; in moral philosophy, this is called "supererogation", and there is an extensive literature addressing whether or when supererogatory actions might be ethically required; (for more on this debate, see Flescher, 2003; Fowers, 2005; Heyd, 1982 and 2012; McBeath and Webb, 2002; McNaughton and Rawling, 2006; Reamer, 1993: 75-76; and Webster, 2011).

Teleological Approaches: Utilitarian Consequentialism

"The second major group of theories, teleological theories (from the Greek *teleios*, "brought to its end or purpose"), takes a different approach to ethical choices. From this point of view, the rightness of any action is determined by the goodness of its consequences" (Reamer, 1999:

66). Utilitarian philosophies are examples of this approach (developed by 19th century thinkers Jeremy Bentham and John Stuart Mill). If we make a decision to take a particular course of action when facing an ethical dilemma based on the potential consequences of that action, we are using utilitarian thinking. Would our intended action result in the greatest amount of good or in good outcomes for the largest number of people? This approach evokes a principle called "utility" finding the "greatest balance of good over evil" (Banks, 2012: 50). However, it differs from deontological approaches in that it focuses on the actions that would result in good ends, purposes or goals rather than principles that would dictate conforming actions (Svara 2007: 59). Ethics educator and author Judith Boss clarifies that presenting "deontology as diametrically opposed to utilitarian theory.… is misleading" (2014: 301). Both approaches view duty as important, though deontologists regard actions abiding by universal principles as good and moral for their own sake rather than for their consequences.

"Utilitarian principles have been the most popular guides to social workers' ethical decisions" (Reamer, 1993: 71). Usually combining and integrating consequential thinking with the deontological approach, "social workers have sought to maximize the good and minimize harm while doing their duty and following their values, principles and codes" (Gray, 2010: 1795). Analyzing how 62 social workers in Israel approached ethical decision-making and reasoning, Osmo and Landau found that "the large majority of social workers in the study based their arguments on either deontological or utilitarian concepts" (2006: 872). McDermott (2011) conducted qualitative research in Australia on how practitioners actually reason when facing ethical dilemmas and found that in addition to ideal principles and rules, many participants in the study also relied on weighing the consequences of their actions. In a recent study of social workers' decision-making in Slovenia, Sobočan (2013) found that although participants did not formally reference applying moral philosophy, they did describe making choices based on a combination of possibilities and consequences among a complexity of other factors.

Using utilitarian thinking, practitioners are more willing to make exceptions to rules that deontological thinking considers absolute. A typical example is that instead of rigidly following a rule that social workers should never deceive, a utilitarian approach would examine what the results of being honest or deceptive would be, and then if lying could bring about greater good, prevent substantial evil, or benefit many people, it might be morally acceptable to lie. The thought process here is conducting a "calculus" forecasting which action would result in the maximal good and minimal harm for clients, practitioners, agencies and society at large (Reamer in Banks and NØhr, 2012: 112). However, what is good for the majority can also be harmful for a minority (Reamer, 1993: 73-74; 2008: 148). And, as with deontological thinking, utilitarian thinking does not always result in a simple or clear direction; it is impossible, after all, to predict future outcomes with certainty. Moreover, within utilitarianism, some ethicists focus on the short-term consequences of a particular action ("act utilitarianism") while others take into account long-term consequences if our decision becomes a precedent ("rule utilitarianism"). This can result in contradictory directions. Under act utilitarian thinking, a lie might be acceptable if it led to a good outcome or prevented a bad outcome in a particular situation; under rule utilitarian thinking, though, lying in general would not bring about the best consequences in the long run because doing so could erode trust (Boss, 2014: 301). In addition, Adams (2009) points out that utilitarianism could be used to justify heinous acts like torturing an individual who has information that could lead to stopping a terrorist attack (hurting one person in an attempt to prevent more damage to many others).

In the process of summarizing deontological and teleological perspectives, the above overviews may have oversimplified each and underemphasized the complexity and sophistication that philosophical thinking and traditions have brought to moral decision making. Readers are encouraged to explore more deeply the strengths and limitations of each as compared with the third perspective that we will be focusing on: virtue ethics.

According to Rhodes, both deontological and teleological perspectives share "three central problems" (1986: 32):

1) "Each can be used to justify conflicting actions";
2) Neither takes into account social or political contexts; and
3) "Neither theory can tell us how to decide between them".

They both also sometimes may draw us to focus on *actions* in response to an ethical quandary. We can use virtue ethics to examine in addition the motivations and goals of the *actor*.

Virtue Ethics: General Introduction

This section provides a summary of basic concepts before we turn to development of virtue ethics within social work. "The term "virtue ethics" refers to a variety of ethical theories or theoretical approaches that have a central focus on the moral qualities ("virtues") of individual people or institutions" (Banks and Gallagher, 2009: 7; see also Adams, 2009; Annas, 2006; Banks, 2010 and 2012; Banks and NØhr, 2012; Barsky, 2010 and 2013; Boss, 2014; Clark, 2006; Clifford and Burke, 2009; Fowers, 2005 and 2012; Gray, 2010; Houston, 2003; Hursthouse, R., 1999 and 2012; MacIntyre, 1985 and 1999; McBeath and Webb, 2002; Peterson, 2013; Oakley and Cocking, 2001; Pullen-Sansfaçon, 2010; Statman, 1997; Webb, 2010; Webster, 2011; Winter, 2012). For two thousand years until the Enlightenment in 18th century, virtue theory was the "default form" of moral philosophy in both western and other traditions, especially Asian; after receding into the background behind deontological and teleological thinking for two centuries, it has recently re-emerged with renewed vigor, offering a "third way" that challenges and enriches the other two perspectives (Annas, 2006: 515, 533). "This revival has been in response, in part, to a sense that ethics cannot be reduced to the determination of right actions with respect to a set of rules or likely consequences" (Pinsent, 2012: 1). Virtue ethics now offers a "flexible alternative to rule-focused ethical theories" (Winter, 2012: 1), a useful "counterweight to deontological and teleological approaches" (Banks and Gallagher, 2009: 49). Before addressing the question "what should I do?" virtue ethics focuses on "what kind of person should I be?" (Peterson, 2013: 33); "virtue ethics emphasizes *right being* over *right action*" (Boss, 2014: 384, italics in original).

Virtues are habits of mind and heart carried out actively in a manner that benefits ourselves and others (Boss, 2014: 395). They are to be cultivated throughout life and not in isolation – they require interactions with others within community to be sustained; they are both worthwhile in themselves and our means to flourish as human beings together in society (MacIntyre, 1985: 191, 219-220 and 273; see also 1999: 111-112). In other words, virtues are strengths of character that ideally are consciously and continuously practiced and reflected upon as contributing to the meaning of our lives. The term virtue encompasses an "overall constellation of particular virtues and the wisdom to enact them well" (Fowers, 2005: 9). No single virtue is seen as key, nor can they function well in a piecemeal fashion; instead, cultivating virtues constitutes leading a good life over time, and various combinations of virtues can be employed to reflect upon particular ethical issues or to address a given ethical quandary or dilemma in all its unique complexity and cultural context. Virtue ethics is thus concerned with the character and integrity of "an individual's life as a whole and with how that life comes together through decisions and actions the person takes" (Fowers, 2005: 48; Banks, 2010; Webb, 2010).

One of the strengths of virtue ethics is how clearly it explains moral motivation (Peterson and Seligman, 2004: 87-88; McDermott, 2011: 57). Acting rightly does not result directly from following principles or rules so much as "growing" from character strengths (Fowers and Davidov, 2005: 582; Fowers, 2005: 12). Among six variations of virtue ethics theory described by Flescher (2003: 287) is the predominant version that judges an action's morality by examining the actor's character and motivations; another version emphasizes that "acting rightly does not require that we maximize the good". "An action is right, according to virtue ethics, if and only if it is what an agent with virtuous character would do in the circumstances" (Adams, 2009: 97). While not ignoring principles or consequences, then, virtue ethics concentrates

instead on comparing our lives and actions with how a virtuous person would live and act, examining our character and motivations in order to distinguish right from wrong (Clark, 2006; Clifford and Burke, 2009; McDermott, 2011; Webb, 2010).

Commentators on virtue ethics often trace the origins of this perspective back to the ancient Greek philosophers, in particular Aristotle. Virtue ethics also resonates with other religious and moral traditions worldwide, including Confucianism, Taoism, Buddhism, Hinduism, Greek, Islam, and the Judeo-Christian tradition (Peterson and Seligman, 2004; Boss, 2014).

Blaine Fowers, an American psychologist, professor of counseling psychology at the University Miami, Florida, USA, and his co-author Barbara Davidov explain that from the perspective of virtue ethics:*"One acquires character strengths intentionally, through gradual efforts, by practicing them, by identifying and counteracting contrary desires, by altering one's cognitions in line with one's knowledge about the virtue, and by becoming the kind of person who habitually engages in these cognitions and actions."* (Fowers and Davidov, 2005: 586).

Nevertheless, we are not always conscious of our virtues, or vices for that matter, even as we enact them since as personal characteristics virtues often become second nature (Fowers and Davidov, 2005: 586; Van Slyke et al. 2013: 2). Sometimes we may recognize the need to have acted in accordance with a certain virtue only when we notice in hindsight that our actions were contrary to that virtue.[2] For example, we might realize after the fact that we have not been fully honest with ourselves or we have failed to take a courageous stand.

One of the leading philosophers who have influenced the revival of virtue ethics, Alasdair MacIntyre, adds that principles and rules also play an important though not exhaustive or exclusive role for evaluating whether or not we are being virtuous (1999: 111). Part of being trustworthy or having integrity is usually acting in accordance with rules, but there will be particular situations as well when no rule or set of rules suffices and virtues such as practical wisdom or courage are needed to guide moral actions.

In order to determine which virtues then we should develop to be a good person (and good social worker), according to virtue ethics we should observe and learn from exemplars, paragons, or role models whose lives show the way to virtuous excellence (Banks, 2012: 90-91; Peterson, 2013: 39; Van Slyke et al., 2013: 2 and 5). These exemplars may include historic figures, current mentors, parents, teachers, supervisors, fictional characters, heroes or saints (for more on the latter three, see Flescher, 2003).

Virtue Ethics as Developing in Social Work

Recently, virtue ethics has emerged as an important perspective for social work ethics internationally. As Banks explains in the preface for the latest edition of her major text, *Values and Ethics in Social Work*, the main focus of the first edition in 1995 was "principle-based ethics" (including teleological approaches as well as deontological); McBeath and Webb call this "the persistent drone of Kantianism and utilitarianism" while remarking on the dearth of considerations of virtue ethics (2002: 31). In Banks' second edition in 2001, though, she added a new chapter covering "character and relationship-based" approaches to ethics….It also took account of the recent revival of virtue ethics in western philosophy (based on qualities of character rather than principles of action)" along with other approaches such as feminist ethics and ethics of care (Banks, 2012: xxi). Subsequent editions and work by other authors in the United Kingdom and Australia have developed the application of virtue ethics in social work further than in the US, where few articles have been published (one being Paul Adam's excellent 2009 publication), and texts tend to devote more attention to deontological and teleological approaches (e.g., Reamer, 1999).

As a resurgent branch of normative ethics that is congruent with multiculturalism (Fowers and Davidov, 2005), virtue ethics is a good fit with social work (Lovat and Gray, 2008). It is strengths-based. It provides a holistic view including both ourselves as moral actors and our actions in their social, cultural, and political contexts. "The practice of virtue developed through experience, reflection and circumspection is the very stuff of good social work" (McBeath and Webb, 2002: 1020; Webb, 2010: 113). Virtue ethics gives conscious

and keen attention to relationships, includes emotional intelligence in conceptualizing rational processes for decision-making, and as noted above shares common threads with a diversity of approaches from cultural or religious traditions. As we cultivate virtues aligned with social work's fundamental values, we may be better able to consistently and reliably bring those values to life.

From a virtue ethics perspective, how we make decisions when facing ethical dilemmas thus depends on our character: "….ethics is as much about *being* a certain sort of person as it is about *doing* certain things" (Flescher, 2003: 298, emphasis in original). A key question under virtue ethics is "What kind of person (or social worker) do I want to be?" instead of "What rules should I follow?" For example, Banks explains that:

"Virtuous people tell the truth, it is argued, not because of some abstract principle stating "you shall not lie," or because on this occasion telling the truth will produce a good result, but because they do not want to be the sorts of people who tell lies….We would have to ask ourselves what it means to be a "good social worker". "Good" would be internal to the role of social worker and would be defined by the community of practitioners who do social work." (Banks, 2012: 72).

Hence, the role of international discourse on ethical issues among social workers becomes vital, as we will discuss further below.

Considering virtue ethics typically will generate a list of virtues that have potential relevance for social workers facing ethical dilemmas. Table 1 offers a list of selected virtues that social work authors have suggested as pertinent. For comparison purposes, the table also includes a comprehensive classification of virtues developed by Peterson and Seligman (2004). (See also Table 3.2 in Banks, 2012: 73).

Table 1: Selected Virtues Relevant for Social Workers

Professional Practical Wisdom (Prudence)

Openness to Others	Integrity
Care	Sincerity
Compassion	Honesty
Kindness	Judgment
Benevolence	Reflection
Tenderness	Diligence
Respectfulness	Loyalty
Empathy	Self-Discipline
Trustworthiness	Hopefulness
Patience	Perseverance
Justice	Gratitude
Reciprocity	Humility
Fairmindedness	Temperance
Courage	Liberality
Righteous Indignation	Just Generosity

"Caring social workers embrace six virtues" (Barsky, 2010: 378):
Attentiveness
Responsibility
Competence
Responsiveness
Integrity of care
Discernment

*Universal Classification of Character Strengths: 6 Core Moral Virtues**
(which are expressed in character strengths or positive traits):

Wisdom & Knowledge
(Creativity, Curiosity, Open-Mindedness, Love of Learning, Perspective)
Courage
(Bravery, Persistence, Integrity, Vitality)
Humanity
(Love, Kindness, Social Intelligence)
Justice
(Citizenship, Fairness, Leadership)
Temperance
(Forgiveness & Mercy, Humility/Modesty, Prudence, Self-regulation)
Transcendence
(Awe/Wonder, Gratitude, Hope, Humor, Spirituality)

From: Adams, 2009; Banks & Gallagher, 2009; Banks & NØhr, 2012; Barsky, 2010, table 1.1: 29-30;
Clifford and Burke, 2009; Fowers & Davidov, 2005; McBeath & Webb, 2002;
Peterson & Seligman, 2004*; Rhodes, 1986; Webster, 2011

Adams argues that as a virtue-based profession, "social work is a field for the exercise of all the

virtues together" using practical wisdom to coordinate them (2009: 88). Thus, the virtue of practical wisdom or prudence (for which Aristotle used the Greek word *phronesis*) plays an important guiding role in finding the best balance of virtues to tap in any given ethical challenge (Fowers, 2005: 13 and 107; Bartlett & Collins, 2011: 313-314; Clark, 2007). It helps decide which action would be most ethical, perhaps following a given duty as in deontological thinking in one situation or taking into account expected outcomes in another situation (Putman, 2012: 143). "It is a quality that needs to be nurtured and developed, through working alongside experienced role models or teachers, and entails the ability to notice, pay attention and see morally relevant features in situations" (Banks and NØhr, 2012: 11).[3] The virtue of practical wisdom can also be critical in finding the middle ground between extremes of excess or deficit (Aristotle's virtuous *golden mean*, the *middle path* of the Buddha, and Confucius' *chung-yung*: Boss, 2014: 391). Practical wisdom can help us conceptualize where a virtue lands between two vices (Bartlett, 2011: see the chart on pages 303-304).[4] For instance, we can use practical wisdom to discern how to take courageous action challenging an unjust agency policy rather than choosing cowardly capitulation at one extreme or foolhardy oppositional tactics at the other (see Sherman and Wenocur, 1983). Similarly, in conducting an honest self-assessment, we can avoid the extremes of either overly positive exaggeration or overly negative self-effacement (MacIntyre, 1999: 95).

As Banks points out (2012: 76 and 112), most social work codes of ethics are "predominantly principle based" and include few specific references to virtues, though many such as NASW do highlight the importance of "character": "Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments" (NASW *Code of Ethics*, 2008: 4). An exception is one of the Swedish social work association's codes (Akademikerförbundet SSR, 2008) which as Banks notes specify a number of virtues including integrity and moral courage (2012: 73). Integrity subsumes other virtues such as honesty, reliability, and authenticity (Banks, 2012: 76; see also Banks, 2010 and Peterson and Seligman, 2004: 205), each of which appears with some frequency in codes of ethics or conduct. For instance, the *Code of Ethics for Social Workers in Slovakia* (Association of Social Workers in the Slovak Republic, 1997, cited in Banks, 2012: 112) lists under fundamental principles of social work and standards for conduct and demeanor the virtue of "Honesty" (*Čestnosť* : II.1.D), one of five headings in this section of the code. Likewise, the 2002 Declaration of Ethics for Professional Social Workers established by the Bombay Association of Trained Social Workers in Mumbai, India, declares that its members "pledge to work with people, guided by…. "values including honesty, personal integrity and accountability" (Appendix IIIb in Joseph and Fernandes, 2006: 118). These are illustrations of one of the typical "ingredients in codes of ethics" that Banks found in her comparative analysis of social work codes globally: "professional practitioners should be honest, trustworthy and reliable" (Banks, 2012: 110). Moreover, Australian professor and author Stephen Webb points out that from the perspective of virtue ethics, attention to honesty is congruent with civic virtues endorsed by most societies; as applied to social work:

"A conscience against lying is good. At the level of social worker-client relations, the client would not want to engage with the worker who lied for advantage because, although it may be to the advantage of a client one day, it may be to her disadvantage the next. The client would never quite be at ease once she realized that the worker lied strategically." (Webb, 2010: 117)

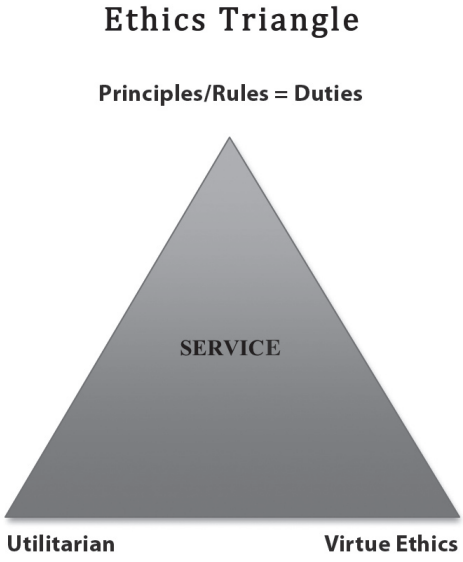
As with other perspectives, there are limitations to virtue ethics. It can turn into a self-righteous personal or idiosyncratic crusade. With its focus on the individual actor, virtue ethics does not directly take into account systems issues or power dynamics including those related to privileges and vulnerabilities entailed with social identities and division, and thus virtuous social workers could find themselves coopted, exploited, or irrelevant (Clifford and Burke, 2009: 114-119). Virtue ethics might not give specific guidance in a given dilemma. It needs to be supplemented by reference to norms,

rules, laws or principles; and virtue "requires a community or tradition that teaches a vision of human life, gives an answer to the question "What is the human being for?" and teaches the skills needed to live out that vision so as to achieve its goals" (Boland, 2007: 190). Thus, it may be more relevant for the development of personal morality rather than professional ethics (Holland, 2010). Defining a virtuous act can appear circular: i.e., one is acting virtuously if one acts as a virtuous person would act. And a virtuous act, like being honest, can result in a bad outcome; e.g., telling a suicidal client truthfully but bluntly that the social worker has contacted the authorities to take the client to a treatment facility could cause the client to bolt from safe custody.

As this overview highlights, each of these three approaches (deontology, teleology, and virtue ethics) offers perspectives that social workers will find useful when thinking through ethical issues and facing ethical dilemmas. None is without significant limitations. Thankfully, we can use all three together, as the three perspectives tend to complement each other and fill in gaps not covered by the others; and we can rely as well on our central social work value of service to others to keep us grounded. I have found a tool for analysis called the "ethics triangle" (Svara, 2007) effective in guiding the integration of principles/rules-based, utilitarian, and virtue ethics approaches centered on service to others. To illustrate how this tool works, I share here a scenario adapted from my own practice in child welfare.

Using the Ethics Triangle

The "ethics triangle" was developed by Professor James Svara (Arizona State University School of Public Affairs), a political scientist and public administration educator (2007). I have adapted it for social work. At the points of the triangle are three approaches to making ethical decisions based on principles/rules and duties (deontological), utilitarian analysis (teleological, consequentialist), and virtue ethics. Svara's view is that any one approach by itself can lead us astray. "Using all the approaches together helps to prevent the shortcomings of using any of the approaches alone" (Svara, 2007: 68). Also, since he developed this tool for public administrators, he put the duty of *public service* in the center of the triangle. I have shortened that to *service*, arguably a core value for social workers and the first listed in the US NASW's code (2008).



To illustrate using the ethics triangle, we will work through the dilemma arising from following scenario, which I have composed for classes and training workshops. I ask participants to imagine that they are a social work supervisor in a child welfare agency:

Scenario

A foster mother has reported that a teenage boy in her care has just shown up in her kitchen after having been out all night without permission. The foster mother suspects that the youth has been drinking or using drugs, and without informing him, she has arranged for an inpatient assessment in a locked facility to which she asks your supervisee to transport the youth. However, she has directed the supervisee not to inform the youth about where they are heading because she fears that if the youth is told that the supervisee will take him to the assessment, the youth will run away again. The supervisee is not sure whether to refrain from informing the youth about where they are going or whether even to take the youth to the inpatient assessment.

Each point on the ethics triangle serves to highlight considerations from one of the three perspectives from moral philosophy with which we have been dealing. The discussion here is meant to illustrate with selected samples the issues, resources, ideas, and further questions that each stop on the triangle can generate; in classes, workshops and consultations, many additional insights emerge. (And other perspectives from moral philosophy can be similarly instructive.)

Principles/Rules/Duties?

Starting at the top of the triangle, we first identify which principles and rules might apply and thus how we may have a duty to act. This also serves to clarify the elements of the dilemma that the social worker faces. What duties and obligations arising out of core values and principles conflict with each other? On the one hand the youth's best interests, health, well-being, and safety must be paramount; the foster parent, who is the immediate legal guardian in charge of the youth's care, is recommending that the youth not be told about the arrangements for placement in the locked treatment center to assess his drug or alcohol use. In her view, fully informing the youth of the plans could result in the youth's endangering himself by running away and continuing to use illegal substances. The social worker's duty to help might entail taking paternalistic control of the youth in carrying out the arrangement for inpatient assessment for his own good. However, on the other hand, if the social worker abides by the foster parent's recommendation, that would be violating a professional ethical standard prohibiting deception as well as the youth's rights to self-determination and fully informed consent to services or treatment. As we noted at the beginning of this article, this is an example of a dilemma typical in social work practice when the social worker must simultaneously fulfill two professional roles: helper and social control agent (Dolgoff, Harrington, and Loewenberg, 2012: 5). And in each role social work's fundamental principles and standards from our codes of ethics can provide some initial guidance, though they too may conflict.

IFSW's Statement of Ethical Principles (2012) lists "respect for the inherent worth and dignity of all people" first, including the rights to self-determination (4.1.1) and full participation in decision and actions that affect their lives (4.1.2); these could require the social worker to object to the foster parent's recommendation. Later provisions in the statement under Professional Conduct indicate that the social worker should act with integrity, compassion, empathy, and care (5.3 and 5.4). These also could support disclosing to the youth the plans for transporting him to the impatient assessment. Yet, respecting the foster parent would include giving serious attention to her recommendation. In addition, a competent knowledgeable social worker would realize that adolescents can be impulsive and not necessarily act in their own interests or safety; ignoring the foster parent's fear that the youth would run away again if told of the plans seems unwise.

American social work professors Ralph Dolgoff, Donna Harrington, and Frank Loewenberg have developed a popular tool for beginning to address a dilemma involving ethical principles and standards that conflict: the Ethical Principle Screen (2012: 80). This tool is a hierarchical pyramid listing seven core principles for social workers, with protection of life ranked at the top and with truthfulness and full disclosure at the bottom; self-determination is ranked higher than truthfulness and full disclosure, but still below protection of life. This ranking could lead the social worker to consider protecting the safety and health of the youth by securing the inpatient assessment even if that means not fully disclosing the plan to the youth.

The IFSW statement also declares that "social workers should act in accordance with the ethical code or guidelines specific to the national context" and abide by international conventions such as the UN Convention on the Rights of the Child (1989). So the supervisor and supervisee should be sure to check out provisions in the code of ethics relevant to their locality, which as discussed above are likely to proscribe deceiving people as well as prescribe acting in the best interests of the service user. If licensed or legally regulated (as increasingly social workers worldwide are – see Bibus and Boutté-Queen, 2011), the social worker should also refer to the rules and standards of conduct that may apply in addition to other legal provisions related to

status offences (behaviors that are crimes for youth but not adults) and use of drugs and alcohol. Agency policies related to service planning and relationships with foster parents should be reviewed; typical provisions call for social workers and foster parents along with clients to collaborate and coordinate as partners in working toward the best interests of the youth in care. Increasingly, policies also now require use of interventions that have been shown in research to be effective; this evidence-based practice should in principle involve the youth as a fully informed participant in the assessment plan (for an overview of evidence-based practices in social work in the US, see Walker et al., 2007).

Assuming that the youth is under 18 years old, the UN Convention on the Rights of the Child applies in every nation except the US. It sets the best interests of the youth as "primary consideration" (Article 3.1), which could entail making sure he gets into inpatient assessment and does not endanger himself further. However, Article 12 stipulates that children or youth capable of forming their own views have a right to express those views, which implies that they should be fully informed of plans regarding their treatment in order to have voice in the planning; (see Toft and Bibus, 2014, for more discussion of children's rights and responsibilities as citizens). Other provisions also may apply such as those involving placement in foster care and Article 33, which requires that "all appropriate measures" be taken "to protect children from illicit use of narcotic drugs" etc.

While recognizing that achieving virtues and being a person of good character are important, Dalgoff et al. focus their attention on the necessity that social workers "be trained and skilled in systematic approach to decision making itself" (2012: 72). In addition to rational analysis of the values (personal, professional, societal), rights, principles, rules, and duties that apply, they advise that social workers weigh "short- and long-term consequences" making sure that their actions result in the least harm possible. This is utilitarian thinking, the next point on the triangle.

Consequences?

Considering consequences of the possible responses to the foster mother's recommendation, the supervisor and supervisee would likely not have much time to deliberate, and of course they cannot forecast with absolute certainty any outcome. Their calculations and weighing of potential outcomes must therefore be tentative and include alternatives and adjustments to what actually happens. Certainly, an orientation to providing the best service possible to the youth and to the foster parent should be central. Given the complexities involved in such situations, knowledge of how to work most effectively with diverse family systems, with people experiencing difficulties with drugs and alcohol, and particularly with involuntary transactions is critical (see Bibus and Jud, 2009, and Rooney and Bibus, 1996). For example, understanding normal and natural reactions when valued freedoms are threatened could improve the accuracy of predictions of the youth's response when he discovers that he is being taken to the locked treatment center (Rooney, 2009). Proceeding with due diligence then, the supervisor can assist the supervisee in predicting what most likely harms (or benefits) could occur if the supervisee does not disclose to the youth the plan to transport him to the inpatient assessment.

From an act utilitarian point of view focused on this specific situation in the short term, the youth might react in reckless or even violent ways when he realizes he is to be confined in a facility; he may feel betrayed and may never believe the social worker's word again or refuse to cooperate with subsequent services including the assessment and follow-up treatment. From a rule utilitarian point of view, the social worker's misleading actions could cast a pall in the long term on the reputation of social work as a trust-worthy profession. On the other hand, the consequences of not following the foster mother's recommendation should also be considered; the youth might run away again as she fears, and she herself may feel discounted and let down, and she may conclude that her expertise as well as responsibility as the youth's guardian is being ignored. She might discontinue foster parenting. Alternatively, the youth could be ready to voluntarily agree to accompany the social worker to the assessment and pursue sobriety; after all he has returned to his foster home. This could be an opportunity

to solidify his relationships with the caring adults in his life, including the social worker. Much thus rides on how the youth views the supervisee as a person as well as his social worker. Questions related to the character of the supervisee are the focus of the final point in the triangle.

Virtues?

Most models for addressing ethical dilemmas suggest questions raised by moral philosophy, some specifying solely deontological and utilitarian approaches. However, whether our decisions and subsequent actions are right or wrong cannot be determined only by comparing them to duties as set in universal standards or by looking at outcomes, which may be chance events (McBeath and Webb, 2002). Virtue ethics' resurgence is in part a reaction both to deontological approaches that may lead to taking certain actions because they are our duty rather than wholeheartedly and to a teleological focus on moral actions that lead to others' good not our own, instead of seeing such actions as good for others *and* ourselves. Virtue ethics generates a series of questions from a fresh perspective. (See Table 2). No matter which of the various models for analysis and decision-making that the supervisor and supervisee might use, these questions can be fruitful and help clarify what the right course of action is. (For decision making frameworks, I recommend those developed by Brodsky, 2010; Clifford and Burke, 2009: 191; Congress, 1999; Link and Ramanathan, 2011: 95; Reamer, 1999; Strom-Gottfried's six questions are especially useful: 2007; see also Banks' discussion of decision-making models and "ethics work", 2012: 203-205).

Table 2: Questions from Virtue Ethics for Deliberating upon Ethical Dilemmas

"How should I live?"
(Banks and Gallagher, 2009: 34)

"What are my ultimate goals for my life?"
(Fowers and Davidov, 2005: 584)

"What kind of person (or social worker) do I want to be?"
(Banks and NØhr, 2012: 5; Rhodes, 1986: 42; Fowers, 2005: 64)

"What are my values?"
(Banks, 2010: 2179-2180)

"What are my motivations?"
(Banks, 2010: 2179-2180; Fowers and Davidov, 2005: 584)

"What virtues will it take to achieve my goals and ideals in this situation?"
(Fowers and Davidov, 2005: 584)

"What consistent actions do I take now or can I take in the future to express these virtues?"
(Fowers and Davidov, 2005: 584)

"What does a caring response require of me?"
(Imre, 1989: 22)

"Will I make this decision with integrity?"
(Rhodes, 1986: 42)

"How does this decision fit with my ideals as a social worker?"
(Rhodes, 1986: 54; Fowers and Davidov, 2005: 584)

"What would a virtuous social worker do?"

"Not "What is good social work", but "what is a good social worker?"
(McBeath and Webb, 2002: 1020).

"How can I best meet my caring responsibilities?"
(Tronto, 1993: 137)

"What more is there left for me to do? What have I missed?"
(Flescher, 2003: 310)

"What if I am wrong? Is there something I am overlooking?" (Barsky, 2010: 262)

"How can I act most wisely?" (Fowers and Davidov, 2005: 584)

Essentially, the supervisee should reflect on how congruent alternative actions are with the kind

of person and social worker she or he wants to be. "What are my ultimate goals and motivation responding to this particular dilemma?" Other critical questions are: "What have I missed?" and "What biases or personal values are influencing my thinking?" It can be helpful to reflect for a moment on what a virtuous social worker whom we admire might do in this situation or what we at our best have done in past similar situations. Such an exemplar would likely approach this dilemma by tapping into virtues such as courage, responsiveness, honesty, integrity, compassion, and practical wisdom. Competent multi-cultural practice would also require the virtue of openness to others (Fowers and Davidov, 2005). This in turn brings to bear social work's dual focus on person-in-environment and our central value of service. Some intensive and effective action on the supervisee's part is needed, but it must be measured so as to avoid doing more harm to the youth, foster mother or others; in other words, reckless snap judgments on whether or not to follow the foster mother's recommendation could be as unwise as thoughtless compliance with the wishes of either the foster mother or the youth. A social worker who misleads the youth would not likely be seen as acting honestly or with integrity. Likewise, a social worker who ignored the foster mother's recommendation would not be seen as be acting professionally by either the foster parent or the youth or the youth's family members (or the supervisor!). So, any deliberate and forthright action taken will benefit from a compassionate rapport that the social worker establishes with both the foster mother and the youth. Each will want to trust and witness that the supervisee has the youth's best interests at heart. The social worker will be most authentic if she or he is wholeheartedly and genuinely honest with the youth and the foster parent. Yet not even the virtue of honesty should predominate in isolation here; the virtue of practical wisdom can guide whether withholding information from the youth is the only way to protect the youth or others from harm.

At this point on the triangle, the supervisee may be leaning toward not following the foster mother's recommendation but instead informing the youth of the plan for inpatient assessment of his drug or alcohol use; the supervisee would proceed in manner that acknowledges the youth's values and goals and involves him in cooperating with a plan, not running away again, while also enlisting the foster parent's and family's support.

The Decision

Once having attended carefully and at a timely pace to each point on the ethics triangle, the supervisor and supervisee should center themselves on their duty to serve in this situation. Doing nothing is not an ethical option. Nor apparently is wholesale deception of the youth called for; from the information available, it does not appear that the risk to the youth's own immediate safety or others' rises to the level that would justify taking paternalistic action in his own interests but against his wishes. Thinking through the dilemma in a systematic, rational, and reasonably informed professional manner, the social worker with the supervisor's support should decide not to follow the foster mother's direction but rather talk with the foster mother about the potential risks in misleading the youth and the potential benefits of persuading the youth to accompany the supervisee to the inpatient assessment voluntarily. If time allows, consultation with colleagues or other resource persons, such as staff at the treatment facility or legal advisors could be helpful. There may also be another way to arrange an assessment that would address the youth's drug or alcohol use and other needs and goals without resorting to a more restrictive placement. The social worker may decide to advocate for a treatment protocol that is more appropriate for the youth given his social identity, history or other factors. Additional resources such as family members or friends might help in negotiating a sound plan that is mutually acceptable to the youth and the foster mother.

As the supervisee heads out to the foster home, she or he should be ready to engage the youth and the foster mother in a mutual assessment of the youth's circumstances, state of mind, goals, strengths, family, social supports, culture, health, safety, and danger to himself or others. The supervisee will need to be at her or his best to facilitate this kind of intervention, and the supervisor will also need to be available and

ready to help as unintended or unpredicted events take place.

Implications for Ethical Social Work Practice

The above case scenario is adapted from a situation that I faced in my child welfare practice; I could have managed the dilemma better, but the end result was fortunate for the eventual well-being of the youth and my growth as a social worker. Through the experience itself and discussing it with colleagues and students over the years, I have learned the value of using a systematic process to consider duties based on ethical principles, the potential consequences of options, and the kind of trustworthy, responsive, caring, and responsible social workers we want to be. Social workers can enact the virtue of prudence or practical wisdom by following a reasoned framework for analysis in making ethical decisions. As Reamer writes, "we are, after all, seeking a certain form of virtue here, one that is informed by reason" (1993: 81). And the ethical triangle is a useful tool for this process.

As discussed above, social workers tend to rely on deontological and utilitarian approaches (Osmo and Landau, 2006: 872). Gray and Webb remark on the perspective that virtue ethics offers; their example relates directly to the deception dilemma that we have focused on in this article: *"For example, a consequentialist may argue that lying is wrong because of the negative consequences produced by lying, though a consequentialist may allow that certain foreseeable consequences might make lying acceptable. A deontologist might argue that lying is always wrong, regardless of any potential "good" that might come from lying. A virtue ethicist, however, would focus less on lying in any particular instance and instead consider what a decision to tell a lie or not tell a lie said about the person's character and moral outlook."* (Gray and Webb, 2010: 113, italics in original)

Hence, deontological and utilitarian perspectives offer opportunities to deliberate on why and under what circumstances a potential decision and actions are right or wrong; and then virtue ethics' perspective supports reflection on how each option fits with the kind of social worker we want to be and what characteristic strengths and virtues will be required to carry out our decisions. Adding other approaches from moral philosophy would further enrich these reflections. The ethics triangle tool could be reshaped into a polygon by adding such approaches as those from ethics of care, feminist ethics, existentialism, environmental, communitarian, contractarian, social-constructivist, narrative, anti-oppressive and other post-modern ethical perspectives. In the concluding chapter of their book on anti-oppressive ethics in social work, Clifford and Burke model applications of six approaches from moral philosophy to ethically reflective practice in organizations (2009: 212-218).

A wider range of perspectives will be especially apt considering the constrictive attention lately on conforming to specific standards and reducing liability risks. Among the helping professions and in social work globally there is a trend toward promulgating statutory rules and regulations that operationalize general principles and toward codes of conduct (also known as "practice acts") that are more specific and prescriptive than codes of ethics (Banks, 2012: 107; Bibus and Boutté-Queen, 2011). The primary purposes of licensing regulations are to set minimum standards and to provide legal recourse for service users whose social workers' practice falls below standards. Yet, "codes contain relatively few statements about the character or virtues of practitioners" (Banks, 2012: 111). They "often miss the wider context of ethical issues in terms of human rights, for example to health, clean water, and sustainable development of communities now and in the future" (Link, 2004: 88). While rules are necessary, since we do not always act virtuously or at our best (Banks, 2012: 91), we need to be ready to reflect beyond the strictures, prescriptions, or prohibitions in regulatory codes that focus on actions so that we also consider the actors' (our own) individual characteristics. We should also see the relationships we cultivate with others (including service users as well as colleagues) as keys to ethical decision making and practice.

International social work scholar Richard Hugman counts *relationship* as one of the four categories that lay "the foundations for the international statement and national codes of ethics": *duty, consequences, virtue, and relationship*

(2010: 123-124). In this article, we have focused on the first three. Inside the ethics triangle is the value of "service" – placed in the middle to keep us centered on the importance of promoting the "good of other persons through the way in which social workers act in relationship with them" (as Hugman defines "relationship", 2010: 124). Focusing on relationships also enacts social work's person-in-environment perspective. Reflecting upon these relationships can nourish development of ethical practice. Moreover, the role of international discourse among social workers relating with each other across borders as we share studies on ethics thus becomes vital.

For example, Sobočan's 2013 doctoral dissertation examines how the ethical judgment of social workers in Slovenia is shaped by relationship with others, toward others and oneself as well. The development of systematized study and education on ethics in social work has just recently begun in Slovenia. Her pioneering study has found that decisions by social workers in the sample there appear to be influenced by reducing uncertainty and risks, negotiating relationships, attending to social workers' own motivation, self-confidence, intuitive moral judgments and beliefs as well as their role expectations and professional identity, and considering whether choices are legitimate. Being a good moral person is key to being a good ethical social worker.

"Decision-making in social work practice is thus not a predominately rational or rule-based endeavor, where choices are a result of the calculation of the best options (for the service user – the "recipient" of the decision), but a continued negotiation process – between different voices, interests, powers, and values" (Sobočan, 2013). Social workers need an environment that supports discourse on ethical issues and clear definition and understanding of social work's goals. Seeking "global dialogue" and sharing case examples internationally are critical for this discourse; equally critical is including service users in discussing and evaluating decisions (Link and Ramanathan, 2011: 95). Fowers elaborates on the need for this kind of mutual reflection among colleagues and service users: *"All of this makes it clear that virtue is inextricably communal. Humans gain an appreciation of character from others, learn the virtues from others, engage in virtuous activity with others, pursue goods we can only hold in common with others, and practice many primary virtues (e.g., friendship, generosity, justice) only with others. Each individual must decide whether or not to engage in admirable activities, but the context, meaning, import, and recognition of fine actions is profoundly social. The ultimate success of such shared efforts depends on one's ability to recognize what is important and make wise choices."* (Fowers, 2005: 104)[5]

Enlightened and encouraged by discourse with other social workers internationally, we are better positioned then to develop ethical practice. With its focus on the practitioner as moral agent, virtue ethics offers insights into such development (Boland, 2007: 162).

When facing an ethical dilemma, we should reflect on how a particular decision or action fits with the kind of human being we want to be, how in the past we have best conducted our life, and how esteemed colleagues might respond in similar circumstances. We must not give in to complacency but continue to strive to be more human in the best sense. We must be constantly vigilant and not retreat into comfort of moral neutrality or the *status quo*; it is ethically healthy to be "ill-at-ease" even when we are reasonably sure that we are right (Flescher, 2003: 309). "Our actions test our old habits and call upon us to reflect on our past actions and to reevaluate ourselves and our choices. Reflection, which is grounded in moral values, in turn generates a habitual moral response." (Boss, 2014: 388). Conversing with colleagues and clients about ethical issues, listening carefully, reading moral philosophy, studying and reflecting on social work as our vocation, we can nurture the habits of mind and heart needed to be good, virtuous social workers.

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2 See Doherty's 1995 discussion of courage: 161; Oakely and Cocking's 2001 identification of 'counterfactual conditions': 30; and Banks and Gallagher's 2009 observations on the role of emotions raising our personal distress when we realize that we have not been able to do what we think and feel is right: 67.

3 Chapter 4 Professional Wisdom in Banks and Gallagher, 2009, provides a useful discussion of this concept: 72-95; also relevant is Doherty's 1995 distinction of prudence as 'not about being cautious but about being wise': 164; see also Fowers, 2005; Rhodes, 1986; and Van Slyke et al., 2013.

4 See also Boss' Table 12.1: 392, and Clifford and Burke's 2009 discussion of the African concept of balance, 'ma'at': 108.

5 Houston, 2003, also highlights the importance of dialogue with others in forging virtues: 823.

Social Work Students' Moral Judgement Competence

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Abstract
A cross-sectional study explored the moral judgement competence of 168 Slovak students of social work. Lind's Moral Judgement Test was used to evaluate moral judgement competence depending on factors such as age, number of semesters of study, gender, and religion.
Students' moral judgement competence scores did not differ significantly according to religion, and gender. On the other hand, students' scores of moral judgement competence did differ significantly according to age and number of semesters of study. The fact that the Slovak students' moral judgement competence increased with age and number of semesters of study completed is an optimistic sign. Findings were discussed in comparison with those of previous studies. Recommendations for future research were discussed as well.

Keywords
moral judgement competence, social work students, age, gender, religion

Introduction

Recently, in Slovakia as well as abroad, wide attention has been given to the formation of moral competence, which is an important aspect of the professional training of social workers. In this context, some authors emphasize the need to use the moral component of personality in an intelligent way, talking about moral intelligence (Hass, 1999; Kaliská, 2013; Kalický, 2013). This complex process is becoming an integral part of the intellectual and personality features of every social worker with the requirement of its creative implementation.

It is evident that the personality of a social worker is that of a helping professional, and it is one of the key tools for working in a helping profession. The helping profession – social work sees helping as its meaning and to fulfil this, looks for ways to promote the benefit of other people. Its purpose is to help people living better (Úlehla, 2009).

As a social worker, being competent (from lat. competere, i.e. appropriate) means giving excellent performance of one's profession. This is a combination of dispositions, which are necessary for the exercise of the profession. Being morally competent means to be able to reach a moral judgement on the basis of one's own internal principles and then act in accordance with those judgments (Lind, 2008). It is the proper application of one's internalized beliefs that represent the humane and human approach in the profession of social worker (Jankovský, 2003). Lind (2008) emphasizes the close link between moral reasoning, decision making and subsequent behaviour and conduct of the individual. He considers the internal principles of a person to be the motive for his moral or immoral action.

The basis of social work is the personal commitment of social workers and the tools for the implementation of the actual content of the work are the relationships between social workers and their clients. Jankovský (2003), in the context of examining the problem, emphasizes the urgency of the issues of morality and ethics, especially in relation to the fragility of the working relationship between the client and the social worker.

To monitor the level of the moral competence among adepts of the helping professions – students of social work was one of the aims of our study. Ráczová and Pinková (2012) compared 60 students of helping disciplines (psychology and medicine) with 60 students of natural and technical disciplines. The average age of participants was 20.69. Based on the results obtained, we concluded that the type of study affects the level of moral competence, but only slightly. The vast majority of students, regardless of their field of study had a medium level of moral competence. However the students of the helping disciplines demonstrated a higher level of moral competence compared with students of natural and technical disciplines.

The level of moral competence of Czech and foreign medical students in relation to their education has been examined by Slováčková (2001), who seemingly came to inconsistent conclusions. On the one hand, she found that moral competence among Czech students significantly decreased during their studies with increasing university year and age, while on the other hand among foreign students it rose insignificantly. Later in 2007, Slováčková and Slováček conducted a cross-sectional study investigating the level of moral competence among 310 Czech and 70 Slovak and international medical students depending on their age, number of completed semesters of study, gender, ethnicity and religion. The level of moral competence in Czech and Slovak medical students significantly decreased with their increasing age, while that of international students did not increase significantly. In summary, the level of moral competence decreased with increasing age and number of completed semesters. No effect of other factors monitored – including gender, nationality and religion – was observed among medical students to be significantly demonstrated.

The level of moral competence in nursing students in relation to the field of study, type of study, current year and age was studied by Bužgová with Sikorová (2012). The sample consisted of 662 students of general nursing and midwifery. The overall level of moral competence of nursing students was low (medium C-index was 14.24 ± 9.56), and moral competence was significantly affected only by the type of study and age ($p < .05$).

In the context of this research study, which focuses on the level of moral competence of candidates for the helping professions, doctors, nurses, we were interested in the moral competence of social workers, also because of the lack of research attention given to that group of helping professionals. We wondered whether the selected sociodemographic variables would affect the level of moral competence of future social workers.

Despite the significant level of empirical studies conducted in the field of moral competence in relation to education, type of study, age, gender and other important parameters, we consider the area of investigation to be far from exhausted.

Purpose

The aim of the study was to evaluate the moral judgment competence of Slovak students of social work and to compare the same and different aspects of moral judgment competence based on the age, the number of semesters of study, gender, and religion.

Method

Participants

The participants were 168 students of social work. The number of students according to their semester of study is shown in Table 1. They aged between 18 and 23 (see Table 2). There were 50 men and 118 women. Filling in the questionnaires was voluntary and anonymous. It contained no identification data. The students were informed about the participation in the survey and its aims. The results were calculated not for individual students but for groups of students. A data sheet was used to record information on the number of semesters of study undertaken, age, gender and religion (see Table 3).

Table 1: The number of respondents according to the number of semesters of study (N = 168)

	Semester of study		
Students	**2nd**	**4th**	**6th***
	59	56	53

* Master's degree study program

Table 2: The number of respondents according to their age range (N = 168)

	Age range (years)		
Students	**18-19**	**20-21**	**22-23**
	58	61	49

Table 3: The number of respondents according to religion (N = 168)

	Religion		
Students	**Roman Catholic**	**Protestant**	**None**
	126	10	32

Instrument

Participants completed the Moral Judgment Test ("MJT") (Lind, 2008), which consists of the workers' dilemma and the mercy-killing dilemma. For each dilemma, a person has to identify to what degree he/she agrees with the solution chosen by the actor(s). Then, this person is confronted with six arguments in favour and six arguments against his/her opinion on how to solve the dilemma. The person then designates, on a 9-point scale from -4 to +4, to what degree these arguments are un(acceptable). The MJT provides a good task for observing subjects' moral judgment competence, that is, their ability to judge in accordance with moral principles. The C score indexes this ability. The C score (C-index) can range from zero, indicating absence of any moral judgment competence, to 100, indicating perfect judgment competence. Most frequently, it is categorized as low (1-9), medium (10-29), high (30-49) and very high (above 50). The MJT provides a pure measure of moral judgment competence. A high C score indicates that the subject can rate arguments consistently from a moral point of view.

It took the participants 30 minutes to complete MJT on average. In this study, the Cronbach's reliability coefficient for MJT was $\alpha = .68$. It demonstrates a high level of internal consistency.

Data Analysis

The C-index scores were calculated according to Lind (2008). To evaluate the association between the C-index and the number of semesters of study, age, religion and gender, the analysis of variance (ANOVA) and t-test at a level of significance of 5% were used.

Results

Data was collected from 168 students of social work at the Slovak universities. The numbers of semesters of study, age, gender and religion were recorded. The impact of number of semesters of study on C-index scores was studied as first. The results showed medium levels of the C-index in students of social work. Upper mean C-index scores were found in students in the sixth semester of study (Master's degree study program). As illustrated by Table 4, the results show statistically significant dependence of the C-index on the number of semesters studied. Nevertheless, significantly higher C-index scores were confirmed in students in the sixth semester of study ($p < .05$).

Table 4: Dependence of mean C-index values on the number of semesters in social work students (N = 168)

	Semester of study		
	2nd	**4th**	**6th**
Number of students	59	56	53
Mean C-index value	23.8	27.4	29.7
St. deviation	14.8	14.6	15.6

We also found the students of social work demonstrating statistically significant dependence of the C-index on age ($p < .05$) (see Table 5).

Table 5: Dependence of mean C-index values on age of social work students (N = 168)

	Age range (years)		
	18-19	**20-21**	**22-23**
Number of students	58	61	49
Mean C-index value	21.7	25.7	28.6
St. deviation	14.7	14.5	15.3

The impact of gender on C-index scores was also studied. As seen from Table 6, the results showed no statistically significant dependence on gender.

Table 6: Dependence of mean C-index values on gender of social work students (N = 168)

	Gender	
	Male	Female
Number of students	50	118
Mean C-index value	22.6	23.6
St. deviation	15.2	14.8

We were also interested in detecting a potential dependence of C-index values on type of religion. Table 7 shows C-score values (mean) according to subjects' information about their religion. It was found there is no significant dependence of C-index values on religion and C-score (p = .996).

Table 7: Dependence of mean C-index values on religion of social work students (N = 168)

	Religion denomination		
	Catholic	Protestant	None
Number of students	126	10	32
Mean C-index value	19.7	15.1	17.2
St. deviation	12.6	11.7	11.3

The C-index increased depending on age and the number of semesters studied. The influence of the other factors on the C-index was not statistically significant in the students of social work.

Discussion

Through our empirical research, we have come to some conclusions as to the moral judgment competence of Slovak students of social work.

There is significant dependence of the C-index (moral judgment competence) on age and number of semesters of study. The general tendency is that of students having a higher C-index with the increasing number of semesters of their study, and therefore it might be concluded that study of social work has played a very important role for the development of the students' moral judgment competence. The moral judgment competence in the Slovak social work students increased significantly during their studies (as they grew older). The increase shown in moral judgment competence during social work studies is caused mainly by the structure of the curriculum. There are a lot of discussions about ethical problems and moral dilemmas. The study offers many possibilities for taking up roles, which is the main requirement for the development of moral judgment competence. Similarly, Auvinen et al. (2004) found significantly higher moral judgment competence of nursing students in their final year compared with those in the first year of study. Felton and Parsons (1987) found that master's degree students reasoned at a higher level than bachelor's degree students. Also Duckett et al. (1997) reported significantly higher scores of moral judgment competence in students who had completed their bachelor's degree studies in nursing.

The opposite conclusion was reached by the above-mentioned research by Slováčková and Slováček (2007), according to which the level of moral competence in medical students decreased dramatically with increasing age. Their results could also be interpreted as follows: the level of moral judgment competence of the students who had attended few semesters of study was higher than that of those who were in the later stages of their course. Lind (2002) found a similar phenomenon – medical students begin their studies with a high level of moral judgment competence, but during the first two years its development stagnates or even regresses. This regression is replaced by a slow increase towards the end of their studies. Lind (2002) calls this "the ceiling or marginal effect". Later, however, when comparing psychology students and teachers, Lind (2008) found that the level of education had a major impact on the level of moral competence of individuals, and most students still had considerable moral character, and therefore are not in need of further influence in this sphere. In the study by Matarazzo and his collaborators (2008), however, neither gender nor age had a significant effect on the level of moral competence.

Similarly, no significant dependence of the C-index on gender was demonstrated in our study. According to our results, gender will not directly influence the level of moral judgment competence. On the contrary, Self et al. (1998) demonstrated a significant correlation between the moral judgment competence and gender: women scored more highly than men. Similarly, Price et al. (1998) found similar gender differences in their study.

Finally, no dependence of the moral judgment competence on religion was found. Similarly,

Schillinger and Lind (2003) strove to detect whether there is any potential correlation between religion and moral judgment competence. They found no significative difference between religion and C-index. This is an interesting finding primarily with respect to the Brazilian population. Adebayo (2007) investigated effects of religiosity and occupation on moral reasoning in a sample of Nigerian adults. His results showed that religiosity has significant effects on moral reasoning. This indicates that religious people differ from nonreligious in their moral reasoning thus corroborating some previous findings in the literature (e. g. Burwell, Cole, 1999). It also lends credence to theories of scholars that have attempted to link religiosity with morality (e.g. Fowler, 1981; Feenstra, 1991). These findings do not, however, support Lupu (2013) who reported that religiosity is not a reliable predictor of morality.

Despite these results, we are aware that their interpretation is not clear and an accurate assessment of the moral competence of social work students would require a longitudinal study.

Conclusion

As far as we know, our study is the first investigation into the moral competence of social work students in Slovakia. Since this is a cross-sectional study, it is not possible to assess the developmental trend of the monitored parameters and there are also some difficulties with the method of comparison with the results of international empirical studies, which are largely longitudinal in nature. The fact that the moral competence of social work students increases with the number of completed semesters can perhaps be interpreted as optimistic. In addition, considering the fact that the interpretation of the data is ambiguous, a more precise assessment of the moral responsibilities of students of social work would require a longitudinal research.

In the future research, participating students should be examined from the beginning of their studies and tested each year to observe their moral development.

Experience of teaching ethics and moral judgment test results indicates that Slovak social work students show medium levels of moral reasoning (medium C-index scores). Therefore, adequate methods should be sought for to develop moral reasoning in social work courses. Based on the results, interventions for the development of ethical argumentation will be incorporated in the educational plan for social work students.

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Endnotes

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Domestic Violence against Men in Partner Relationships – A Social Work Perspective

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Kristýna Pešáková[1] studied Social Policy and Social Work at the Faculty of Social Studies of Masaryk University. She continues her studies of social work at the same faculty as a doctoral student. She is focused long-term on the issue of domestic violence, both within the context of work in the nonprofit sector and academia.

Abstract
The objective of this text is to introduce the issue of domestic violence against men from the social work perspective. The author focuses on the question of, *How do adult men cope with a life situation when they become victims of violence in intimate partner relationships?* The concept of a life situation and ways of coping are described. The author consequently focuses on the situation of male victims of domestic violence and the role of gender in violence against men. In addition, the text summarizes psychological responses by men to violence and their coping strategies. The author also outlines the results of the existing research concerning the issue while focusing on the life situation of male victims. Finally, the text introduces possibilities for help which are available to male victims of violence from the social work perspective.

Keywords
life situation, coping, violence, domestic violence, victim, gender, intimate relationships

Introduction

The objective of this article is to introduce the issue of domestic violence against men. I focus on the question, *How do adult men cope with a life situation when they become victims of violence in intimate partner relationships?* First, one should define the terms involved, in particular, the following: life situation, victim of violence, domestic violence, violence against men, perpetrators (female perpetrators). Afterwards, based on a summary of the literature and research, I illustrate the life situation of men, the victims of violence. My work departs from the assumption that gender plays a significant role in domestic violence. In order to better understand the life situation in which male victims of violence find themselves, I introduce psychological responses by men to violence and the coping strategies described in literature along with the existing findings about violence against men known from literature and research. A knowledge of the life situation of the men who experience the violence is significant from the social work perspective. Thanks to a more detailed understanding of their life situation, the attitude of social workers towards men can be influenced and changed in order to minimize further victimization, if men are seeking help.

Men are a relatively hidden group in terms of domestic violence victims. They are invisible because our society, including the helping professionals, is reluctant to accept male vulnerability (Lenz in Heitmeyer, Schröttle, 2006). Men as victims of violence do not correspond to our deep-rooted notion of domestic violence which is often influenced by gender stereotypes, i.e., the ideas of male and female roles, their qualities and capabilities (see Renzetti, 2003). My previous research was also focused on gender stereotypes towards

male victims of violence (Pešáková, 2008). This research focused on social workers revealed that even when selected social workers did not perceive the male clients as strongly stereotyped, there were still certain stereotypes identified. These involved the tendency to see men of a productive age as more likely to be an aggressor than a victim, the tendency to imagine violence against men as primarily psychological violence (considering the important characteristic of men as the physically strong gender) and the tendency to perceive women as physically weak and unable to perpetrate physical violence against men (Pešáková, 2008: 57). The research also revealed an unpreparedness on the part of social workers to work with potential male clients in the role of a victim and an inadequate knowledge of the specific violence against men (ibid.).

Social work is a discipline which should be able to approach this neglected and unexplored topic from a complex perspective and thus discover the various levels of this serious issue which make assisting male victims of violence more difficult.

1 Life situation and coping with it

Experiencing violence from a life partner is an extremely difficult life situation for men. The concept of life situations and strategies for coping from the point of social work have been extensively described in the work of Bartlett (1970). She discusses the former within the wider concept of social functioning, which she conceives as interactions taking place between environmental demands and human beings (Navrátil, 2001). According to Bartlett, coping involves efforts on the part of human beings to deal with the life situations they encounter, which they experience as pressures from the social environment. The environmental demands and human coping are found in mutual interaction (Navrátil, 2001). As Navrátil explains (2001), this concept includes the social context in which the person is involved:

"At the core of the entire concept, is this notion that human beings and their environment are in permanent interaction, while the environment lays certain demands and the person has to respond to them. The *'environmental demands' (emphasis and parentheses by the author)* and the person have to be brought into balance. In those cases when people cannot cope with the demands of their environment, the social worker provides assistance." (Navrátil, 2001:12)

Navrátil (2001) also understands the concept of the life situation within the context of social functioning. In his view, each person is an individual and thus life situation thus represents a specific, individual configuration. John F. Longres is another author who works with the term of social functioning. He also understands social functioning as the ability to cope with the role expectations related to a person's status and role (in Navrátil, 2001). This becomes particularly useful when we look at how men cope with the life situations in which they become victims of violence from their partners or wives. This is to say that this role is extremely unusual for men in our society and culture. Firstly, the very role of a man as a victim, and secondly, the role of a man experiencing violence from a woman. Each of these is viewed as an explicit antidote to the societal perceptions of the "traditional" or "correct" role of an adult man. A man is generally pictured in the role of a protector (e.g. against violence), and the corresponding characteristics include physical fitness, or even aggressiveness.

2 The life situation of male victims of violence

The life situations of male victims of domestic violence are described in stories recorded in the U.S.A, Germany, Austria, but also in the Czech Republic. The literature and research reveal that men suffer from various forms of violence: psychological violence (reproach, name-calling), physical violence (throwing of things, slapping, hitting the groin, use of a knife…), waking up to or violence during sleep, or extreme control (see e.g. Cook, 1997, Čírtková, 2011, Fasurová, 2011, Lenz in Heitmeyer, Schröttle, 2006). Men in these stories can be characterized by strong ties to children and not being aware of the violence. The impact on men's health, both physical and psychological, has been described. Many of these men had been exposed to violence in childhood.

2. 1 The role of gender in intimate partner violence

Gender, in the present author's view, plays an important role in partner violence. I do not build upon feminist theories, however, which

perceive domestic violence as violence caused by inequalities between men and women. The shared scheme in these theories is that man is the perpetrator and woman is the perpetrator's victim (see e.g. Voňková, Spoustová, 2008). As Střílková and Fryšták (2009) have stated, this approach is discriminatory against male victims[2]. I therefore lean more towards criminal theories of domestic violence (e.g. Voňková, Spoustová, 2008) whereupon *anyone* can become a victim regardless of sex. Or, in the case of intimate partner violence, regardless of sex *and* type of partnership, or even sexual orientation.

The imbalance of power between men and women in our society and still prevailing ideas of "correct" male and female roles and their qualities and capabilities result in unequal opportunities not only for women but also for men in many fields. Due to these prevailing gender stereotypes in our society, men seem inappropriate as victims. Masculinity and femininity continue to be seen as traditional opposites with there being different expectations for men and women (Vágnerová, 2007). Men tend to be perceived as perpetrators rather than victims of violence. They are viewed as possessing physical strength and consequently people think that they are able to defend themselves easily against violence. Since domestic violence against men perpetrated by women is (due to stereotypes) perceived as something non-existent or extremely rare, I focus to a greater extent on violence against men in heterosexual relationships[3].

Čírtková (2011) speaks of a loss of masculine identity for a man who becomes a victim of violence. In relation to changes in the status of men and women over recent years, she suggests the hypothesis that the loss of male identity need not be a consequence, but instead a starting point for domestic violence.

Men are consequently confronted with numerous barriers which are related to expectations by their environment or to coping with their own vulnerability.

2. 2 Male response to violence: psychological responses and strategies for coping with violence described in literature

Problematic life situations of male victims of violence can be better understood by describing the psychological responses of men to violence. The following examples have been listed in the relevant literature and research:

- emotional deprivation (Follingstad et al in Kashobera Crawford, 2006)
- low self-esteem (Fasurová, 2011, Tutty in Kashobera Crawford, 2006)
- fear of partner's aggression (Tutty in Kashobera Crawford, 2006)
- shame (ibid.)
- psychological violence is perceived as worse than physical violence (the worst is humiliation of a man in front of another man) (ibid.)
- silence and denial (Buriánek, 2006)
- social isolation (Stitt and Macklin in Kashobera Crawford, 2006)
- worries about children (Gemünden, Habermehl, in Cizek et al., 2002)
- accepting the role of a weak one (Stitt and Macklin in Kashobera Crawford, 2006)
- physical superiority, yet emotional dependency (Lenz in Heitmeyer, Schröttle, 2006)
- non-retaliation (Stets and Straus, 1990, in Cizek et al., 2002).

The Austrian report on violence (Cizek et al., 2002) revealed strategies of men in coping with violence. According to the report, men choose the strategy of "drawing consequences", e.g. rejection or break-up less often than women. They also mobilize resources and seek help from third parties less often. According to the report, the most frequent strategy for men is so-called normalization, i.e., adapting to the violent situation, its justification or minimization.

3 Domestic violence and violence against men

Domestic violence against men is a relatively new topic in terms of the available literature and research. There are numerous theoretical approaches and definitions of domestic violence as such. Domestic violence is often defined in the relevant Czech literature in relation to women as victims of violence. By domestic violence, they mean violence between partners, i.e., intimate partner violence, partner abuse (in contrast to wider definitions of domestic violence as violence within the family, including inter-generational violence, defined for example in Huňková, Voňková, 2004). Domestic violence here means violence

behind closed doors, repeated, long-term and escalating, with a clear role division and power imbalance, characterized by fear on the part of the victim and the one-sidedness of the violent acts. This definition reveals that there is a frequent tendency not to see violence against men as domestic violence.

Information concerning violence against men has been available in academic literature as far back as the 1970s, particularly in the U.S.A. Research dealing with this issue began to appear in the U.S.A and in other countries. These research studies are often problematic, in my opinion, since different concepts were used (domestic violence, violence, partner violence), different methodologies applied, the research samples were not representative and the results varied a great deal.

An American research study carried out by Gelles (in Cizek et al., 2002) showed that men most often suffer from throwing things, kicking, stomping, or beating with an object. Later on Gelles along with Straus and Steinmetz (Straus, Gelles, Steinmetz, in Cizek et al., 2002) came up with the first representative study about all forms of violence in the family. They came to the conclusion that 11.6% of women used violence against their partners during the year when the interviews were conducted. Steinmetz was the first researcher to use the term "Battered Husband Syndrome" in 1977 (Steinmetz in Cizek et al., 2002) which has been previously known only as the battered wife syndrome. Szinovacz (in Cizek et al., 2002) revealed that men do not talk about atypical forms of violence (for them) and do not report all acts of violence because they do not consider them serious enough.

In Germany, Habermehl (in Cizek et al., 2002) discovered that it was women as opposed to men who would more often minimize the violence that they perpetrate. Employed women, according to Habermehl, behave more violently than unemployed (ibid.). A pilot study focusing on violence against man entitled Gewalt gegen Männer (Jungnitz et al., 2004) summarizes the information about the forms of violence that men in Germany often suffer from:

- physical violence (every fourth man has experienced it at least once or more often, including lighter forms, such as slapping, biting, stomping, throwing things),
- psychological violence (more frequent in general; social control), sexual violence (scruples, shame, enforcing sexual needs, coercion to have sex).

This research has also identified that the assistance services for male victims of violence are insufficient.

Only one study focused on male victims of violence has been carried out in the Czech Republic (Buriánek et al., 2006). Information about male victims of violence can also, however, be found in statistics concerning restraining orders against perpetrators, or in the registers and client lists of NGOS and intervention centres.

3. 1 The victim and the perpetrator

A typical trait of domestic violence lies in the clear division between the perpetrator and the victim. The victim is the person who is endangered by the perpetrator, which victimology views as the imminent danger of criminal offense. Hamrlová (2008) speaks about the double stigmatization of male victims, being first, stigmatized by stereotypes about domestic violence as such (e.g. that violence which only occurs in problematic families), and second, by gender stereotypes (e.g. that a man would defend himself and not allow violence to happen). A specific problem of a male victim lies in the fact that they would not see themselves as victims and would suffer from feelings of shame.

The perpetrator is characterized by an effort to control his/her partner. A question often discussed in connection with violence against men is whether women only perpetrate violence in self-defense. Čírtková (2011) opposes this view. In her view, women are motivated to act violently against their partners by their desire to express emotions; bring their partner to his knees; draw attention; gain control and authority, or avenge prior offenses. According to Čírtková (2011), only 5-15% of aggressive female acts can be explained by self-defense, while 50% are related to anger or a desire to dominate, suppress the partner. Čírtková (2011) also comments on growing aggressiveness among girls, and thus a possible increase in violence committed by women against men.

4 Helping male victims of domestic violence

If social workers want to help male victims of violence in their difficult life situations, they need to be aware of the fact that help is currently hindered by various barriers. As far as the social environment is concerned, the issue of violence against men remains relatively hidden. Many people, including helping professionals, are not able to accept male vulnerability. This is related to the common perception of male roles and abilities, which, as Janebová (2006) notes, is currently not reflected in the work of social workers. Janebová states that Czech social work only rarely reflects gender aspects.

If a social worker is in contact with a male victim of domestic violence, they should be wary of general assumptions concerning male and female roles burdened by gender stereotypes. They should take into account the fact that even men can suffer from various forms of sexual violence.

Moreover, violence and its tolerance are part of male socialization. Additional stereotypes about violence against men, such as that thanks to their strength men cannot become victims of violence, also play an important role here. If violence occurs, a man should leave and if he does not and suffers from violence, he must be a weakling, or that violence committed by a woman against a man is only self-defense (Buriánek, 2006).

These barriers are also found in the psychological sphere. Male perception of their victimization is weak, and they do not seek help, as seeking help is viewed as weakness. Fasurová (2011), a psychologist, as well as Čírtková (2011), assume from their practice that male victims suffer from the same feelings of shame and fear of being exposed to the public. Within the context of this statement it seems reasonable (when working with male victims of domestic violence) to introduce men to the issue of domestic/partner violence, its course and forms, and also to the fact that man can also become victims of this type of violence. There is also a need to assure these men that none of the information shared with the social worker will be shared with anyone else (this being the basic rule amongst helping professionals).

Finally, there are barriers in terms of access to services: specialized services dealing with male victims are nonexistent, there are no support groups or asylums for men who have experienced violence (unlike those that we know of from abroad). It is therefore somewhat problematic to offer men a place or a person to turn to.

Effective help for a man, a victim of violence, entails having a knowledge of the issue of domestic violence and approaching the victim without prejudice. Men are specific victims, they have a strong feeling that they can deal with the violence and are afraid of ridicule.

The following recommendations, based on Cook (1997), an American author, may serve as inspiration for working with clients, victims of partner violence:

- Identifying violence, according to Cook, male victims often do not view the violence against them as serious enough and think that they can cope with it. Cook (1997) states that it is important to help these men as they cannot cope by themselves, and that it is important to identify violence early. Various behavioral patterns can serve as early signals, for example: accepting a violent activity and rewarding a female partner afterwards in order to calm her down; a violent reaction to a female partner's attack or other passive-aggressive reactions, such as feigning illness or forgetfulness; avoiding contact with friends, family or people not favored by the female partner in order to prevent her attacks; becoming introverted, trying to avoid eye contact with the partner, spending time in places where the partner is not present (e.g. garage, study room); or making up excuses for not coming home. As Cook (1997) notes, a violent relationship can also be identified by male victims and helping professionals based on the female perpetrator's behavior, such as: obstructing an exit from a room; reading personal e-mails; preventing the man from meeting his friends and family; insulting the partner in front of other people; telling him that no one else would be interested in him; threatening the male partner with suicide if he leaves the relationship; interrupting the male partner's sleep even though the female partner knows he has to get up early; viewing the male partner as absolutely incapable; being submissive in public but dominant in

private; being angry with the male partner's insufficient manliness, etc.
- Identifying physical violence, and if the signs are present, motivate the man to seek treatment and have the injuries documented;
- Getting to know the personal and family history of both partners; much of the Czech as well as foreign research states that people from families where violence between parents was present are more prone to becoming a victim or a perpetrator of violence themselves;
- Working with the man's efforts to be strong and cope with the situation. Cook (1997) warns that trying to be "man enough" can be very dangerous for these men. He argues that it causes men to not seek help because they consider it a weakness (ibid.). Cook (1997) therefore recommends trying to overcome this barrier by comparing the situation to a situation at the workplace, where, if conflict arises, one can ask a consultant for their opinion. This person can consequently help the affected people continue working without obstacles.

Conclusion

In this article I focused on how adult men cope with the life situation when they become victims of violence from their partner. This text introduced the concepts of the life situation and coping with it. It summarized the developments in the topic of violence against men in literature and research (primarily from abroad), and attempted to describe the violence against men, its form and male responses to it. In conclusion, the possibilities for effective help and its obstacles were discussed.

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Endnotes

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2 Feminist theories of domestic violence are, however, also discriminatory towards other groups of victims of domestic violence (children, siblings, grandparents, etc.), even though these, are also part of the domestic violence phenomena (Střílková, Fryšták, 2009).

3 Men become victims, however, in other situations. For example, they make up the majority of crime victims (but also the majority of the criminals) (ČSÚ, 2012), and they are often victimized in spaces outside of the family (e.g. the army or prisons). They can also become victims of domestic violence in other roles, such as in the role of a parent, senior, sibling or male child, or within a gay partnership. This article is focused on *domestic* violence, specifically on violence within heterosexual relationships, because this type of violence debunks myths and stereotypes about men and women and transcends the image of domestic violence presented to us by most Czech, but also foreign, academic literature.

Social Workers in Schools[1]

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Abstract
A school counselling system began to develop in the 1970s. Since that time, however, the student population along with the public order have changed. There has been an increase in the number of pupils from a socially disadvantaged environment, from families with a variety of problems in social interactions and pupils with behavioural disorders. The social problems of pupils negatively affect their school results. Pedagogical and psychological interventions do not respond to all the needs of pupils and their families. The purpose of this paper is to report on the results of the research.
The basic research questions answered in paper are as follows: (1) Which areas of problems are considered the domain of social workers by the representative of individual professions? (2) Which competences would the representative of individual professions share with social workers? The results of the research indicate the growth potential of school social work which is discussed in a more detailed way in the conclusions of the paper.

Keywords
social work, social worker, school, social disadvantage, pupil, institutionalization

Introduction

The opening part of the present article explains the theoretical basis of the research, while the following part presents selected findings of the research. The cognitive goal of the article is to answer the question as to whether the selected groups of professionals recognise the existence of specific problems of pupils in the school environment, namely those problems which should be managed and addressed by a social worker. The application goal of the article is to initiate and stimulate discussion on possible preparation of conditions for proper institutionalisation of school social work in post-modern Czech society.
An analysis of the relevant Czech legislation in the area of the education system demonstrates that there are no legislative prerequisites for establishing the position of a school social worker. There are no institutions in the tertiary education system in the Czech Republic at present which would prepare and train social workers for being a specialist in the school environment. Although there are social

workers employed in the school sector, their job description consists of administration rather than assistance provided in a professional manner. It can be concluded that the profession of school social worker is unrecognised in this system.

There are several reasons for the current state which appear unsatisfactory from the perspective of social work. One of them is the fact that the counselling system at schools was established in the 1970s. Social work at the time, due to ideology, was no longer institutionalised as a profession in the Czech society. The counselling system was consequently created as a space for providing services of the specialised pedagogical and psychological profession.

Theoretical background

This article provides partial findings in the search for an answer to the following research question: "Are the conditions for establishing the position of school social worker met in the Czech education system?" Theoretical background for this research is formed by the theory of post-modern institutionalisation of social work. Libor Musil (2008, 2012) has dealt with the issues of identity and institutionalisation of social work on a long-term basis. In his most recent articles (e.g. 2012), he discusses the differences in institutionalisation processes in the modern and post-modern age. He draws on the characteristics of the modern and post-modern age as defined in sociology. The modern age, which gave rise to social work as a profession and a science, is characterised, for example, by the so-called grand theories (projects) and trust in the possibilities of expert professions. The post-modern age, characterised by uncertainty, fragmentation and relativism, requires new methods of profession institutionalisation, Musil suggests (cf. Musil, 2012). What are the conditions for institutionalisation of social work? Applying Musil's definition of conditions for institutionalisation, representatives of the professions which have already been established within education should be able to identify those specific problems which need to be managed and addressed by the social worker and admit that they need to be addressed using social work methods. Other conditions include the fulfilment of expectations held by society and potential clients, i.e. that school social workers will provide assistance to those who are confronted with specific problems.

Since the position of school social worker has not been established in the Czech education system and its environment, one inevitably needs to obtain some evidence from the research in order to know whether the conditions for post-modern institutionalisation are, at least partially, being fulfilled.

Methodology

The goal of the research mapping the opinions of pedagogues, counsellors and social workers concerning the possibilities and barriers of establishing a hitherto non-existent position of school social worker, was to obtain the initial data, the first research evidence. A quantitative methodology was used. Data collection was carried out by the students involved in the research. The specifically designed questionnaire was tested at the pre-research stage. It comprised 21 questions (of which 7 pertains to identification). The individual questions were formulated as closed. They were focused on 6 areas: the roles of social workers in school; managing those problems which should also involve school social workers; activities of social workers in school, the performance of which should increase the success rate of pupils in school; target groups which the social worker should cooperate with; obstacles and conditions for establishing the position of a school social worker.

The findings answering the following research questions are presented in the paper:

- Which areas of problems are considered the domain of social workers by the representatives of individual professions?
- Which competences would the representative of individual professions share with social workers?

The examined group was comprised of 648 respondents professionally active in the school sector throughout the Liberec Region and the Ústí nad Labem Region, willing to participate and be involved in the research. As concerns the statistics of the school sector, the Liberec Region and the Ústí nad Labem Region rank among those with the highest degree of exposure to social exclusion among pupils.

The proportionality of the professions involved in the research corresponds with the practice. 70% of the respondents were pedagogues (including teachers, special pedagogues, prevention tutors, school counsellors, head teachers and other representatives of schools). 16% of the respondents were counsellors working at the counselling offices and 14% were social workers.

Pupils from a socially disadvantaged environment in Czech primary schools

What specific problems do social workers have to manage and address in schools? The problem identification is based on the current discourse of academics and pedagogues, as presented in the specialised literature and statistics issued by the Ministry of Education, Youth and Sports. A social worker is an expert in the social environment, he/she contributes to the promotion of social justice and enforcement of children's rights. Through his/her activity, he/she helps achieve proper social functioning, solving life situations and hurdles in interpersonal relations (interactions).

With reference to this brief definition of the mission and job description of social work, another partial topic, currently under discussion concerning the Czech school and education system, is that of interpersonal relations and interactions. The discussion covers such topics as the atmosphere in schools, particularly between teachers, pupils and parents. In general, the identified problems include a lack of discipline amongst a certain number of pupils connected with a lax attitude to parenting, which is primarily caused by the existence and proportion of single-parent families and family dysfunctions (Čáp, Mareš, 2001; Matějček, 2002; Matoušek, Kroftová, 2003; Marková, 2007; Lazarová et al., 2011). The discussion within this context also covers the occurrence of risk phenomena in school. Another subject of discussion is the demonstrable increase in education-related, social and health problems in pupils and their families which is also confirmed by the research results (e.g. Broulíková, Kuchařová, 2002; Pešatová, 2007; ČŠI, 2013: 65). Major topics also include: issues related to leisure time, communication in the school environment, management of difficult life situations of pupils and their families, as well as issues concerning poverty and social exclusion.

"Children and youth in all types of schools encounter problematic, anxious, difficult and demanding, distressing, psycho-traumatic, frustrating (i.e. interfering with the adequate satisfaction of one's needs, interests, goals), depriving (leading to destitution) and conflict situations, processes and states which may impact their health (i.e. physical, mental and social comfort)" (Kohoutek, 2012).

Although the current statistics of the Czech Ministry of Education reveal that the average percentage of pupils from a socially disadvantaged environment is only 0.8 (ČŠI, 2013: 32), they also mention a persisting problem with economic provision of welfare benefits for pupils suffering from a social disadvantage. The aforementioned statistics indicate that the highest proportion of pupils with special education needs was seen in the school year 2011/2012 (ČŠI, 2013: 32) in the Ústí nad Labem Region – 22% as compared with the nationwide average of 12.5%.

The failure rate of pupils, evaluated on the basis of the number of pupils who need to repeat a class, is an important question. The ČŠI annual report (2013: 38), for example, implies that the Liberec and Ústí nad Labem Regions, which rank amongst those regions with the highest number of socially excluded communities, take the lowest places in the evaluation of the first nationwide general examination.

Teachers often mention the following among the major causes of such failures and poor records on the part of pupils (ČŠI, 2013: 40): a less stimulating family background (52%), difficulty with focusing attention (41.1%), intellectual immaturity (32.5%), dependence and insufficient work habits (25.9%).

Identification of a specific problem of school social work

Respondents were offered a list of eleven problems identified on the basis of the previous analysis of the academic and pedagogic discourse. They were asked to fill in their opinion on each problem, namely whether they consider it appropriate to involve the school social workers in the solution thereof (Table 1).

Table 1: Pupils from a socially disadvantaged environment in Czech primary schools

Problem		YES						NO					
		pedagogues/%		counsellors/%		social workers/%		pedagogues/%		counsellors/%		social workers/%	
1	developmental disorders	107	16.85	23	3.62	14	2.20	**338**	53.23	**80**	12.60	**73**	11.50
2	neurotic problems	129	20.25	19	2.98	20	3.14	**319**	50.08	**83**	13.03	**67**	10.52
3	learning difficulties	139	21.72	23	3.59	27	4.22	**312**	48.75	**79**	12.34	**60**	9.38
4	problems with learning resulting from a different language and cultural environment of the pupil	**320**	50.31	**64**	10.06	**64**	10.06	129	20.28	37	5.82	22	3.46
5	problems with learning resulting from socially disadvantaged environment of the pupil's family	**396**	61.97	**83**	12.99	**74**	11.58	54	8.45	19	2.97	13	2.03
6	irregular school attendance, repeated lateness, truancy	**407**	63.40	**93**	14.49	**79**	12.31	45	7.01	10	1.56	8	1.25
7	behavioural disorders	**239**	37.34	**60**	9.38	**45**	7.03	210	32.81	44	6.88	42	6.56
8	problematic behaviour of pupils towards authorities	**271**	42.34	**73**	11.41	**52**	8.13	179	27.97	30	4.69	35	5.47
9	disputes and quarrels among pupils	186	29.38	48	7.58	**51**	8.06	**257**	40.60	**56**	8.85	35	5.53
10	bullying, cyberbullying	**286**	45.11	**76**	11.99	**51**	8.04	158	24.92	27	4.26	36	5.68
11	creating a healthy social climate in school	**293**	45.64%	**82**	12.77	**63**	9.81	158	24.61	22	3.43	24	3.74
Prevailing response for each sub-group is in **bold typeface**.													
Absolute numbers express the number of valid votes.													
Relative numbers are given in lines.													

It is evident that the majority of respondents (irrespective of their profession) believe that developmental disorders, neurotic problems and learning difficulties should not be addressed by school social workers. On the other hand, problems with learning resulting from a different language and cultural environment of the pupil, irregular attendance, truancy, behavioural disorders, bullying or creating a healthy social climate in school are seen by the respondents as problems the solution of which requires involvement of school social workers.

Identification of a specific method for a problematic solution

In the opening part, the article pointed out the issue of the success rate of pupils in school. The research examined whether the respondents think that a school social worker (if acquainted with the indicated responsibilities) would contribute to an increase in the school success rate. The respondents were provided with thirteen activities which correspond to the basic activities of social workers, as determined e.g. by the applicable legislation in the field of social services and social-legal protection of children and youth in the Czech Republic. All these activities are viewed as helpful for improving the success rate of pupils in schools by the respondents from all three professions (i.e. pedagogues, counsellors and social workers). These activities include: early diagnosis of the pupil's exposure to danger, searching (depistage), crisis intervention, remedial activity, social counselling, creating equal opportunities, working with parents, school and family mediation, collaboration with selected institutions in dealing with individual cases, acquisition of resources, communication with media and other organisations (Table 2).

It is clearly visible that there is a general positive attitude on the part of professionals involved in the present school education system (pedagogues including teachers, special pedagogues, prevention tutors, school counsellors, principals and other representatives of schools, counsellors at the counselling offices, social workers) to the possible introduction of the school social worker position. The respondents confirmed that the above listed and questioned areas of responsibilities would be suitable for a specific new position, a school social worker.

Discussion

Intense debate is currently taking place about identity and the need for legislation for Czech social work (Kodymová, Suda, Musil, 2012). In particular, issues concerning the definition of social work are being discussed. Social workers from various "sectors" of social work, particularly from public administration and academia are becoming involved in the discussion. The challenge for the participants in the ongoing discussion is to respect the particularities of each "branch" of social work along with a demand to clarify the definition of the essentials of social work suitable for the legal norm. Simultaneously, a reform of the system for children's protection and care for vulnerable children is taking place. The Action Plan for The Fulfilment of The National Strategy to Protect Children's Rights is a crucial document. Its aim is to create complete protection of the rights of every child and a system supporting the enhancement of the quality of life for children and families.

There are no results as yet, however, concerning a representative survey concerning the views of teachers, psychologists and social workers on the need for the establishment of a position for social workers in school. The research presented in this paper cannot be considered statistically representative, although it does provide information about the opinions of teachers, special education teachers, school psychologists and social workers (employees of the department of social and legal protection) in two regions of the Czech Republic. The presented results indicate the potential development of social work at schools. The respondents declared that they consider social workers competent to participate in solving problems by employing social work methods, particularly when dealing with pupils from socially disadvantaged backgrounds. The findings of the research can be used in further discussion concerning the need for development of social work at schools, about the specifics of social work at schools and also about the current state of cooperation between the Ministries of Labour, Social Affairs and Education in the field of children's rights and their needs.

The current foreign literature of Anglo-Saxon provenance is more focused on the issue of evaluation of school social work programs as opposed to the issues of its establishment as a specialized field of social work (Speck, 2009). This is due to the fact that school social work already has a long tradition in the majority of English speaking countries. The presented research can be used as a model study in countries with a similar situation with regard to the development of social work. The research,

Table 2: Identification of the specific method for the problem solution

Activities		YES						NO					
		pedagogues/%		counsellors/%		social workers/%		pedagogues/%		counsellors/%		social workers/%	
1	early diagnosis of the pupil's exposure to danger	**359**	56.36	**91**	14.29	**74**	11.62	90	14.13	10	1.57	13	2.04
2	searching activity with a view to finding pupils in material and social distress	**343**	53.85	**88**	13.81	**71**	11.15	104	16.33	15	2.35	16	2.51
3	crisis intervention	**338**	53.74	**84**	13.35	**74**	11.76	103	16.38	17	2.70	13	2.07
4	remedial activity which incorporates all the measures which are necessary for achieving a positive change in the pupil's behaviour with a view to relieving material or social distress	**373**	58.28	**84**	13.13	**70**	10.94	77	12.03	19	2.97	17	2.66
5	social counselling aimed at identification of the severity and nature of the material or social distress	**397**	62.32	**84**	13.19	**73**	11.46	52	8.16	18	2.83	13	2.04
6	social counselling aimed at recommending professional counselling services to parents and pupils by specialised institutions	**396**	61.78	**98**	15.29	**76**	11.86	54	8.42	6	0.94	11	1.72
7	creating equal opportunities in education for pupils from socially excluded groups	**323**	51.03	**81**	12.80	**62**	9.79	120	18.96	22	3.48	25	3.95
8	work with the parents of pupils, using social work methods combined with adult education methods	**339**	53.22	**86**	13.50	**65**	10.20	108	16.95	17	2.67	22	3.45
9	school and family mediation	**293**	46.81	**83**	13.26	**51**	8.15	146	23.32	17	2.72	36	5.75
10	collaboration with selected institutions in dealing with individual cases	**388**	60.91	**98**	15.38	**79**	12.40	58	9.11	6	0.94	8	1.26
11	support in creating a multicultural school environment	**319**	50.55	**83**	13.15	**69**	10.94	123	19.49	19	3.01	18	2.85
12	acquiring the resources, e.g. through projects or media coverage	**267**	42.05	**64**	10.08	**50**	7.87	179	28.19	38	5.98	37	5.83
13	communication with media and other organisations in the area of social work, as delegated by the founder	**262**	41.32	**65**	10.25	**52**	8.20	183	28.86	37	5.84	35	5.52
The prevailing response for each sub-group is in **bold typeface**.													
The absolute numbers express the number of valid votes. The relative numbers are given in the lines.													

carried out using the same methodology was also carried out in the Slovak Republic (Skyba, 2013)

Conclusions

Generally speaking, the strategic goal of the education policy in the Czech Republic is the development of an inclusive education system. The issues concerning conceptions of integration and inclusion of pupils with special education needs and those from socially disadvantaged environment form the core topic of the current discourse.

The premise of the research, i.e. that teachers do not consider themselves competent in managing the problems of pupils with social disadvantages, and would thereby welcome collaboration with social workers in tackling this social problem and dealing with cases of failures in school, has been confirmed. In the process of data collection, it was demonstrated that many respondents do not precisely know what the profession of social work can offer, although in the questionnaires they admit they would appreciate the assistance of social workers. The most critical obstacle in establishing the new position of social worker is seen in the lack of legislation and insufficient financial resources in the sector of the school system.

Social workers have virtually stood aside from the current expert and political discourse on reforms in education, prevention and solution of pupils' problems in spite of the fact that an essential portion of their clients comprise families with children from a socially disadvantaged environment and, in many cases, families with children with special education needs.

The institutionalisation process should encompass pressure on the part of social workers. The process assumes sufficient evidence in the form of research results. The part of the research results, presented herein, obtained in two regions of the Czech Republic, demonstrates that the requirement for the recognition of the existence of specific problem to be managed and addressed by social workers, and for recognition of the existence of specific social work methods used for a solution to these problems might have been fulfilled. It would seem that the school success rate of pupils from a socially disadvantaged environment is a specific problem which should be examined in the near future. In order to obtain a more comprehensive view, representative quantitative research, completed with a qualitative examination, needs to be carried out.

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Endnotes

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