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Editorial

New Ways of Thinking About and Doing Social Work in Health Care

This special edition seeks to generate discussion on the topic of health related social work and more specifically, to re-examine the practice, education and research implications in response to the global changes in the provision of health care. Social work is a well-established interdisciplinary and transnational health profession, which has contributed to the development of effective interventions, new technologies and measurable outcomes in health and well-being. An historical perspective reminds us that the development of professional social work had its origins in hospital or medical social work. During the early 1900s the Royal Free Hospital and St Thomas Hospital, United Kingdom, J. J. Hospital Bombay, India, Adelaide Hospital, Republic of Ireland and the Massachusetts General Hospital, USA were some of the first institutions to employ designated medical social workers. Hospital or medical social work can confidently claim to be a sub-field of social work, offering expertise in interdisciplinary practice, holistic care and assessment and most importantly, evidence informed or based practice (Epstein, 2011).

The articles published in this edition demonstrate that social work in health has undergone far reaching changes since these historical beginnings, primarily in response to increasing globalisation and technological advances in the provision of health services. Whilst social work practice in health is firmly located in national health care settings it enjoys an international status, i.e. conferences,

specialist journals and publications. Readers are reminded that the 9th International Conference on Social Work in Health and Mental Health will be held in York, United Kingdom in 2019. Shamila Sivakumaran's review of Melissa Petrakis and Carrie Lethborg's recently published edited book on Social Work Practice in Health: An Introduction to Contexts, Theories and Skills (Petrakis, Lethborg, 2018) is also evidence that despite the diversity found in health settings throughout the world, social workers share a great deal in common and have the capacity to learn from each other.

The concept of health adopted by most social workers is that of the World Health Organisation (WHO, 1948), and is defined as the "state of complete physical, mental, and social well-being, and not merely the absence

of disease or infirmity". There are three key dimensions contained within this definition that are intuitively attractive to social workers. Firstly, the inherent claim is that an individual is not healthy unless they also experience complete well-being. Secondly, the WHO definition places emphasis on the individual's subjective experience of health, acknowledging levels of importance placed on particular physical and social conditions by different individuals. Thirdly, the definition recognises the observable relationship between the total environmental context of the individual and their physical well-being. Repeatedly, research demonstrates that the treatment of disease and disability has less overall impact on the morbidity and mortality levels of populations than general improvements in social and environmental conditions. Wilkinson and Marmott (2003) contributed to an understanding of the critical relationship between the social gradient and health. Life expectancy is shorter, and most diseases are more common further down the socio-economic ladder in each society, and therefore health practice and policy must address the social determinants of health to achieve equality and social justice for all. The association between social inequalities and health inequalities therefore provide a critical and ongoing rationale for the basis of social work interventions in health settings.

There are of course criticisms of any conceptualisation of health, of which social workers are aware. The status of well-being, a concept so intrinsically linked to health is difficult to define and measure, and consequently is under emphasised in health policy and services. The fields of well-being and social quality offer new frontiers for social work research. Notions of health and well-being also involve environmental, spiritual and cultural concerns, particularly for indigenous and minority communities, which as social workers we acknowledge as critical if further inequality and oppression is to be avoided. A more dynamic definition of health should also consider promoting capacity or the ability to self-adapt and self-manage (Huber et al., 2011). Cameron and McDermott (2007) promote a broad view of health (inclusive of

environmental, economic and geographical challenges) along with 'middle-distance' and 'close-up views' of health and well-being. Whilst a wide-lens approach is advocated by the IFSW Policy Statement on Health (IFSW, 2008) for addressing social inequalities. Combining both narrow lenses (local) and a wide-lens (global) approach within social work education would ensure social workers students and practitioners understand the dynamic interrelationship between local needs and contexts and global issues, trends and pressures and in so doing apply a concept of global mindedness to their daily practice (Anand, Das, 2018).

This collection of articles reflects a comprehensive and international understanding of health and well-being and acknowledges the changes and new frontiers in global health care. However, both challenges and opportunities exist for social work in addressing health equality and social justice at a local and global scale. Tensions exist between competing economic, medical, and social and human rights agendas, which have pushed practitioners, educators, academics and students of social work to consider new ways of thinking about and doing health related practice. For example, the social gradient is more evident, even within western countries, resulting in major human rights issues for the marginalised and oppressed. The health and well-being of the large number of people on the move is of concern to international and national aid organisations and host countries. In Finland, for example, a recently completed study on the quality of life of recent Middle Eastern refugees outlines the implications for health and social care services (Anand et al., 2017). Across a number of European nation states, major economic and organisational health reforms are underway, involving cutbacks to the welfare state, the integration of health and social care and the commercialisation of health and welfare. Advances in technology and robotics have resulted in new methods of providing, promoting and managing care. The increasing empowerment of health care consumers has resulted in a demand for greater choice and more personalised and participatory services. Paradoxically, whilst the profession enjoys a long history in health and the need for

social interventions to address social inequity increases, the relevance of social work in health care setting is frequently questioned given the current competitive environment.

Since the 1980s, most western countries have experienced pressures to reduce public health spending, and medical social workers in countries such as Canada and Finland complain of working harder and reporting lower job satisfaction (Heinonen et al., 2001). These experiences reflect broader neoliberal pressures facing the welfare state, of which the health care sector is an integral part (Pockett, Beddoe, 2017). Hospital funding cutbacks, trends toward generic or interdisciplinary health practice and the decentralisation of social work departments all represents potential threats to the role of social work in the health care sector. Maria Pentaraki's article on *Social Work Practice of Hospital Social Workers under the Structural Adjustment Program in Greece* describes the effects of the Structural Adjustment Program (SAP) and its resultant social spending cuts and austerity measures on social work practice in Greek public hospitals. Underfunding and understaffing has resulted in social workers intensifying their professional efforts by becoming increasingly engaged in more informal contacts and resources, to respond to the needs of service users. Despite austerity measures, a strong theme of resistance has emerged; with social workers, actively questioning assumptions that health care is a commodity and not a right. The importance of attributes such as resistance and a critical perspective should not be understated in social work education and practice.

Understanding the social determinants of health and well-being is a central theme in social work education. UK authors, Linda Homan and Emma Regan explore the nature of addiction from a systems approach in an article on *Young People's Perceptions of Smoking Behaviours.* This article explores how young people construct the need to smoke and in so doing reveals the different layers of social, political, family, community and friendship structures that influence young people's worldview. The application of an ecosystems perspective facilitates a critical shift from an introspective view of health problems to a more macro understanding of the socio-cultural and economic factors that determine individual behaviour. The implications for critical policy and practice in challenging, accepted oppressive discourses and empowering young people to look at alternative ways to tackle problems are mentioned. Furthermore, in the article on *Health, Wellbeing and Social Support in the Groups of Employed and Unemployed in a Finnish Community* Timo Toikko, Yerkin Kulymbaevitch Uisimbayev and Pehkonen Aini highlight the effect of labour market status on self-rated health and subjective well-being. Unemployed people with a low health status had a much lower rating with respect to subjective well-being compared to employed people with a similar low-rated health situation. These findings suggest that disadvantaged unemployed people should be been offered intensive services to promote their well-being and reduce health inequalities. Not only does this study demonstrates the effectiveness of quantitative evidence in identifying social, economic and health pressure points but suggests the need for structural reform promoting closer cooperation between health, labour, and social services.

Public health education and health promotion and prevention are vital components of the sustainability of any health care system. Anna Lena Rademaker and Katrin Liel's article on *New Paradigms in German Health Promotion – (New) Challenges for Social Work* analyses recent German legislation seeking to empower health promotion and prevention through professional practice. Most importantly, this article questions the concept of "health in everyday life" and stresses the extent of environmental limitations in shaping health-related agency and the availability of real options. The preparedness of social worker graduates to undertake effective roles in health promotion and prevention demands further attention in undergraduate curriculum.

The agency of health professionals to take responsibly and manage their own health and well-being represents an ongoing of concern in professional practice. Vladimír Lichner, Magdaléna Halachová and Ladislav

Lovaš's article, ***The Concept of Self-Care, Work Engagement, and Burnout Syndrome among Slovak Social Workers***, explores the uncertainty and risks involved for health professionals if they fail to take responsibility for their own self-care. For example, negative consequences arise for the working environment and quality of client services. The authors talk about the paradox of self-care, as one person's source of care and support may be another person's source of stress. Social determinants of health and well-being also play an important role for the health of professionals including factors such as living conditions, environment, history, and work culture. Social work has always been a profession where personal maturity, experience, ethical attitude and training are expected. Measures to prevent burn out and promoting job satisfaction should be introduced in the early stages of the undergraduate curriculum together with skills in self-care and prompting a caring and functional environment.

The quality and effectiveness of health services and interventions represents a topical issue in most health care systems. American authors Julie Anne Laser-Maira, Granger Petersen, Haily Stephens, Donna Michelle Peach in the article ***Civil and Forensic Patients: Comparing Demographics, Risk Factors, and Negative Life Events*** make a convincing case as to why Social Workers in prison systems need to increase their knowledge of mental illness and interventions. They argue that social workers have an educative role with law enforcement agencies regarding de-escalation tactics with prisoners who have a mental illness. They advocate for prisoners experiencing mental health conditions to be accommodated in psychiatric hospitals rather than be imprisoned so that they receive adequate psychiatric care. This study reinforces the professions commitment to the needs of the most oppressed and those whose voices are frequently ignored or overlooked.

Assessing social risks is a controversial and complex process in health related social work. Arguably, social diagnostics contribute to the quality of social support and the effectiveness of decision making in health and social care. In her research report, titled The Use of Social Diagnostic Instruments in the Youth Welfare Service Practices in Foster Placements of Vorarlberg, Carla Frei examines the involvement of children and their legal guardians in the clarification and refinement of the diagnostic processes. The research findings suggests that social diagnostics are a valuable scientific approach to clinical social work. Likewise, Monika Bačová's systematic book review of Beáta Balogová and Eva Žiaková recently edited text, Social Work. Terminological Dictionary (2017) reinforces the importance of a sound scientific base to social work practice. A dictionary of social work is a valuable text in evidencing social work as an established scientific discipline.

Australian authors Debbie Ling, John Olver and Melissa Petrakis remind us that compassion and common humanity remain the core values in social work in health care. In their article, ***Outcomes from a Compassion Training Intervention for Health Care Workers*** the effectiveness of compassion training in supporting health care workers to do their job well, maintain a positive state of mind and prevent emotional overload brought about by empathic distress, is evaluated. The effectiveness of training sessions indicated that health care workers found compassion training useful and felt that further training would be beneficial. An innovative compassion training module using the latest technology has been developed for use in healthcare organisations based on the evidence generated from this inquiry. The active support of core values in professional practice underpins the quality of the work environment and more importantly client intervention.

The topics explored by such a diverse group of international authors truly reflects the ever-increasing scope of social work practice in health. The authors openly acknowledge that social workers face complex challenges in light of global trends and populist ways of thinking. However, each article has demonstrated that social workers along with other allied health professionals have new opportunities to engage in creating more equitable, evidence informed, inclusive and compassionate practices and policies for the promotion of health equity for all. Changing social, political and economic

conditions demand new forms of professional engagement and have implications for the relevance of social work practice, education, and research and theory development. I hope that this special edition will inspire academics, students and practitioners to consider the implication of health and well-being in all fields of social work endeavour, but more specifically help to promote new and relevant approaches in education and research to as to equip social workers to take future leadership roles in health and social care.

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Social Work Practice of Hospital Social Workers under the Structural Adjustment Program in Greece: Social Workers Protecting the Right to Health Care within the Context of Neoliberalism

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Abstract

OBJECTIVES: This study explores the effects of the Structural Adjustment Program (SAP) and its resultant social spending cuts and austerity measures on social work practice in Greek public hospitals. THEORETICAL BASE: The research is informed by a critical social theory approach. METHODS: Qualitative interviews were conducted with eleven senior social workers. OUTCOMES: Data gathered from qualitative interviews in 2011 reveal that underfunding and understaffing causes workers to intensify their professional efforts and to increasingly draw on more informal contacts, as well as on their personal resources, to respond to the needs of service users. Health care spending cuts within the context of neoliberal capitalism clearly undermine participants' ability to effectively perform their work, but they do the best they can with the available resources. Faced with an increasing inability to provide optimal care, participants reorient their focus to at least providing emotional support. A strong theme of resistance emerged, with participants insisting that health care is a right and not a commodity. SOCIAL WORK IMPLICATIONS: The paper maintains that it is imperative for the social work profession to understand that the difficulties they experience emerge within the context of neoliberal capitalism and thus austerity measures and social spending cuts need to become a locus of intervention.

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INTRODUCTION

Since the 1980s, most developed countries have experienced pressures to cut public health care spending with medical social workers in countries from Canada to Finland, working harder and reporting lower job satisfaction (see Michalski, Creghton, Jackson, 2000; Heinomen et al., 2001). These pressures have been part of the neoliberal pressures facing the welfare state (Clayton, Pontusson, 1998; Pierson, 2002; Pentaraki, 2015; 2017a; 2017b; 2018; Garrett, Bertotti, 2017; Cummins, 2018; Verde-Diego, Prado Conde, Aguiar Fernández, 2018) of which the health care sector is an integral part (Pockett, Beddoe, 2017). A country in which health care public spending cuts are drastic is Greece. The Greek national health care system (NHS) is undergoing rapid changes and challenges due to budget cuts imposed by a Structural Adjustment Program (SAP) imposed by the Troica (International Monetary Fund, European Central Bank and European Commission) and accepted by successive Greek governments due to a public debt crisis (PDC). This PDC was not accrued due to social spending, unlike the dominant discourse, but was mostly due to low corporate taxation rates and high military spending (for a detailed analysis of the main factors that contributed to the PDC see Pentaraki, 2013). The SAP imposed policies were created along neoliberal lines (Markantonatou, 2012) and were a mandatory condition of the loan given to Greece as a result of its highly publicized debt crisis. Some of these policies related to the NHS were: Budget cuts that resulted in the introduction of user fees, cost-sharing schemes for medicines, the erosion of universal coverage, reduced hospital stays, reduced hospital staff, and a decreased availability of beds – all of which have affected the most vulnerable segments of society. It has been estimated that 9% of the health care budget has been cut every year since 2009, with cuts totalling almost 40% by 2012 (Kentekelenis et al., 2011; Zacharias, 2012). The senselessness of these mandated cuts is reinforced when one takes into account the official estimates (Hellenic Parliament, 2011) that the money paid to banks as interest on the public debt will be higher than the amount spent on health care and social protection combined. Further, a working paper by the research department of the IMF (Blanchard, Leigh, 2013), reported that the austerity policies imposed on Greece were based on incorrect calculations. This has led to suggestions that the policies imposed were the result of intense pressure by Germany rather than evidence-based policy. Thus, these policies seem to be more political than practical, 'raising concerns on various fronts about the threat to equal access and to the availability of quality health care services' (Heinomen et al., 2001:73). This ideological basis for the SAP is evident when considering the low percentage of the Greek budget that is spent on public health. In 2010, the percentage of Greece's health-related spending that was publically funded was well below the OECD average (59.4% and 72.2%, respectively), and Greece has below-average per capita health spending among OECD countries (2914 and 3268 USD, respectively; OECD, 2012). However, despite Greece's below-average per capita spending, it was subjected to the deepest social-spending cuts of any country in the EU.

These changes to the medical system have been exacerbated by the overall deterioration in Greek socio-economic conditions, with massive lay-offs giving rise to an unemployment rate of 23.6% (Eurostat, 2018a), cuts in pension and salary payments ranging from 25% to 45%, and over one third of the population being at risk of poverty (Eurostat, 2018c). It is worth noting that Greece has experienced the highest increase in its unemployment rate in the EU between 2005 to 2016, when the unemployment rate of 10% in 2005 jumped to 23.6% in 2016 (Eurostat, 2018a).

This paper aims to explore the effects of the SAP and its resultant social spending cuts on social work practice in Greek public hospitals, from the perspective of senior frontline state medical social workers. This is the first study focusing exclusively on medical social workers' perceptions conducted under the present changing circumstances in Greece. Health care budget cuts and the effects of the SAP are approached by looking at the issues that a small group of medical social workers consider meaningful. This paper aims to explore medical social work perspectives and experiences to analyze how budget cuts and SAP measures are manifested in the social services

of the public hospitals. It also aims to explore how social work practice is reconfigured under the challenging conditions of budget cuts. Before the empirical research is presented the paper will briefly outline the NHS in Greece and the general socio-economic context of the SAP as well as a brief discussion of the health care system and social work in Greece.

Greek health care system, socio-economic context of the SAP and social work

According to the Greek constitution, health is a social right. Greece was a signatory of the Alma-Ata Declaration (WHO, 1978), committing itself to working towards universal access to primary health care and declaring health to be a human right. In this context, in 1983 Greece developed a national health care system (NHS), intending to universalize care, remove disparities, and restrict the private sector. Many public hospitals were established and services were provided at no cost to citizens (Tragekes, Polyzos, 1998). Near-universal coverage was provided, along with stable socio-economic conditions. This resulted in good health status outcomes as compared to other OECD countries: Greece had some of the lowest suicide, infant and maternal mortality rates among high income countries, and life expectancy was a year above the OECD average (UNICEF, 2009; OECD, 2011).

Since the onset of the economic crisis, there have been disturbing trends, with infant and maternal mortality rates almost doubling and becoming among the worst in high income countries for falling life expectancy (Kentikelenis et al., 2011; Greek National Medical Conference, 2012). It has been documented by Mantzouranis et al. (2012), that 70% of Greek participants in their study could not afford to pay for medicines prescribed by their doctors, and 79% of participants felt that the anxiety associated with this inability to receive necessary medications was associated with increased rates of anxiety, depression, and sleep disorders. Reports by medical and humanitarian organizations have reported that Greece – especially Athens, where almost half the population lives–is at the brink of a humanitarian crisis (Doctors of the World, 2012).

As a result, social workers in general increasingly find themselves working in deteriorating socio-economic conditions among an underfunded health care system which are features of neoliberal capitalism (Navarro, 2009). Social workers operating within a hospital setting are particularly affected, as they are primarily concerned about the connection between health and the physical and social environment.

Direct psychosocial intervention with people who are ill, disabled or injured is important and necessary work drawing on social workers' energy and resources. Helping people to deal with stress and loss, adopt and thrive despite disabling and chronic conditions, and succeed in the transition from health facilities to residences and communities are focal (Heinomen et al., 2001:73). Informed by this definition, medical social workers utilize psychosocial interventions informed by the person-in-environment approach since they aim to activate available resources in all interconnected systems to facilitate the transition from health care facilities to families and communities, ensuring continuity of care and improving or restoring health status.

It is evident that a context of austerity which brings deteriorating socio-economic conditions, along with underfunding and understaffing, undermines the work of medical social workers as, on the one hand, there is a lack of available infrastructure and, on the other hand, families which could help are already stretched. For example, social spending cuts have decreased the availability of elderly care in the community. Families that traditionally were providing care for the elderly now lack the necessary resources. Greek public hospital social services struggle to support patients and address the social problems they face within the framework of state policies (Government Gazette of the Hellenic Parliament, FEK, 1986). The overall deterioration in socio-economic conditions caused by austerity measures has not only exacerbated the social problems that patients face, but has also damaged the health care system, placing enormous challenges on social work practitioners.

METHODOLOGY

A small-scale, explorative qualitative study was conducted in order to learn more about the perceptions of senior, frontline medical social workers regarding the impact of the SAP and related austerity measures on their work. This was not intended to be a representative study with generalizable results, but is part of a larger, on-going research project (Pentaraki, 2015; 2017a; 2017b; 2018) studying the response of social workers to the Greek public debt crisis and informed by a critical social theory approach (Kincheloe, McLaren, 2000).

Data collection
Data were collected through 11 semi-structured, in-depth interviews. Participants worked in seven public hospitals in three cities. One city was the greater Athens area; the other cities are unnamed to protect participant anonymity. Study permission was granted by hospital directors or deputy directors of social services; directors and deputy directors were often interviewed as participants, due to a lack of other staff. One of the main questions that guided the open-ended semi-structured interviews reported here was: How has the delivery of the social services been influenced by the SAP and the economic crisis?

Participants
Participants were selected using the purposeful sampling techniques of snowball and convenience sampling. All participants were currently working as senior medical social work practitioners in the social service department of public hospitals as directors (*n*=7), deputy directors (*n*=2), or other senior staff (*n*=2). Two participants held post-graduate degrees in social work, and the rest held undergraduate degrees in social work. All participants were full-time public sector employees, female, and natural-born Greek citizens. Ethical approval for the interviews was obtained through the relevant Ethics University committee.

Procedures
Interviews (all but one) were conducted in a hospital setting, from December 2010 to September 2011 (average length = 40 minutes). Interviews were recorded and transcribed, then thematically organized to identify, categorize, and analyse themes and patterns within the data (Braun, Clarke, 2006).

RESULTS

The main themes that emerged from the data were changing working conditions that are characterized by the *intensification of workload* and the collapse of hospital, community and family recourses that denotes and changes of working practices with participants acknowledging the use *of the self and the empathetic relationship*, as social workers realize that 'the only thing I can do is to empathise', as empathy is the only remaining resource. The final main theme discussed is an *emerging collective identity*.

Working conditions
Participants all reported pressures to their working conditions that are characterized by intensified and increased workloads due to diminished resources and deteriorating socio-economic conditions.

Workload pressures
The nature of participants' workload has changed; they see a great number of service users with more pressing problems, but with fewer resources available to address them. This reflects the 24% rise in admissions to state hospitals in 2010 as compared with 2009 (Kentekelenis et al., 2011),

and the increasing number of uninsured people, during the time of the interviews, that asked for assistance from the social services.

Underfunding was highlighted by all participants, with wide-ranging implications for their practice, undermining their ability to fulfil even basic needs such as procuring basic hospital gowns for service users, obtaining bus tickets for the service users to get home, or fulfilling basic administration duties. Study participants reported needing to buy their own printer ink and photocopy paper. One participant and her husband painted the social service office since there was no money designated for it. When office supplies are exhausted, participants reported difficulties in locating ways to substitute for them, similar to social workers in Ghana interviewed by Laird (2008).

Resources are sought after more intensely, with an increasing dependence on churches and the invocation of familial duty, which are signs of the breakdown of state solidarity structures. Social workers have to spend much more time locating resources. Every participant mentioned how, traditionally, the hospitals could depend on church collection box donations (Pentaraki, 2017b); however, this source of revenue has greatly decreased, necessitating resorting to informal sources of revenues such as volunteer networks and nearby churches. Participants reported fundraising in the hospital through organizing bazaars, or by asking for money from more highly paid medical staff, such as consultants. Many participants give their own money to clients in dire need. One director said: *"We have many elderly people at the day of their discharge that ask me, "Can you give me two euros so I can I buy a yogurt for the night?" We give all the time [...] up to this point, I have given about 400 euros from my own pocket"*.

Participant workloads have also been affected by the rise in unemployment, which has resulted in an increased number of uninsured people. While those who were previously salaried employees are eligible for health insurance coverage through the public social security fund, immigrants who lose their jobs and, consequently, their residency status are excluded. Small business owners who went bankrupt and were unable to pay their health insurance contributions are also excluded. All participants stated that they did what they could for both uninsured immigrants and bankrupt business owners to get them access to health care services. One participant, echoing all participants, stated: *"Traditionally we had to deal with only immigrant uninsured people, but now we see people that for the biggest part of their lives were living well in their own house, having a good income having lost everything for no fault of their own. They lost their business due to the economic crisis and now their lives are devastated. A lot of these cases are people that come to us with cancer and no access to health care. You can see their families dressed in really expensive clothes that remind of their previous lives and now…"*.

These changing working conditions gave rise to changing working practices. Participants reported making use of their personal contacts to attempt to overcome bureaucratic hurdles denying health care access to the bankrupted small-business owners who because they were owing money on their own insurance policy did not have access to health care. They all stated that without personal contacts and good networking skills they could not do their job. One of them mentioned how she had to appeal to the regional governor of her area and "his known humanism" in order to intervene with the local tax offices so that they can give tax exemption documents for one of her clients to get access to health insurance. *"Everything we have to do take ages and ages. I had to chase down the regional governor, he is well known for his humanism. I needed him to intervene in the local tax office in order to persuade them to issue tax exempt documents so I can use them to insure them uninsured people. I have been successful towards that but it takes ages and it should not be left to the humanism of the governor or my personal contacts"*.

Another stated: *"Trying to get insurance coverage and jump all these administrative hurdles is so time consuming. Other public sector colleagues cannot understand why we spent so much time. I had one other public servant asking me; is he your uncle since you are concerned so much to get him coverage. It is obvious they do not understand and cannot see why we do it. They have become so individualized in their responses"*.

In cases in which social workers were unsuccessful in helping clients obtain health care insurance (i.e. in cases where they could not get tax exemption documents) they were reverting to collaboration with socially conscious doctors for the reclassification of cases to 'emergency cases', making service users eligible for free emergency access to health care. One social worker stated: *"We are lucky that in our hospital there is a group of very conscious doctors that they are concerned as much as we are in providing health care to all. Not all colleagues are lucky though in other hospitals"*.

Both these practices intensify hospital social workers' workloads but also demonstrate that they approach health care as a right and that they defend that right against SAP-imposed policies that recast health care as a commodity. Their responses can be viewed as active, albeit indirect, acts of resistance to SAP policies and to the neoliberal restructuring and exclusion it entails. Participant 5 stressed that this necessitates a good culture of cooperation between medical professionals and social workers, becoming a collective act of resistance. Every social worker stated clearly that they attempt to secure coverage for uninsured service users but not all social workers were engaged in utilizing the emergency health care resource to access. One participant stated very clearly: *"These are the new policy framework we have to work under. There is not much else we can do. If they are uninsured we inform them about the new policy context and then we refer them to solidarity health clinics"*.

Her comment clearly reflects various approaches being taken. However, the encouraging thing was that they were medical social workers who were trying to utilize creatively the opportunities despite the existing austerity environment. This was achieved by creatively transforming cases of service users as emergency cases and thus exercising rights based social work (Ife, 2012). They seemed to be creative in providing equal access to health care to all, possibly being informed by a 'health equality imagination' (Giles, 2009). Other social work scholars who theoretically conceptualize social workers as engaging in resistance to neoliberalism through their professional discretion have reached similar conclusions. They see social workers who resist and reinterpret procedures as quiet challengers (White, 2009). In some respect they can be regarded as challenges to neo-liberalism's erosion of solidarity (Lorenz, 2005), as work-based activism informed by social work ethics (Giannou, 2011) or as micro acts of ethical resistance (Pentaraki, 2017b).

Such behaviour can also be seen as a way of retaining one's professional dignity and upholding one's code of professional ethics within an uncaring neoliberal world order, offering hopeful glimpses of an ethic of resistance. However, Carey and Foster (2011) disagree with the meaning of this behaviour. Although these researchers conceptualize these actions in political terms, terming them counter hegemonic, they deny their exclusively political nature by arguing that there is a whole range of motives that inspire these acts, ranging from altruism or the relief of boredom due to bureaucratization, to 'a rational response to dissatisfaction or resentment felt towards patronizing or didactic advice offered by colleagues, managers or higher professionals' (Carey, Foster, 2011:586). However, this is not reflected in this study. Further, many participants mentioned taking part in demonstrations against SAP policies, thereby supporting an explicitly political justification for their actions. They seem to be fulfilling Giles' (2009) call on social workers to develop a 'health equality imagination'; however, this has been possible in Greece due to the collaboration of the social work staff with progressive doctors. How possible this is in other contexts, as austerity progresses along with tight bureaucratic policies, remains to be seen. However, social workers have been always working as street level bureaucrats and this is an optimistic sign that they continue to do so. (Lipsky, 2010; Evans, Harris, 2004).

Breakdown of both informal and formal modes of elderly care

Another theme that was identified by the majority of participants was the breakdown of both informal and formal modes of service delivery and provision of care. This is connected to the crisis of social reproduction that is consistent with neoliberalism, both in Greece and elsewhere, and the consequent withdrawal or minimization of state activity in social reproduction, as well as the

inability of the market to yield the jobs and income needed for family maintenance (Abramovitz, 2010). Crises in social reproduction have a gendered impact, with women disproportionately affected. This is because they constitute the majority of professionals in areas of state-controlled social reproduction, such as social work, education, and health care; they also do more than men in picking up the slack that accompanies decreased state care.

Participants highlighted that families, due to increased economic hardship, can no longer provide care for the recovery of a family member. Even middle-class families that traditionally hired private caretakers (most often immigrant women) to care for ill or recovering family members no longer have the necessary resources, increasing the length of hospital stays for service users. Hospital social workers were traditionally able to mobilize an extended family network to take care of family members in need, but this has become more difficult. This, combined with the decrease in care at the community level, has changed the workload of social workers. Discharge planning takes longer as social workers scramble to arrange resources, sometimes resulting in tensions between social workers and doctors, who do not always understand how the absence of a family support network influences the ability of professionals to arrange rapid discharge planning. For example, one participant reported: *Families are under extreme hardships. Families that used to take care of the elderly through paying a carer […] cannot do so any more. […]. They beg us to find a solution for their elderly parents. But the available places in the community for elderly care have been decreased. We cannot do anything and they can't either. They do not have the resources to take care of elderly parents and here we are trying to evoke a familial duty to them […]*.

Participants' statements gave glimpses of intergenerational familial solidarity being undermined as a result of the neoliberal transformation of society (Pentaraki, 2017a; Papadopoulos, Roumpakis, 2013). The economic pressures faced by Greek families make it extremely difficult to fulfil traditional social expectations of caring for their parents. Harvey (2005) argues that neoliberalism entails both a specific economic process and a reconfiguration of society, which brings much 'creative destruction' (Harvey, 2005:3) of prior institutional frameworks, divisions of labour, social relations, welfare divisions, reproductive activities, and ways of life. Neoliberal policies have placed the responsibility of the state in the hands of individuals, but families are unable to meet these responsibilities.

In Greece, elder care in middle-income families has traditionally been provided by female immigrants who worked as home care workers. This enhanced the status of middle class Greek women as it enabled them to avoid the constraints of kinship care. However, decreased income has now made this impossible (Bettio et al., 2006). This has resulted not only in a loss of care for middle-class elders but also in a loss of economic opportunities for immigrants. This has affected not only them but also the dependents in their home countries to whom they were often sending remittances. Nevertheless, we need to remember that these economic opportunities for immigrants also had an exploitative dimension, as in many cases the work done by immigrant women was undocumented and without any protection (Parreñas, 2001; Isaksen, Devi, Hochschild, 2008). This reflects a global care chain characterized by the unequal and transnational division of social reproductive labour along gendered, ethnic, regional and class lines (Parreñas, 2001).

The breakdown of both informal and public provisions for elder care also translates into more pressure placed on women, as a result of prevailing gender roles by which women do a disproportionate amount of caring, undermining advances in gender equality. This care burden will become even more evident during the next few decades as Greece ages, with Greece having one of the highest shares of people over 65, higher than the EU average (Eurostat, 2018b).

'The only thing I can do is to empathise': Use of the self and the empathetic relationship
Participants described how deteriorating socio-economic conditions have undermined their capacity to effectively assist service users, leading to what participants referred to as a 'first aid approach'. 'We provide first aid', stated a director to explain the sort of social work that they must

now engage in. Howe (1996) refers to this type of social work as 'surface' social work. This is consistent with previous research findings that social workers in Greece now provide first-aid type service (Georgoussi et al., 2003; Papadaki, Papadaki, 2008).

Participants in the present study echoed the demoralization and alienation that characterized frontline social workers recently interviewed in England (Jones, 2001, 2005). For example, one participant stated: *"You feel the misery even with the space surrounding you […]. It takes me 15 minutes to access my documents in the computer. It's misery not to have a space for interviews. And this misery keeps getting worse. When you do not feel proud in your space, when you are not paid a respectable wage, you cannot work well and face the misery that you see in front of you. Few are the cases that you see well."*

However, despite these difficult feelings, social workers do the best they can. To that end, they turn to the only resource that they have left: themselves. In many schools of psychology and counselling, use of self has been conceptualized as a necessary pre-condition for a successful therapeutic relationship (Rogers, 1957). Similarly, relationship based social work, entailing the use of the self, has been conceptualized as the basis for any important social work intervention (Ruch, Turney, Ward, 2018). A different conceptualization of the self under conditions of austerity is gleaned from the findings. The conceptualization we see emerging is one as the only available resource that can be utilized for the interests for the service users and as the only resource a professional can use to maintain a sense of professional integrity and dignity in an uncaring neoliberal world (Pentaraki, 2017b). This conceptualization seems to emerge out of an acknowledged shared interest or shared austerity reality as it has been argued elsewhere (Pentaraki, 2017a) between social workers and service users.

The participants in this study utilize the self as one of the few resources left. While the use of self as a resource has been a feature of social work practice, it has always been only one intervention among others. Participants focus on offering emotional support, recognizing that their ability to make a difference has been compromised. As one of the participants put it: *"... Thus, you [emotionally] support the service user. [There is not much else you can do]. Things are very constrained. Greece has become completely bankrupt; both the health care and the welfare system, too, which are bankrupted even more. "And I just remain here fooling myself that I do something but the only thing I do is […] to talk to people when they come to me […]. Thus, I empower him or her so they can breathe for a couple of more days until they come back to us. The only think I do is to empathise [….] because you are also in the same difficult position as him or her in terms that we have become poorer […]. I also have a husband with [health needs]. Thus, I needed to do a lot of work so I did not get influenced because, in addition to being a social worker, you are human too"* (Pentaraki, 2017a).

This statement also reflects demoralization as to the legitimacy of this type of social work, as well as burn-out resulting from overextending emotionally. As fewer resources are available, medical social workers overextend themselves trying to meet their clients' needs. Social workers are expected to utilize a psycho-social approach to assist service users whose lives have been devastated by socio-economic forces, as social workers have been left with no resources or community services. As a result, participants reported working harder and harder, and in very emotionally demanding ways, but feeling increasingly futile. This has resulted in a decreased sense of self-efficacy, as well as a contradictory sense of growing helplessness. Participants felt that it was important to acknowledge that these feelings stemmed from going the extra mile for their service users, and that these experiences were shared as both them and the service users experienced a shared austerity reality (Pentaraki, 2017a, 2017b).

An emerging collective identity

Another theme which was identified reflects an emerging collective identity through their use of the word 'we'. As a director of social services stated: *"We talk with each other over the phone and discuss what to do since there are new cuts now and then. […]. We experience a state of high levels of insecurity"*.

The same participant continued to discuss how talking to colleagues is a source of support both for personal and professional strains resulting from austerity measures. Talking with colleagues and offering mutual support also has been previously identified as a protective factor against emotional dissonance in medical social work practice (Nelson, Merighi, 2003).

This mutual support seems to enable them to continue working, supporting the service users any way they can despite the difficulties and also mitigates the wider pressures.

Furthermore, talking with colleagues may be both a sign of mutual support and a collective means of addressing social spending cuts. It offers the potential of resistance as it suggests an understanding that austerity cuts need to be dealt with collectively rather than remain unquestioned as the pressures felt at work are not of their own doing but are a result of the imposed policies. This understanding challenges the dominant discourse that there is no alternative (Pentaraki, 2013). These findings suggest that these participants may not hold a neoliberal individualistic understanding of the world, as they talk with each other in search of a collective approach to finding a solution. How far will this quest go and what kind of solution will be reached, remains to be explored in a future study. Such work could further explore if and how their grievances have been articulated for political purposes and if their shared concerns are enough to motivate them to political action (Polletta, Jasper, 2001).

CONCLUSION

As part of the neoliberal restructuring of the Greek society and the welfare state, the imposition of the SAP has undermined the welfare state by creating a prohibitively complex environment for the delivery of social services. Changing socio-economic conditions have placed new challenges on medical social work practitioners: work overload, resource constraints, and demoralization. Health care spending cuts within the context of neoliberal capitalism clearly undermine participants' ability to effectively perform their work but they do the best they can with the available resources. The participants in this study do the best they can to uphold health care as a right, intensifying their efforts to locate resources, build networks, draw from personal resources, and go the extra mile. For some practitioners, this environment has led them to focus on a first aid approach. Others have made use of subversive strategies, such as reclassifying service users as emergency cases to ensure care, while many, in the face of a lack of external resources, have begun increasing using themselves as a resource, pushing the families of services users to care for those in need (which is extremely difficult, as many families do not have any sources of support, themselves), or returning to pre-welfare state practices, seeking philanthropic contributions from churches and volunteers. Surprisingly these findings have been identified even in countries like Sweden with traditional strong welfare states (Jönsson, 2014).

The findings of this study concur with previous findings documenting how social services and health care have been undermined by SAP in countries of the global south (among others see Nayar, 1998; Kawewe, Dibie, 2000; Handa, King, 2003; Laird, 2008; Hossen, Westhues, 2012). Greece, a country which was already strained since the welfare state in Greece was not fully developed (Markadonatou, 2012; Papadopoulos, Roumpakis, 2013) has been affected harshly. This undermining of the welfare state and the health care mirrors the experience of other Western countries, such as Canada and Finland, which have experienced reduced hospital stays, service privatization, and user fees, to the detriment of both professionals and service users (Heinonen et al., 2001; Baines, 2006). Wallace and Peace (2011) argue that Australian social work is part of a neoliberal project (Healy, Meagher, 2004); Jones (2001) agrees with regard to social work in the UK.

The insufficient community infrastructure documented in developing countries (Crabtree, 2005) is appearing now in developed countries such as Greece, suggesting that there is a downwards convergence of socio-economic conditions (Hermann, 2014). Instead of the conditions in the countries of the global south converging with the conditions of global north and thus improve

(Comaroff, Comaroff, 2012), the opposite is happening. Findings from this study indicate that changes in Greek social work practice are a function of changes in the overall socio-economic environment (Pentaraki, 2017a, 2017b), which are met with resistance, in keeping with one theoretical model of social work, in which the overall socio-economic system is cast as the site of social work intervention (Pentaraki, 2013). This approach is informed by the international definition of social work produced by the IASSW and IFSW, moving beyond an individualistic approach to problems by acknowledging that individuals are continuously affected by their environments.

The majority of the participants in this study seem to adhere to this politicized definition of social work; however, it is unclear how they will use this definition in the evolving Greek context. What is clear is that these participants see their work as strongly associated with a political commitment to upholding health care as a human right. Hence, they practice rights based social work despite the constraints of the policy framework. This is compatible with the International Federation of Social Workers' (International Federation of Social Workers IFSW, 2008:1) statement on Health which states that: *"All people [need to] have an equal right to access resources and services that promote health and address illness, injury and impairment, including social services. IFSW will demand and continue to work for the realisation of these universal rights through the development, articulation and pursuit of socially just health and social policies".*

It also states that health "is an issue of fundamental human rights and social justice and binds social work to apply these principles in policy, education, research and practice".

Social workers' practice has to be informed by these guidelines along with the IFSW (2016:1) statement against austerity which urges social workers to challenge austerity as it is a flawed economic theory that increases inequality and distress in people's lives. It also urges social workers to "challenge any political ideologies that prioritise profit and the financial sector over people".

What hospital social workers in Greece as well as elsewhere face is a manifestation of the neoliberal agenda which prioritises profit and the financial sector over people. Their pressures and difficulties are a manifestation of neoliberal capitalism (Pentaraki, 2017b) This has undermined both their working conditions and practices, threatening not only the professional quality but also the prestige of the profession. When social workers are left with depleted resources the public trust of social services can be undermined. To offset this and protect their professional dignity the participants use their self as the only resource left. They also use subversive tactics to protect health care as a right. This can offer a glimpse of hope provided that these practices of resistance continue to grow and furthermore find articulation at the macro level.

Limitations and future research

The small, non-representative sample on which study findings were based makes generalization limited (although the small size has less of an impact than it otherwise might, as at the time of the interviews all public hospitals were centrally administered). Further, a lack of longitudinal data makes a comparison of how service delivery has been impacted following the SAP impossible. A larger sample including service users, not just service providers, would provide more detailed and generalizable information. Given the lack of longitudinal comparison studies, it would be helpful to ask for more quantifiable information from participants, such as the number of service users per social worker in the past in comparison to those at the time of interviewing. Follow up research is also needed as there has been a change of government in Greece since the time of the interviews. The last government was elected on an anti-austerity agenda, unfortunately though it continues to enforce the SAP austerity measures due to the bullying tactics of the TROICA (Pentaraki, Speake, 2015). However, despite the intensification of austerity measures, the last government improved access to public hospital services. This needs to be researched in future.

Despite these limitations, this study offered useful insights on the delivery of social services under SAPs characterized by stringent austerity. As more and more countries are moving towards

neoliberal-informed social service delivery systems, the author hope that the experiences of social workers detailed in this study will highlight the negative impact that such changes can have not only for service users but also for social workers. It is anticipated that these findings will stimulate public debate on ethical limits to austerity. A first glimpse is seen in the resolutions and the recommendations about equal access to health passed by the council of Europe (2013) whereas European countries are urged to protect the right to health as enshrined in article 11 of the European Social Chapter. However, despite these recommendations, the health care budgets in many countries have been decreased, indicating that the social model of European Union is seriously undermined (Hermann, 2014). Rising inequalities within a context of neoliberal capitalism necessitate neoliberalism to become a locus of intervention for the social work profession (Pentaraki, 2013; 2017a; 2017b; 2018). Social work professional associations, informed by the social justice mandate of the global definition of social work, along with other progressive organizations have to flag-up the misery caused by neoliberalism and at the same time to organize to stop it. This is not easy as there is a segment of the population, even some social workers (Pentaraki, 2018), who have bought into the neoliberal mantra of 'There is No Alternative' and have adopted "austerity common sense" ideas (Pentaraki, 2018) i.e. that austerity is inevitable. However, austerity is part of an ideological project (Pentaraki, 2013; IFSW, 2016) and as such has to be challenged and counteracted with the social work values and principles of social justice and human rights for all.

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Young People's Perceptions of Smoking Behaviour and the Implications for Social and Health Workers

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Abstract

OBJECTIVES: Addiction to smoking has serious health implications, particularly as addiction may lead to a lifetime smoking. Social workers work with socially deprived clients and therefore can have a role in assisting in health behaviour choices. THEORETICAL BASE: Social constructionism - what constitutes young people's need to smoke. METHODS: To understand why young people smoke qualitative phase one interviews (n=40) took place in six deprived areas of Essex, in England. A quantitative questionnaire was sent to 14 districts of Essex. Comparison was made between Higher deprivation (HD) and Lower Deprivation (LD) areas (Total n=1711). Ethical approval was via Anglia Ruskin University Faculty Research Ethics Panel, and Essex, Thurrock and Southend local authorities. OUTCOMES: Phase One: The phase one results demonstrate that young people who smoke are mainly stimulated by stress (14 of the 40 participants). Phase Two: Found that 70.1% of high deprived area (HD) and 62.6% of less deprived area (LD) Smokers identified 'stress' as the most significant reason for smoking. IMPLICATIONS FOR SOCIAL WORK: Social workers can help people understand their feelings of needing to smoke cigarettes / smoking behaviour, and to help them manage stress without the need to smoke.

Keywords
young people, smoking, stress, addiction, boredom, poverty

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INTRODUCTION

This article sets out some of the results of a research project which looked into smoking disparities amongst young people in Essex, England (UK). Smoking is a risk to the long-term health of children and young people throughout the world, and in England, it is estimated that 463 out of 3.7 million children aged 11–15, begin to smoke daily (Hopkinson et al., 2014). Although smoking prevalence in the UK is just 15.5% (LTCP, 2016), and the smoking prevalence for Essex is 14% (LTCP, 2016), amongst those people who have routine or manual jobs in Essex, the rate of smoking is 23.8%. UK legislation is briefly presented here. The Children and Young Persons (Sale of Tobacco etc.) Order 2007 increased the age of children purchasing tobacco products to 18 years (this was previously at age 16 in the Children and Young Persons (Protection from Tobacco) Act 1991. The Health Act 2006 brought about enforcement of smoke free public places such as restaurants and public houses, and smoke free workplaces. The Children and Families Act 2014 (HM Government, 2014) has been an important breakthrough in UK legislation, ruling that it is an offence for children to be subjected to passive smoking in cars, highlighting the passive effect on children from adults smoking. Tobacco packaging guidance was introduced in the UK in May 2016, meaning that all cigarette packaging by law needs to be neutral and contain health warnings. The EU Commission of the European Communities Council made recommendations in 2002 which sought to tighten tobacco control measures with a particular emphasis on youth access to tobacco (EUCECC, 2002). This proposal included the removal of tobacco products from display, and for young people to prove their age prior to purchase. Despite the attempts of legislation to curb smoking uptake, 8% of 15 year old young people in England smoke (NHS, 2015), and because most smokers start in their youth (ASH, 2015) this is a concern for youth, health and social care workers as the inherent risk is that young people will develop an addiction and will become lifelong smokers (US, 2014). To address high rates of smoking in deprived areas of Essex, the Smoke Free Essex Tobacco Control Alliance (SFECTA) invited members to join an Anglia Ruskin University (ARU) researcher to examine why young people take up *or refuse* smoking (particularly in areas of High Deprivation (HD)) Emma Regan, and one other member of SFETCA joined researcher Linda Homan (several other professionals wished to be informed of updates only). Poverty and deprivation in England are measured using the English Indices of Multiple Deprivation 2010 (IMD) (IMD, 2010; McLennan et al., 2011). These Indices have been developed to encapsulate poverty on seven levels looking closely at local areas known as Local Super Output Area's (LSOA). These levels of domain indices are compared in order to reveal the vast range of deprivation experienced by people in England and applied at a local level. The seven levels are: income deprivation, employment deprivation, health deprivation and disability, education skills and training deprivation, barriers to housing and services, living environment deprivation, and crime (McLennan et al., 2011:7). This fine-grained local level data has been useful in helping local authorities and health providers in England assess local needs and target interventions towards the most vulnerable and have been instrumental in identifying poorer parts of the geographical area of Essex for this research. In 2011 six LSOA areas of Essex which are high on the IMD were identified. The areas were not chosen by IMD score, they were identified by SFETCA colleagues as deprived areas with high smoking rates, however, they all feature highly on the IMD. These six areas are listed here with information regarding their IMD status:
1. Basildon – which has 12 areas that are in the most deprived 10% on IMD.
2. Colchester which has Four LSOA's in the top 10% of most deprived in the country.
3. Harlow does not have any areas in the top 10% of most deprived on the IMD, however overall deprivation is significant, with Harlow being amongst the most deprived 10-20% of local authorities in England, this is compared to Tendring which is in the most deprived 20-30% and Basildon which is in the most deprived 40-50%.

4. Southend has 18 LSOA's in the top 20% of the most deprived on the IMD, with four of those areas having parts of the district in the top 10% of most deprived.
5. Tendring has 89 neighbourhoods, and 14 of these areas feature among the 10% most deprived in the country. The suburb of Jaywick (in Tendring) has the overall lowest score of all the 32,844 districts of England.
6. Thurrock has five LSOA's which are in the 10% most deprived areas of England and 12 are in the 20% most deprived areas.

Qualitative Interviews began Phase One of what turned out to be a two-phase sequential design project (Creswell, Clark, 2007). Results from this phase revealed a high number of young people with a self-perceived 'need to smoke', and the reason for smoking mainly given as stress relief. This was of interest particularly as socioeconomic disadvantage is associated with higher rates of both self-perceived stress (Fidler, West, 2009), and smoking initiation and escalation of smoking (O'Loughlin et al., 2009).

THEORETICAL BASE

The theoretical underpinning of the research project in Essex, was that of social constructivism. The social constructivist view acknowledges that the reality of those studied manifest in personal constructs, in this case, that of the reasons for smoking behaviours. These constructs are therefore central to understanding the meaning attributed to actions and world views. Social constructionism is concerned with analysing the processes that people use to make sense of and describe the world (including themselves) in which they live (Gergen, 1985). The focus of this approach therefore concerns the construction of the reality as perceived by a group and how they crate meaning and knowledge, and representing these as accurately as possible in research. Khun addresses this as a group process: '*Knowledge is intrinsically the common property of a group or else nothing at all. To understand it we shall need to know the special characteristics of the groups that create and use it*' (Kuhn, 1970:210).
Understanding how meaning and knowledge are made in this constructivist way also involves acknowledging the influence of the different layers of social political, family, community and friendship structures. These layers of influence affect the world view of the people living in an area, and therefore affect their interpretation of reality. The ecological perspective of the many layers of impact from direct social relations to public and community forces is one proposed by Bronfenbrenner (1979). According to Bronfenbrenner a fundamental integration between public policy and the basic social science of understanding the impacts on populations is necessary to fully understand what is happening in both the societal setting and in individual construct of the situation (Bronfenbrenner, 1979:8).
This perspective can shift the balance from introspection of social problems to the macro view of what the socio-cultural and economic impacts are. Critical social work requires that practitioners re-define service user's (SU) problems in terms of challenging the accepted oppressive discourse, and to empower them to look at new ways to tackle problems (Roscoe, Madoc, 2009). Health issues such as smoking can then be viewed holistically in terms of the functionality smoking offers to those coming from higher deprivation groups (Amos et al., 2006). This would involve the social worker in exploring new ways for SU to function and cope without the need to smoke. The conceptualisation of poverty as a social construct has gained much attention. Social status and wealth need to be examined from a structural perspective. Those who do not have the means to improve their social position are limited in choice and in personal development. They are often subjected to longer working hours and less favourable working conditions. This in turn impacts on stress and health. This type of unequal pressure does not happen to individuals only, but communities and groups can suffer from the effects of poorer working conditions and poorer

housing provision. This type of housing and employment poverty ultimately stems from policy and is reproduced because of the lack of opportunities causing a poverty trap (Lawson, 2012). From Durkheim (2013:158) we learn that if a situation is replicated, then we can confirm that this is a *social fact*. On youth he noted that: "… *in order to ascertain the direction in which a social phenomenon is evolving, one will compare what it is during the 'youth' of every species with what the phenomenon becomes in the 'youth' of the succeeding species*".

Research on smoking confirms the *social fact* that there is still a youth problem with smoking, and also that there are higher rates of smoking in poorer areas of society (Fergusson et al., 2007; Moore et al., 2012; Hiscock et al., 2012a, 2012b). It is also acknowledged that smoking is seen as a coping mechanism to help with stress (Tsourtos, Ward, Muller, 2008; Fidler, West, 2009; Sperlich, Maina, Noeres, 2013). Poverty linked with health damaging behaviours are repeated throughout cities in the UK and across the world (Dahlgren, Whitehead, 1993, 2007; Wilkinson, Marmot, 2003; Wilkinson, Pickett, 2010). In an exploration on smoking and socioeconomic status in England, Hiscock et al. (2012a) found that between 2001–2008 there were four times as many smokers in poorer areas, and that incidence of smoking carried on longer in this group with fewer quitters. Whatever the reason for smoking, the life limiting illnesses associated with smoking mean that this 'habit' is serious and any help to stop smoking and cope with stress are welcome. People who start to smoke soon become dependent on smoking, making the quitting process more difficult. Although the term 'addiction' should be used carefully, there is no set number of cigarettes within which one is classed as addicted to smoking, rather, the need for nicotine coupled with the intensive need to smoke throughout the day is measured, usually by an assessment of the desire to smoke (stop-tobacco. ch). In America, the Fargerström Test for Nicotine Dependence (Fargerström et al., 2012) is used, however, as Benowitz notes (2008:4) the terms dependency and addiction are applied to those who have little or no control over the (smoking) behaviour. Below, in the findings from qualitative interviews, there are signs of loss of control in the need to smoke, however, this is understood here to be associated with heightened emotional circumstances (this is discussed fuller below). Theories concerning the addictiveness of smoking behaviour suggest that nicotine addiction causes the compulsion to smoke, and that the withdrawal of nicotine triggers this compulsion (Abreu-Villaca, Seidler, 2003; Scragg et al., 2008; Racicot, McGrath, O'Loughlin, 2011). Research concerning compulsion to smoke not only highlights the pharmacological effect of nicotine dependency (of which the physical withdrawal symptoms are just one part); but also highlights the effects which have a dominant psychological and behavioural effect (Abreu-Villaca, Seidler, 2003; Scragg et al., 2008; Racicot, McGrath, O'Loughlin, 2011). The experiences of clinical withdrawal, and the behavioural and psychological aspects, appear to be two very different (although related and overlapping) components of continuing smoking. Nicotine addiction is not simply a chemical response (Benowitz, 2008, 2010; O'Loughlin et al., 2009) and there are many complex factors for each individual which determine their susceptibility to nicotine. Benowitz (2010) notes that addiction to nicotine combines learned factors as part of conditioning from social and environmental factors, and that this interplays with the pharmacological effects. These views on addiction to smoking tend to share a focus both on the medical aspects of smoking addiction (pharmacological, genetic), and the social influences (learned behaviour and environmental factors) that lead to smoking uptake (Okoli et al., 2009). Light smokers or experimenters (light smoking is usually based on ≤5 cigarettes per day) have been found to show symptoms typically associated with nicotine addiction such as impulsivity and 'feeling the need to smoke' (Benowitz, 2010). The criteria of 'needing a cigarette' has been shown to affect smoking uptake with those claiming to have smoked just 3 to 4 cigarettes in their lifetime having a diminished autonomy with regard to smoking of between 20 to 35% (Scragg et al., 2008). Self-perceived addiction has been shown to be a key predictor of smoking initiation and (to a lesser degree) daily smoking (Okoli et al., 2009), also self-perceived mental and physical addiction has

been shown to predict those who would go on to sustained smoking habits (O'Loughlin et al., 2009). A study by Panday et al. (2007) found that weekly and monthly teenage smokers, who smoked as few as one cigarette per week, reported high levels of dependency. Despite only smoking monthly 28.5% reported withdrawal symptoms of craving to smoke, 22.8% reported feeling irritable, and 18.9% reported that they were unable to concentrate (Panday et al., 2007). Whilst this study was not undertaken in the UK, similar findings in a UK study by Wilkinson and Abraham (2004), found that behavioural intension was a significant indicator in future smoking. It has been suggested that it is the associated thoughts and feelings, as well as the psychological effects which trigger the desire to smoke the next cigarette (Wilkinson, Abraham, 2004; Panday et al., 2007; West, 2009). This means that it is important to understand how cravings affect people, and at what point light smokers perceive themselves as addicted. The 'needing to smoke' category moves on to 'cravings' to smoke, and this can ultimately trigger continued smoking, and as detailed above, this has been shown to be experienced by those who smoke very few cigarettes or even irregularly (West, 2006). An important question to ask therefore is whether this is actual addiction to nicotine, or perceived addiction when 'craving' a cigarette is asserted by a young person. West (2009) suggests that assessment of nicotine addiction should always consider how much the behaviour controls the individual's repertoire, and also his self-image (West, Brown, 2013). The type of language used to describe the need for a cigarette can reveal a lot about the severity of feelings being experienced. In a study by Fidler and West (2009), addiction to cigarettes and continued smoking was directly related to both the description of the enjoyment of smoking and the strength of any urges to smoke. Also, that the emotional gratification found from low level nicotine consumption has been found to have the same behavioural components as confirmed nicotine dependence. There is no doubt that experiencing physiological or psychological effects, especially those associated with withdrawal, make giving up smoking a difficult task (Scragg et al., 2008; Doubeni, Reed, Difranza, 2010; Wileyto et al., 2009; Hughes, 2009). West describes the urges to smoke as a 'nicotine hunger' (2006) which is satisfied by continuing to smoke. This 'hunger' to smoke can be non-nicotine related and this assertion is born out in a study utilising nicotine free cigarettes (Perkins et al., 2010) which identified that smoking was found to alleviate the negative effects of stress despite nicotine content of the cigarettes. Therefore, there is a case to suggest that regular smoking can take place when young people *feel* the need to smoke because of a psychological desire for nicotine, however, they may not necessarily have reached a *clinical* or physiological nicotine addiction. It is important that young people do not adopt the label of addiction to nicotine and define themselves as smokers (Haines, Poland, Johnson, 2009; Vangeli, West, 2012), but are helped to cope with stress and other associated behaviours. Essex stop smoking services were particularly keen to find out what young people (local to them) were saying and experiencing in relation to smoking uptake and refusal. To date, apart from the Schools Health Education Unit (SHEU) survey, which does not look closely into aspects of smoking, detailed information pertinent to smoking was not available, and so this study was carried out.

OBJECTIVES

The Smoke Free Essex Tobacco Control Alliance (SFETCA) and Anglia Ruskin University (ARU) undertook a professional collaborative/participatory research project with an exploratory two-phase design. The working group consisted of two representatives from SFETCA (including Emma Regan), and the social work researcher Linda Homan. SFETCA were instrumental in highlighting the areas of concern within Essex, co-reviewing the qualitative findings with ARU, and co-suggesting a further stage. The first phase involved qualitative interviews with individuals, friendship pairs, and small groups (*n=40*) in the six most deprived areas of Essex according to the Indices of Multiple Deprivation.

In Phase One, the main researcher met with young people in schools, youth clubs and at youth drop in meeting places (*n=40*) to ask them about their encounters with the habit of smoking. Youth leaders and teachers helped advertise the sessions in some of the most socioeconomically deprived places in Essex and were on hand for support. The young people chose either one to one interviews or friendship pair interviews; also there were two group meetings. The results were transcribed and analysed using 'FrameWork' software (now incorporated into NVivo), and Colaizzi's procedural analysis (1978) to discover the significant themes from the dialogue. The themes arising included whole family entrenched smoking, buying single cigarettes at school, and smoking to help cope with stress. The smoking rates in the six areas are listed below showing the overall area rate, and the smoking rate for routine and manual workers.

1. Basildon: 18.5% smoking rate and 24.2% for routine and manual workers.
2. Colchester: 21% smoking rate and 36.3% for routine and manual workers.
3. Harlow: 23.8% smoking rate and 36.4% for routine and manual workers.
4. Southend: 22.5% smoking rate and 36.4% for routine and manual workers.
5. Tendring: 22.5% and smoking rate and 30.9% for routine and manual workers.
6. Thurrock: 21.3% smoking rate and 25.8% for routine and manual workers.

In Phase Two, a questionnaire was used to see whether some of the phase one themes/findings applied to a wider cohort, and also to compare various smoking behaviours and views between HD and LD areas. The sample included two schools in each of Essex's 14 districts (*n=28*) (Basildon, Braintree, Brentwood, Castle Point, Chelmsford, Colchester, Epping Forest, Harlow, Maldon, Rochford, Southend, Tendring, Thurrock and Uttlesford). In each area two schools were chosen. One nearest the highest and one from nearest the lowest super output areas (LSOAs) on the Indices of Multiple Deprivation (IMD). In each school four tutor groups of year 10 pupils (ages from 14–15) were chosen randomly by the head of Personal, Social and Health Education (sample *n=120*), and each class was invited to complete the questionnaire. The responses (sample *n=1711*) were analysed using SPSS. Chi-square and Likelihood ratio tests were used to produce inferential statistics, and some statistics are presented as % of the cohort to make a comparison between HD and LD areas straightforward.

The 17 questions concerned reasons for, and attitudes towards smoking. Amongst the questions, young people who took part were asked: Do you/did you smoke? And What makes you/made you smoke most? The questionnaire contained a list of reasons developed from phase one, as well as a space to write any 'other' comments. The list included: Boredom; To fit in with friends; To socialize; Hooked on nicotine; To look older; To look good; Stress; and Other (please state). The findings from both phases were integrated and analysed on a topic by topic basis. Non and ex-smokers were included in the research along with smokers as the researcher wanted to find out what made people refuse smoking or give up smoking. This was one of the findings in Phase One.

OUTCOMES

This section presents the results of the Phase One qualitative study, and the Phase Two quantitative questionnaire, as they apply to the topic of the '*need*' to smoke and stress in young people from Essex. The qualitative phase one findings will examine the discourse around stress and smoking, and one chart from the phase two findings will be linked to this.

Phase One Qualitative Results
The qualitative phase one findings show that the 'need' to smoke was most often directly related to stress. 12 of the 40 participant's mention wanting or needing to smoke, and 14 of the 40 participants mention stress as a reason for smoking. Young people reported a *need* to smoke,

and a *need* to carry on smoking. *'I didn't really see why everyone wanted to smoke but 'er, as I got older it's kind of like I just ... it was there at the back of my mind. I need a fag.'* (15 year old female smoker, from a smoking home). Similarly, another young person reported continuing after first trying a cigarette as a 'need': *'I threw up after my fist cigarette but after your first one you feel you need another one and it goes on from there…'* (17 year old male smoker, from a smoking home). Smoking can become a habit, and it can also become a perceived relief from stress. Smoking as a coping strategy has been noted by West (2009) who acknowledges that smokers form beliefs about the benefits of smoking (evaluations), such as the belief that smoking will help relieve stress, and that these beliefs contribute to their smoking choices. This is particularly pertinent when emotions are extreme, as they can be in adolescence. One young person reported extreme emotions when needing a cigarette: *'Other people get really stressed out and need a cigarette. Like me yesterday, I was so upset, I was just really in a mood and I looked in my bag and someone had taken my cigarettes, and I just thought 'Oh my God', like I actually walked off and I just cried, I was so wound up'* (15 year old female smoker, from a smoking home. Smokes up to 20 cigarettes a day). Another young person reported: *'I have been using it (smoking) as a stress relief because as soon as I have a fag then I am fine. Smoking helps with my stress.'* (17 year old female smoker, from a smoking home. Smokes 5-10 cigarettes a day). Similarly two other young people reported smoking 'helps' if you are stressed, and that smoking 'relieves stress'. Another young person said: *'…when I am stressed the first thing that comes into my mind is a fag.'* (15 year old female smoker, from a smoking home. Non-daily smoker). Some young people reported that they smoked without 'needing' to smoke: *'Four years I have been smoking now. I smoke 10 a day. I am cutting down. I don't NEED a cigarette, I just do it.'* (13 year old female smoker, from a smoking home). Despite reporting that she has a smoking habit of 10 cigarettes per day, and that she has been smoking for four years, this young person went on to say: *'In the holidays I didn't have a fag for a week until we came back (to school) and it was alright.'* Similarly another young person stated: *'I think smoking does relieve stress but it's psychological… [..] ... I gave up last year for 12 weeks and every time I got stressed I had a chewing gum instead that was really good.'* (17 year old female smoker, from a smoking home. Smokes 25 cigarettes a day). It was acknowledged by some of the young respondents that parents and older siblings smoked to ease stress, thus adding to a picture of social learning (social construction). Four non-smokers acknowledge that stress had an effect on smokers. Those young people who lived in a smoking home, but did not themselves smoke (non-smokers) were of great interest to the researcher as they could offer some insight into resilience to smoking uptake (this will be the discussion of another article).

Phase Two Quantitative Results:
In phase two smokers were asked to tick a set of pre-fixed answers developed from phase one responses. There were 1711 returned questionnaires. The 17 question questionnaire contained questions about smoking habits etc., however, only part of the results relevant to this article are presented here (why young people smoked the most). Table 1. Contains the results comparing HD and LD schools for this question. The most significant reason young people gave was 'stress'. 70.1% of HD and 62.6% of LD cited this as the reason they most want to smoke. The second highest response was 'boredom' with 42% of MD and 42.9% of LD school pupils indicating this as a reason for smoking. The third most popular response was to 'socialise' while the next most popular reasons young people indicated were being 'hooked on nicotine' and 'to fit in with friends'.

Table 1: Results from unpublished research in Essex amongst 14–15 year old young people (response to questionnaire *n=1711*)

What makes you/made you smoke most?	School HD	School LD
Stress	70.1%	62.6%
Boredom	52.2%	42.9%
Socialize	35.8%	49.0%
To fit in with friends	30.6%	25.9%
Hooked on nicotine	26.9%	29.9%
To look good	17.9%	11.6%
To look older	11.9%	11.6%
Other	11.2%	12.9%

The results in the table above confirm the findings prom Phase One of the study, that young people use smoking to cope with stress. They also confirm that smoking is still more prevalent in HD areas.

IMPLICATIONS FOR SOCIAL WORK

Social workers are not stop smoking advisors, and yet they work with people who are in the most deprived groups in society who are therefore most likely to be smokers. Social workers working with young people are well placed to give advice which can be health promoting, and this part of the article has presented the implications of what it means to rely on cigarettes as a relief for stress, boredom, or just to socialise for those young people living in poorer areas of Essex. It is hoped that an understanding of reasons young people smoke, will give social workers insights into how to help young people deal with stress, boredom, and socialising, without having to smoke. In phase one, the *need* to smoke was expressed in various ways. A couple of young people mentioned the word addiction in relation to nicotine dependence and withdrawal, however many smokers offered descriptions of a *need* or *want* to smoke. This was almost always referred to in the context of stress relief. Some were specific in their explanation of the need to smoke because they depended on smoking to relieve cravings. One participant revealed very deep feelings concerning this stating 'You see like when I get stressed, if I don't have a fag I will end up like just sitting there and punching walls.' This graphic depiction, whilst not common, helps to highlight an intensity of feelings expressed when smoking is needed.

The terminology or language used, can reveal intensity of feelings about the need to smoke or how much stress is impacting on them (Wilkinson, Abraham, 2004; Fidler, West, 2009; Ursprung, DiFranza, 2010), however, as adolescence is a stage of increased intense emotions (Yurgelun-Todd, 2007; Zimmermann, Iwanski, 2014), it is important to put this into context and listen carefully to young people about the nature and degree of their smoking habit, as well as any other negative behaviours when they are feeling stressed. The proposal here is not to take lightly or suggest that young people are not 'addicted' to nicotine and merely experiencing emotional extremes; but that if their emotions lead them to smoke (and smoke when emotions are intense) then they may well need the help of professionals such as stop smoking services earlier in their smoking habit. They may also benefit from help offered by youth and social workers to access strategies to help them cope with stress such as emotional intelligence and advice on positive ways to cope with stress. If such help to avoid smoking are in place for these early smokers, there could be alternatives on offer when the 'need' to smoke arises. Some purport that e-cigarettes can aid smoking cessation. E-cigarettes are a contentious issue however, in the UK, stop smoking services acknowledge the

fact that e-cigarettes can help people quit (Hartmann-Boyce et al., 2016) and that professionals should take an e-cigarette friendly approach (PHE, 2017). Having healthy alternatives and strategies to occupy time in a healthy is also important in avoiding smoking. Some young people in the Essex research reported that if they wanted to, that they would be able to give up easily when they decide to. This could be harnessed by using strategies to help young people gain a non-smoking identity (Vangeli, West, 2012). This seems to add to the proposal I am making here that suggests that a perceived mental and emotional dependence on smoking exists for some, rather than actual dependence on nicotine. This concept has not been fully explored in research, however some research does confirm aspects of this phenomenon. A study by Okoli et al. found that non-smokers and light smokers were susceptible to perceived mental, (and not perceived physical) addiction to smoking, and that this led to greater susceptibility to future smoking. Young people have strong emotions affecting their motivations, and these have sometimes been associated with withdrawal symptoms (Hoffman et al., 2006, 2007; McGee et al., 2013). Amos et al. (2006) highlights the importance of understanding the attitudes and perceptions of young smokers, and how will power (being in control) plays an important role in smoking cessation. Trinidad et al. (2004) found that emotional intelligence was a strong protective factor in smoking choices. This seems to suggest that the perception of lack of control vs. having control, or at the very least a lack of access to understanding empowerment and emotional intelligence could be a key factor in understanding young people's perceptions in quit attempts. Perceived dependence vs. actual dependence on nicotine therefore needs further exploration. It is important when trying to help young people who are making health behaviour choices (such as alcohol, drugs, smoking, consensual sex, etc.) that health and social care professionals try to understand the way that the young people themselves perceive their own need to smoke, or undertake health behaviour choices, and also to gauge how any extreme emotions might be handled. Emotional literacy advice may empower young people so that they are better able to understand and interpret their feelings and emotions, especially if these emotions impact on negative health behaviours. If help was provided to young people by giving them strategies to cope with their emotions alongside advice on alternatives to smoking, this may help prevent the young person turning to cigarettes as an emotional prop. Another young person in the qualitative phase of this study described heightened emotions when cigarettes are withheld and reports crying as a result of the upset of this. Whatever the perceptions of the young people are regarding the need to smoke, the fact remains that they *perceive* themselves as dependent on cigarettes and should be taken seriously. Psychological and *perceived* dependence, without a clinical nicotine *addiction*, may be a stage that is, for some young smokers, a very real part of the progression to smoking addiction, and one that could be at risk of being overlooked by smoking cessation services. A novel new theory proposed by Robert West (2006, 2009; West, Brown, 2013) 'PRIME theory', proposes five motivational layers: Plans, Responses, Impulses, Motives, and Evaluations. The fist layer is in the mind, the plans which someone has in order to undertake the health behaviour. The impulses which trigger the intended plans, and motives to rationalise, and finally the evaluation of whether to smoke or not. Utilising this theory, West and Brown (2013) have proposed that smokers can adopt a non-smoking image. Closely aligning their identity and the 'self' image that they have, the person can construct a self which can exist without the negative health behaviours. Social workers can utilise PRIME theory to engage SU by empowering people and helping them utilise self-efficacy gained in quit attempts, thus helping the person develop coping skills. This has been shown to work with substance abusers (Stall, Biernacki, 1986; McIntosh, McKeganey, 2000). Smoking cessation interventions are usually targeted at confirmed nicotine addicted smokers. What is needed is an acknowledgement of the strength and significance of young people's feelings, and support for young people to interpret and manage these feelings and stresses and have a repertoire of coping skills which do not rely on substances such as nicotine. Whilst a nicotine substitute may be an important part of any treatment of smoking addiction, this

needs to be delivered alongside skills-based interventions to help young people understand and cope with stress in order to adequately address and promote smoking cessation. In Essex the SFETCA have been utilising these results with young people in school educating them on how to cope with stress and how to become more emotionally literate. The stop smoking services have tools such as a stress ball so that the young people have something physical to use when tension is high. Often young people want to deal with their stress and not just react to it and by upskilling young people professionals can aid them in coping with stress throughout life. Social workers are well placed to help with emotional literacy, helping to build self-efficacy, helping people re-frame and challenge the negative identities which are so often associated with users of social care services, and those dependent on substances such as nicotine. Social workers should also consider empowering people from poorer areas to challenge government regarding unacceptable health outcomes in poorer areas, campaigning for additional funding to support health outcomes and put in place coping skills at a grass roots level.

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Health, Wellbeing and Social Support in the Groups of Employed and Unemployed in a Finnish Community

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Abstract

OBJECTIVES: In the present study, we examine whether the labour market status is a significant factor in explaining the association between self-rated health and subjective well-being. THEORETICAL BASE: We test whether social support reduces the negative effects of impaired health on well-being. Hence, we analysed whether the groups of employed and unemployed are different in terms of how they each benefit from receiving social support. METHODS: The study is based on a survey conducted in 2016. The data consist of 841 respondents from which 732 had the labour market status of employed people and 109 had the labour market status of unemployed people. OUTCOMES: Labour market status is a significant factor in explaining the association between self-rated health and subjective well-being. Unemployed people with a low health status had a much lower rating with respect to subjective well-being compared to employed people with a similar low-rated health situation. There is a greater reduction in the impact of negative factors on subjective well-being via social support in the group of employed people. SOCIAL WORK IMPLICATIONS: The findings suggest that disadvantaged people should have been offered intensified services. From a policy perspective, the findings suggest a need for close cooperation between health, labour and social services.

Keywords

well-being, health, social support, unemployment

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INTRODUCTION

The association between well-being and health has been broadly studied. Practitioners in the Health sciences field assume that happy people live longer (Koivumaa-Honkanen et al., 2000). Similarly, Newman (2011) argues that happiness improves health. In their meta-analysis, Diener and Chan (2011) summarized that subjective well-being influences health. From a health policy perspective, it is necessary to set health at the centre of policies and to emphasize the need of society-wide interventions for promoting citizens' subjective well-being (cf. Drydakis, 2015; Urbanos-Garrido, Lopez-Valcarcel, 2015). On the other hand, the association of health and well-being may be approached from a different perspective. At an individual level, a difficult health situation influences well-being negatively. In this sense, the direction of an explanation is from health to well-being.

We developed a study design for exploring how an individual's health situation influences subjective well-being (cf. Gore, 1978). According to the previous studies, one can expect that the health situation differently influences the groups of employed and unemployed (e.g. Carlier et al., 2013). More precisely, we assume that an impaired health situation more negatively influences the well-being of the group of unemployed than in the group of employed (e.g. Bambra, 2010). Furthermore, we explore the significance of social support within the study design. We analyze whether perceived social support reduces the adverse health effects similarly in the groups of employed and unemployed.

The study design simulates the challenges of human professions, where professionals try to help clients whose health is impaired. This is a typical situation for instance in social work, where social workers try to help unemployed people with impaired health by strengthening their social networks. Social work theories assume that social relationships form the basis of human well-being (e.g. Hall et al., 2013; Payne, 2015). Therefore, social work interventions are directed at clients' social networks for creating and strengthening clients' interaction with their families, relatives, friends, groups and communities. It is assumed that this kind of social support reduces the negative effects of impaired health. In this sense, the study is focused on a classic buffering hypothesis, which assumes that social support protects persons from the adverse effects of stressful events (Cohen, McKay, 1984; Cohen, Wills, 1985).

BACKGROUND

Unemployment, well-being and health

Unemployment is a risk factor that is linked to a weakened income level and a reduced subjective well-being. The negative effect of unemployment on subjective well-being has been well researched, Clark and Oswald (1994). However, Winkelmann and Winkelmann (1998) have also shown that unemployment will strongly and consistently attenuate subjective well-being (Lucas et al., 2004). Later, Dorling (2009) also found that unemployment increases rates of depression, particularly in young people. Parasuicide rates are also found to be much higher among young unemployed men compared to young employed men.

Furthermore, the association between unemployment and health is also well documented in the empirical literature (e.g. Carlier et al., 2013; Norström et al., 2014). Various studies report a strong negative correlation between individual health and the experience of unemployment (e.g. Adams et al., 2003). According to Bambra (2010), the association between unemployment and impaired health has been explained through two inter-related concepts: the material consequences of unemployment (e.g. wage loss) and the psychosocial effects of unemployment (e.g. stigma).

However, the connection between unemployment and health is not unequivocal. For instance, Schmitz (2011) found that there is no causal effect of unemployment on health, although the unemployed have on average a worse health situation than the employed. The result may be based

on the situation where workers who are ill are selected into unemployment and healthy workers are selected out of unemployment. Also, Virtanen et al. (2013) argue that there is a health-related selection into unemployment in early middle age. On the other hand, Schmitz (2011) explains that the absence of negative effects of unemployment might be based on the nature of the welfare state. For instance, the Nordic countries have a relatively high level of health insurance and other social benefits, which might buffer the negative effect of job loss. This could explain why unemployment does not lead to adverse health outcomes as it does in countries such as the US, for example.

Furthermore, the association between subjective well-being and health is broadly studied (e.g. Sabatini, 2014) and the implication is that healthy people are more satisfied in their lives than sick people. On the other hand, the direction of causality is not unambiguous. Diener and Chan (2011) argue that happy people live longer. In their meta-analysis, they summarize that subjective well-being has an influence on health. Similarly, Steptoe, Deaton and Stone (2015) suggest that well-being may even be a protective factor in health, reducing the risk of chronic physical illness and promoting longevity.

Social support

Social support can be seen as a basic instrument of social work, which aims to reduce the negative effects of health problems on clients' subjective well-being. In this sense, social support is a key concept of social work. Barrera's (1986) classic formulation on social support focuses on three different types of support: social embeddedness, perceived social support, and enacted social support. Social embeddedness refers to actual connections people have to significant others, which may be measured by focusing on one's social network. Perceived social support views support as a cognitive appraisal of one's connections to others. From this perspective, it is necessary to realize that not all linkages between individuals and their environment result in social support. Enacted support refers to the specific behaviours performed by others as they exhibit expressions of support and assistance. For instance, social support can include such activities as listening, expressing concern, lending money, helping with a task, offering suggestions, giving advice, and showing affection.

Social support can be derived from many different sources. Streeter and Franklin (1992) make a distinction between support that is provided informally from friends and family and that, which is provided through the formal human service system. On the other hand, researchers have found evidence from direct and indirect social support. According to Janlert and Hammarström (2009), it is typical to differentiate two different mechanisms for social support, the direct effect and the buffer effect. According to the direct effect model, a lack of social network is supposed to have immediate consequences for well-being. According to the buffer model, social support acts as a shield against different types of stress, e.g. unemployment. Similarly, Lakey and Cohen (2000) explain that social support reduces the effects of stressful life events on well-being (i.e. it acts as a stress buffer) through either the supportive actions of others (e.g. advice) or the belief that support is available. An individual can use his or her social network when confronted with challenges, although a social network does not automatically guarantee social support. Furthermore, social support seems to have different effects depending on people's living circumstances. In their study, Åslund, Larm, Starrin and Nilsson (2014) found that social support had its strongest effect at high levels of financial stress. On the other hand, Bartley, Sacker and Clarke (2004) found in their study that people in secure employment recovered more quickly from illness comparing to people in unsecure employment. Unemployment seems to increase the chance of being ill, especially for those who have never worked or have had poorly paid jobs. There is also evidence that unemployed workers with higher social support cope better psychologically than those without such support (Milner et al., 2016).

METHODOLOGY

Finnish context

Finland represents a country in which the state has the main responsibility for welfare. Finland has a relatively high level of social insurance (for health and unemployment) and other social benefits. Health counselling and health checks have been made available to all citizens based on the idea of universal public services. However, it has been criticized that employed people have better services available to them compared to pensioners, for example. The unemployed are probably in the weakest position in this respect (Saikku, 2012; Sinervo, Hietapakka, 2013), although the Health Care Act aims at securing their health care services (Health Care Act 1326/2010, section 11).

Unemployment has probably been the most challenging problem for Finnish society during recent decades. The huge economic depressions at the beginning of the 1990s, at the turn of the new Millenium, and once again in 2008 with several mass-layoffs in employment created a hard core of unemployment which has been difficult to dismantle (Kyyrä, Pesola, 2018). The state has aimed at creating a variety of instruments for tackling unemployment. For instance, the Youth Guarantee Implementation Plan offers everyone under the age of 25 years, as well as recent graduates under the age of 30 years some form of employment, a study place, a place in an on-the-job training scheme or in some form of rehabilitation within three months after becoming unemployed. On the other hand, the state has implemented reforms that are based more on the ideology of the workfare state than on the traditional Nordic welfare state and its universalism principle (cf. Deeming, 2015).

Sample

The data are based on a survey provided by the Department of Social Sciences at the University of Eastern Finland in 2016. The survey was focused on an ordinary life in a small town in Finland. The target town had 21 500 inhabitants (the median of Finnish municipalities was 6 178, the population of the whole country was 5 503 297) in 2016. The town is a traditional industrial town but it is located within a rural region. Its economic structure is based on industries having a share of 24.1 percent (average of 2014 and 2015) compared to the average of 14.4 percent for all municipalities. The percentage of unemployed people (as % of labour force) was 17.2 (the average for the whole country: 13.2) in 2016.

The study was focused on 5 000 urban residents aged 18–85 years who were selected randomly from data at the Population Register Centre. In the first wave (October 2016) the questionnaire was sent by post but the respondents were asked to use the Internet for responding to the electronic survey. In the second wave, those respondents who did not answer were sent a paper form and were asked to fill out either an electronic form or a paper form (November 2016). In the third wave, a reminder was sent to those who had not yet responded, and especially to those in the age group of 18-36 years because there were fewer respondents in this group than in other age groups. Finally, the response rate was 1970, which is 39.4 percent of the whole sample.

Design and hypotheses

The framework of the study is based on the relationship between self-rated health and subjective well-being in the groups of unemployed and employed people. According to previous studies, we can assume that self-rated health and subjective well-being are positively associated (e.g. Sabatini, 2014). Also, we assume that self-rated health and subjective well-being are rated lower among unemployed people than among employed people. Thus, the main aim of the study is to test whether labour market status is a significant factor in explaining the association between self-rated health and subjective well-being. Further, we assume that there is a difference between the groups of employed and unemployed in terms of how they benefit from social support. More precisely, the analysis is based on the following hypotheses:

H1: Labour market status (LMS) moderates the effect of health (H) on subjective well-being (SWB).

H2: The effect of health (H) on subjective well-being (SWB) is moderated by labour market status (LMS), which itself is moderated by social support (SS).

The hypotheses were tested in the following way. The analysis was started with a descriptive analysis and the focus was set on the relationship between self-rated health (H) and subjective well-being (SWB) by describing the relationship separately among employed and also among unemployed people. The correlations between the variables were examined by using the Pearson product-moment correlation coefficient (PPMCC). Furthermore, the mean rates of SWB and H were calculated in the groups of unemployed and employed. In the next phase of analysis, the study was focused on whether LMS effects on the relationship of H and SWB. That is, whether the effect of health on well-being is the function of labour market status (Hypothesis 1). In the final phase, we tested whether there is a difference between the groups of employed and unemployed in terms of how they benefit from social support (Hypothesis 2). The moderation model was tested by using a conditional process analysis program (PROCESS), which computes ordinary least square (OLS) regressions to test for moderation models (Hayes, 2013).

Measures

The measure of subjective well-being (SWB) can be constructed by including various components (Adler, Seligman, 2016). Life satisfaction refers to well-being, which is based on the individual's assessment and cognitive reflection of their life situation (Diener et al., 1985). Another way of measuring subjective well-being is based on emotions. Affective well-being is seen to contribute to upward spirals in coping ability, self-esteem, performance, and productivity at work (Watson et al., 1998). Furthermore, subjective well-being may be approached as a meaning of life. Meaning has been defined in various ways and for example as simply the response to the question of "What does my life mean?" In this study, subjective well-being is a sum variable, consisting of six Likert-type scale items (1= Strongly disagree…, 5= Strongly agree). Three of the items are a measure of an individual's cognitive reflection of their life situation, and another three items focus on the meaning of life. The reliability of the constructed variable was .904 in the entire data. Its distribution of normality was checked using a histogram of the entire data and separately in the groups having employment status.

Self-reported health (H) was constructed from a single variable which asked "How is your physical health at the moment?" Eligible responses were scaled from 5 to 1: "bad", "quite bad", "neither good nor bad", "quite good", and "good". Labour market status (LMS) was measured by using a categorical variable, which contained seven options: employed, student, unemployed, sick, retired, conscript, caring for children, disabled, or elderly. However, only the categories of employed and unemployed were taken into the analysis, thus the data were divided into two groups consisting of 732 employed and 109 unemployed respondents. The variable was treated as a dummy.

Social support (SS) represents the individual's perceptions of the extent to which people from their social network are available to provide social support (Cauce, Mason, Gonzales et al., 1994; Demaray, Malecki, 2002). Wills and Shinar (2000) list five important functions: emotional support, instrumental support, informational support, companionship support, and validation support. The present study focuses on the cognitive and emotional aspects of social support. Social support was measured with 11 items, from which a sum variable was constructed. All items were on a Likert-type scale (1= Strongly disagree…, 5= Strongly agree). The reliability of the constructed variable was .954 in the entire data.

Furthermore, the variables of age and gender were used as control variables. The mean of age was 48.93 in the group of employed people and 50.73 in the group of unemployed people. The number of females was slightly higher in both groups (the mean was 0.58 in the group of employed people and 0.60 in the group of unemployed people).

RESULTS

We started the analysis by examining the means of self-reported health (H), subjective well-being (SWB) and social support (SS) in the groups of employed and unemployed (Table 1). The employed group had the higher mean in health, subjective well-being and social support compared to the unemployed group. Also, we examined the correlations between health, subjective well-being and social support. As expected, health, subjective well-being and social support were positively and moderately correlated in both groups (Table 2ab).

Table 1: Mean scores of health (H), subjective well-being (SWB), and social support (SS) in the groups of employed and unemployed people

	Mean H	Mean SWB	Mean SS	n(N)
Employed	4,15 (.79)	4,21 (.63)	4.22 (.68)	732 (841)
Unemployed	3,78 (.94)	3,80 (.82)	3.88 (.82)	109 (841)

Table 2a: Correlations between subjective well-being (SWB), health (H), and social support (SS) in the group of employed people

	SWB	H
H	.313***	1
SS	.523***	201***

***<.001

Table 2b: Correlations between subjective well-being (SWB), health (H), and social support (SS) in the group of unemployed people

	SWB	H
H	.533***	1
SS	.483***	435***

***<.001

In the next phase, we conducted a model of mediated moderation for testing various interactions (Table 3). The first interaction shows the relationship between health (H) and labour market status (LMS), thus we studied whether the effect of health on well-being was different at different values in the groups of employed and unemployed. It can be seen that the regression coefficient for the product of health and employment status is b_3 = -0.194**, which suggests that as health increases by one unit, the difference in subjective well-being between the groups decreases by 0.194 units regardless of social support. In this sense, the effect of health on subjective well-being is different between the groups of employed and unemployed. The result supports Hypothesis 1. In contrast, the interaction between health and social support was not statistically significant, and neither was the interaction between employment status and social support.

Table 3: The model of moderated moderation: self-rated health (H), subjective well-being (SWB), labour market status (LMS), and social support (SS), controlled by age and gender

		Coeff.	SE	t	p
Intercept	i_1	3.918	.080	48.832	.000
H	b1	.202	.025	8.020	.000
LMS	b2	.202	.064	3.179	.002
HxLMS, Interaction 1	b_3	-.194	.073	-2.651	.008
SS	b_4	.420	.030	14.051	.000
HxSS, Interaction 2	b_5	-.057	.030	-1.909	.057
LMSxSS, Interaction 3	b_6	.013	.088	.144	.886
HxLMSxSS, Interaction 4	b_7	-.130	.065	-1.986	.047
Gender (C1)	c_1	-.048	.040	1.199	.231
Age (C2)	c_2	.061	.017	3.699	.000
		R²=.355, MSE=298			
		F(9,792)=48.506, p<.001			

Furthermore, we can see a three-way interaction (HxLMSxSS), whose regression coefficient is statistically significant, b_7 = -0.130, t(792) = -1.986, p = .046, which means that there is a difference between the groups of employed and unemployed in terms of how they benefit from social support. In this sense, Hypothesis 2 is supported. However, the three-way interaction accounts for only 0.34% of the variance in subjective well-being. On the other hand, the model can also be visualized, which makes it clearer what is happening in the data (Figure 1). As we can see, both groups benefit from the growth of social support. However, the difference between the groups is greatest in the combination of low-rated health and high level of social support.

Figure 1: Visual representation of the effect of health on subjective well-being by labour market status (employed = grey, unemployed = black) at the different levels of social support

Figure 1a: High level of social support (the scale of well-being: 3.4-4.8, health: low, medium, and high)
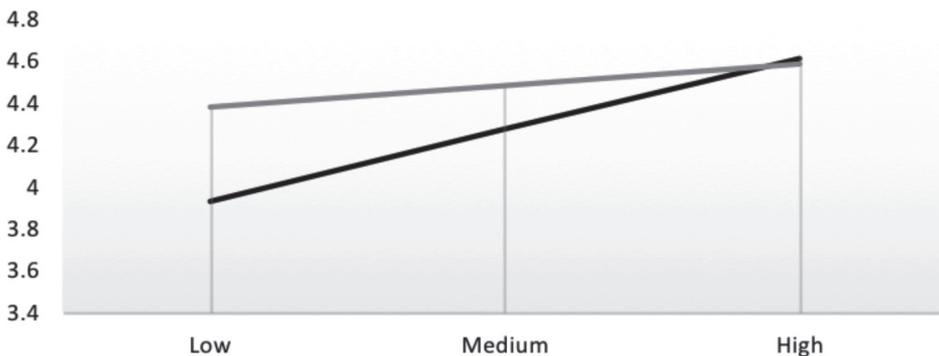
Figure 1b: Low level of social support (the scale of well-being: 3.4-4.2, health: low, medium, and high)
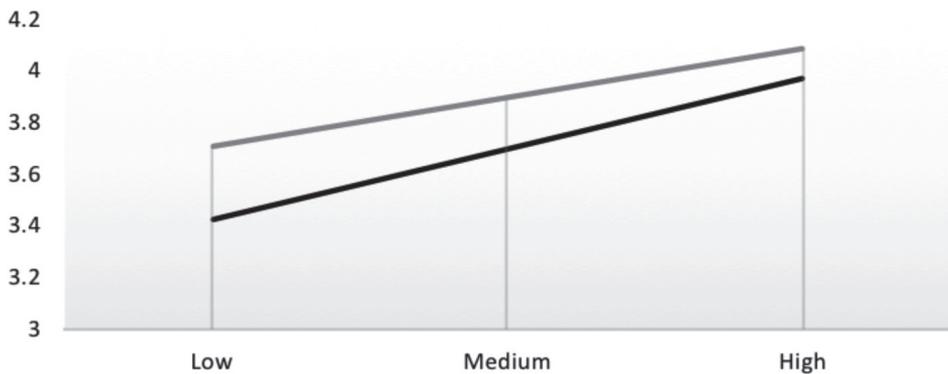
DISCUSSION

The study aimed to explore the association of self-reported health and subjective well-being within employment status. In general, it was obvious that health and subjective well-being are positively associated. The higher the rate of health, the higher is the rating for the well-being. However, the results of the present study encourage us to address the issue from two perspectives.

First, we find that the unemployed had lower rates of health and subjective well-being compared to the employed. In this sense, unemployment is a serious risk as suggested by the previous studies. For instance, Norström et al. (2014) show that unemployment is strongly associated with a lower level of subjective well-being. Furthermore, we find that the association between health and subjective well-being is conditional so that in the case of impaired health the well-being of the unemployed is lower than the well-being of the employed. The similar difference is not observed in the case of high-rated health. Thus, we found that the labour market status is a significant factor in explaining the association between self-rated health and subjective well-being and especially in the case of impaired health.

From the perspective of health and social services, the combination of impaired health and unemployment is a significant risk factor. Typically, the unemployed do not use the available services in a similar manner as the employed. For this reason, Saikku (2012) and Sinervo and Hietapakka (2013) suggest that health counselling and health checks should be offered to the unemployed in the same way that occupational services are offered to the employed. In this sense, health and social services could promote also the well-being of unemployed. Furthermore, the result of the present study underlines the significance of the integration of social and health services. Integration is a way to enhance the effectiveness of services in situations where a client's problems entangle both the social services and the health services, which is typical for the case of the unemployed. On the other hand, health and social services could also enhance their clients' chances for accessing employment. From this perspective, Virtanen, Janlert, and Hammarström (2013) suggest the use of preventive policies so that people with a history of health problems will not be excluded from the possibility of future employment. In this sense, the need of integration covers the health, social and labour services.

Second, we analyze whether there is a difference between the groups of employed and unemployed in terms of how they benefit from social support. In general, social support in our study was positively associated with subjective well-being, as expected. The greater the access to social support

for people, the higher is their subjective well-being. Similarly, Milner et al. (2016) found that the unemployed with higher social support cope better psychologically than those without such support. However, we also found that the difference in subjective wellbeing between the groups of the employed and unemployed is greatest in the case of low-rated health, although people could have access to a high level of social support. In this sense, social support protects against the negative effect of impaired health more among the employed than among the unemployed. Disadvantaged groups, for instance the unemployed with impaired health, cannot benefit from social support as much as one might commonly assume.

Studies in the body of literature describe the buffering effect as a process in which a social resource reduces (protects) the impact of negative factors on subjective well-being (Cohen, Wills, 1985). We find that social support has different effects depending on people's living circumstances, which is a consistent result with respect to the work of Bartley, Sacker, and Clarke (2004). However, this result is interesting from the perspective of social work, because a huge part of social work interventions is based on social support. Social work aims to help clients, for instance, by focusing on their social networks, an aspect that is aimed at promoting clients' social capability. According to the common assumption, the most disadvantaged clients are expected to benefit the most from social support. Even a small amount of support is aimed at being significant for the disadvantaged group. However, the present study suggests that the most disadvantaged clients are not able to utilize the received help in the same way as clients who live in better social circumstances. Hence, the perceived social support does not benefit all of those clients in the same way. Social support can have different effects depending upon the clients' living circumstances.

There are some limitations in relation to the results of this study. In general, the data were collected from a single town, hence, the results cannot be generalized in statistical terms. Nevertheless, the results are consistent with previous studies in the literature, which argue that among the unemployed their subjective well-being and self-rated health are rated at a lower level than among the employed. Furthermore, the main argument of this study is focused on the buffering effect of social support, which explains only a small part of the variance in subjective well-being. However, the visual presentation shows the mechanism of mediated moderation. Finally, in the discussion section of this paper, it is necessary to underline that the measure of social support was based on general social support received from family and friends, for example. Thus, further research is needed to deepen the knowledge on the nature of professional support.

CONCLUSION

We find that the labour market status is a significant factor in explaining the association between self-rated health and subjective well-being. In our study, there is a difference between the groups of unemployed and employed, especially in the case of impaired health. The unemployed whose health status was impaired had a much lower rating in subjective well-being compared to the employed with impaired health. Furthermore, we find that social support reduces the impact of negative factors on subjective well-being. However, this buffering effect is conditional so that the employed benefited more from received social support than the unemployed people.

From a health and social policy perspective, the results of the present study permit us to recommend that health and social professionals should enhance their cooperation with respect to resolving the needs of the unemployed. Unemployment and impaired health are a combination of risk factors, which requires close cooperation between the health and social professionals without forgetting the labour services. Furthermore, the results suggest that we should invest even more into the support which is offered to the disadvantaged groups. People in good social standing benefit more from the support they receive compared to people in a disadvantaged situation. This is why disadvantaged people should be offered enhanced services so that the buffering effect of social support will function.

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New Paradigms in German Health Promotion – (New) Challenges for Social Work

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Abstract

OBJECTIVES: This article addresses the new paradigms in German health promotion, as there is a new law (German Prevention Act) since summer 2015, asking for (new) challenges for social work. THEORETICAL BASE: This so-called "law to empower health promotion and prevention" encourages actors in this field to collaborate and forces the health insurances to put more than 500 million euros per year into a national health fund. The national prevention committee described recommendations on how to invest the money, and defined core areas (for example childcare services, schools, communities and care facilities) and core topics (for example the reduction of health inequalities). METHODS: Theoretical discussion and reflection on the current opportunities and the challenge for social work in health promotion and prevention. OUTCOME and SOCIAL WORK IMPLICATIONS: Lifeworld orientation in social work is derived as a theoretical framework to reduce health inequalities. Therefore, we focus on "health in everyday life" and discuss to what extend environmental limitations shape health-related agency – people's *real* options for action to decide either for or against an action. From a professional perspective it is inevitable to mandate for social work clients and their living environments, to include their agency in all considerations and to consequently address social disadvantaged target groups.

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INTRODUCTION

With the Act for the Improvement of Health Promotion and Prevention (Prevention Act – PrävG), which came into force on 25 July 2015, a process of development has been set in motion that will also usher in changes for social work. This act not only strengthens the collaboration of actors in prevention and health promotion, but health insurance funds in the future will invest more than 500 million euros annually for health promotion and prevention. The distribution of financial funds has so far been fairly sparse and overwhelmingly focused on measures linked to behaviour. The National Prevention Conference (NPC) has passed the first nationwide, cross-provider federal general recommendations for health promotion in living environments and businesses, which are intended for implementation in the corresponding state framework agreements (Bundesrahmenempfehlungen, 2016). "*Currently, the details of its implementation are discussed on a nationwide basis*" (Mielck et al., 2018:318). As a result, fields of activity in social work will also increasingly count towards this in future.

The main emphasis here should focus on health promotion in non-commercial living environments ('settings') such as kindergartens, schools, local authorities and care facilities, and focus on the reduction of health inequality. The same still holds true in Germany as in all industrialised societies: Members of society with poor social and economic circumstances have a higher morbidity and mortality rate (Siegrist, Marmot, 2006; Bauer et al., 2009; Janßen, 2011). Welfare systems have drawn attention to the social inequalities of health, but little attention has been given to the way in which health is a factor mediating inequalities of opportunity in education, employment and patterns of leaving home (Coles, 2000:178). In the other way around, practices of activism and behaviour limit health in a sophisticated way which seems to be predestined in reproducing health inequalities rather than reducing them. This analytical focus refers to realization of opportunities, how people's health is shaped by the social context in their life world and how social practices impact their health (MacDonald, Shildrick, 2013). Social work practice could change the view on health in the lifeworld (life reality) of the people and its "function" of social integration that goes beyond 'settings'.

In 2003 the national Coordination Network (CN) "Equity in Health", funded by the national ministry of health was established supporting setting approaches aimed at reducing health inequalities and improving health promotion for the socially disadvantaged. Today, the CN is a well-accepted partner providing concepts, methods and a strong and long-standing network, comprised of a total of 66 institutional coordination partners and, since 2004 Coordination Centres (CC's) in the 16 federal states in Germany: "*The CN was aware of the fact that the promotion of local projects should be based on a decentralized structure covering all federal states*" (Mielck, 2018:320). The expansion of coordination centres in the federal states is intended to initiate and strengthen inter-actor activities and structures in living environments as well as for the target groups mentioned in the federal general recommendations, with a clear focus on health equality. The expansion of the CC's for health equality in the states is a chance to boost equal health opportunities at the community level. Social work is an important player here with its significant potential for positioning socially disadvantaged persons directly in the living environment and improving this living environment based on health (Rademaker, 2017a). The German Professional Association for Social Work in Health Care (DVSG) has recently begun to grapple with this development with the foundation of the specialist working group for 'health promotion and prevention'. In the German associational landscape there are mainly three professional bodies that become very relevant related to Health Social Worker interests (Sjöström, 2013:113). The trade union, the Deutscher Berufsverband für Soziale Arbeit e.V. (DBSH) represents the interests of a variety of academic professions within the social science field, and predominantly employee interests, social policy and professional interests for the social work profession in general. The German Society for Social Work (Deutsche Gesellschaft für Soziale Arbeit e.V., DGSA) is a politically

independent voluntary organisation uniting the interests of members of social work and social pedagogy faculties (Sjöström, 2013). The professional body DVSG represents the interests of all social workers in a wide range of healthcare settings, grown historically from social workers working in hospitals (1926). Its scope covers permanent working groups, from special fields like psychiatry to special strategies, such as health promotion in the latest funded working group. The DVSG opens the professional interest to health social work, which is understood in social work in healthcare and fields of social work working within health intentions in social welfare. The overall goal is to reduce gateway problems between social welfare and healthcare systems and to put forth a social work definition of health that includes a lifeworld-oriented perspective of health. The DVSG working group 'health promotion and prevention' aims to build a network all over Germany, to connect practitioners, researchers, scientists and politicians in social services, and to encourage a platform for the social work profession to raise the voice for more lifeworld orientation in health promotion and prevention in policy, science and practice.

FRAMEWORK IN GERMAN HEALTH PROMOTION

In Germany the role of the state is reduced to the provision of applicable legal frameworks in the federal states (Länder) that have the responsibility to organize measures of health promotion. Health care is basically described and funded by the social insurance, set by the country's Social Code (Sozialgesetzbuch, SGB), which, however, set the framework to organize health promotion and prevention. Health promotion is mainly organized in the health care sector and financed by social insurance agencies.

In 2015 the Prevention Act was passed as an act to strengthen health promotion and preventive health care. This 4th attempt after 2005, 2007 and 2010 finally found a majority in the *Deutsche Bundestag*. The key points of the Prevention Act are:

- "*A joint cooperation of national health insurances, pension insurance, accident insurance and social care insurance*
- *A national conference on prevention with the Federation, the German states and communities (with financial participation of national and private health insurances)*
- *A doubling of expenses on prevention and health promotion by the national health insurances from 250 M euros to 490 M euros*
- *Intensification and amplification of early diagnosis in children, adolescents and adults (focus on vaccination)*
- *Healthy crèche, healthy school, healthy workplace and healthy nursing home*
- *A relief for disadvantaged families (e.g. shift worker, single parent)*
- *Strengthening of workplace health promotion, particularly in smaller and mid-size firms*" (Borgmann et al., 2015:online).

Health promotion among socially disadvantaged persons in non-commercial living environments is placed in the mostly medically dominated healthcare sector and in the social welfare sector as well. These two systems characterize different basic structures, such as risk and disease prevention in the healthcare and resource and lifeworld orientation in the social welfare system. In the social work tradition the lifeworld concept differs from health care's definition of lifeworld as settings like schools, work places or other non-commercial living environments. In social work the lifeworld concept offers a relevant theoretical background, to understand individuals in terms of their own self-concept and the subjectivity of their own interpretative and habitual patterns (Grunwald, Thiersch, 2009:135). Health is a subjective concept, which is shaped by the cultural embedded phenomenon and experience of health, evolves in the context of 'normal life' in which people practice health relevant activities and the context of experiences with health and disease (e.g. chronic illness) (Flick, 2003:483). Health is a fundamental part of everyday life. This

perspective can make the original approach of health promotion (WHO, 1986, 1997) become real: strengthening personal resources, environmental opportunities and a healthy policy for all. The aims of the Prevention Act can only be achieved if it is possible to overcome a profit orientation and the logic of prevention based on disease and risk. An appropriate solution needs to bring both different systems - health care and social services - closer together. And the federal states will have to focus on a resource and lifeworld orientated health promotion approach such as the WHO primarily defined (WHO 1986, 1997), in which social work has the leading expertise.

THEORETICAL IMPLICATIONS ON HEALTH PROMOTION AND PREVENTION

Health promotion and prevention are different strategies with the same aim - to enhance the health of the people. Within prevention this aim focuses on strategies of disease avoiding throughout addressing health risks, risky behaviour and so called risky populations, like children of mentally ill parents, chronically ill or other disadvantaged people. Health promotion bases on a salutogenetic approach by strengthening health resources, positive outcomes and providing healthy environments, as defined in 1986 by the WHO and advanced in the Jakarta Declaration on Health Promotion in 1997: "*Health is a basic human right and is essential for social and economic development. Increasingly, health promotion is being recognized as an essential element of health development. It is a process of enabling people to increase control over, and to improve, their health. Health promotion, through investment and action, has a marked impact on the determinants of health so as to create the greatest health gain for people, to contribute significantly to the reduction of inequities in health, to further human rights, and to build social capital. The ultimate goal is to increase health expectancy, and to narrow the gap in health expectancy between countries and groups*" (WHO, 1997:17). Health promotion focuses on the health resources referring to three main dimensions and five concrete strategies on these dimensions (WHO, 1986, 1997). The three dimensions, which in fact provide clear evidence for health promotion outcomes, are:

1. Comprehensive approaches to health development, and especially those that use combinations of the five strategies.
2. Particular settings to offer practical opportunities for the implementation of comprehensive strategies, which include all environments in the lives of the people, like local communities, schools, the workplace, and health care facilities.
3. Participation to have people to be at the centre of health promotion action and decision-making processes, and moreover access to education and information to achieve effective participation and the empowerment of people and communities.

Based on these dimensions the following strategies provide the framework for health promotion worldwide (WHO, 1986, 1997):

1. Build healthy public policy to promote social responsibility for health.
2. Create supportive environments to increase investments for health development.
3. Strengthen community action to consolidate and expand partnerships for health.
4. Increase community capacity and empower the individual to develop personal skills.
5. Reorient health services to secure an infrastructure for health promotion.

The dimensions and strategies access health as a constitutive element as a right for everyone (OHCHR, 2002), which in fact means to provide health promotion in an approach that is broad and overcomes system borders among the whole population, addressing health promotion thorough all classes and societies. Even if this seems to be consensual, the reality, analyzing the German example is disillusioning: current practices are more likely to concentrate on risk avoidance, and the possibilities in changing environments are by far not exhausted! Within the Prevention Act one avenue for collaboration and overcoming different systematics of profit and

non-profit orientated institutions is open. But, multidisciplinary, and moreover co-operation needs are a widespread challenge for the federal states at the same time. Health care systems tend to preventive strategies while the social sector refers to the lifeworld but is more likely to forget about health as a constitutive part of people's everyday life. But, health in the lifeworld of disadvantaged people is a collaborative approach. To enhance health opportunities by providing "*peace, shelter, education, social security, social relations, food, income, the empowerment of women, a stable eco-system, sustainable resource use, social justice, respect for human rights, and equity*" (WHO, 1997:18) in everyday life is the best health promotion for all.

Lifeworld orientation

Health is a constitutive element of a person's everyday life, and this is where it is established and maintained (WHO, 1986; OHCHR, 2002). Health promotion cannot be understood to be an *add on* here, but rather the job of society as a whole to provide all people with equal health in a fair way (WHO, 1986). The promotion of health among socially disadvantaged persons relies on the community structure, which links to this immediate lifeworld, which in the sense put forward by Thiersch[3] in the 1970's. Individuals must be understood in terms of their own self-concept and the subjectivity of their own interpretative and habitual patterns (Grunwald, Thiersch, 2009:135). This subjectivity is formed in a process of exchange and interaction with others and emphasizes the value of the individual's self-assertion and self-representation in society (Grunwald, Thiersch, 2009). Reconstructions of the everyday and of the lifeworld reassemble the thinking patterns and living structures in which the everyday is experienced (Grunwald, Thiersch, 2009). Lifeworld orientation in social work derives from the question of the recipient's living environment. Following Thiersch and Obert, this is a trivial conclusion that must naturally apply to all social work and all work (Thiersch, Obert, 2015:11). It seeks to protect people, to advance them and to help them. The fact that this is being specially emphasized as a maxim in lifeworld-oriented social work is based on the fact that it is precisely this implicitness that is always under threat of being overlooked, forgotten and pushed aside (Thiersch, Obert, 2015). Thiersch and Obert see a significant difficulty of lifeworld-oriented practice in the fact that institutions' activities are determined according to specific interests. "*These activities lead to problems and issues in which people act being viewed in specific ways: Everyone has a pair of glasses, their own specific glasses, and they view everything through them*" (Thiersch, Obert, 2015:11). The concept of the lifeworld refers to the interplay of concrete life circumstances and social welfare, and how human behaviour and everyday coping patterns in the struggle for a successful everyday life were shaped by structure and subjectivity. This issue of opportunities for health in everyday life seems to be one core starting point to a precise analysis of health promotion in social work practices. Understanding health in its subjectivity, as WHO emphasizes (1948) in a subjective psychological, physically and socially well-being, is more like being free of disease or even social determinants on health. Health is constituted in a subject-orientated everyday theory (Leventhal et al., 1984), to what extent persons have own values, habitual practices and coping patterns within one's body, like Boltanski assumes in his construct of a somatic culture (Boltanski, 1976). These subjectively satisfying coping strategies emerge in concrete life circumstances, in the lifeworld of the people, and, however, in return were shaped by these circumstances at the same time. The subjectivity of health is limited by socio-cultural habits. In his theory of structuration Giddens emphasizes the terms "structure" and "agency" (1984). "*To be a human being is to be a purposive agent, who both has reasons for his or her activities and is able, if asked, to elaborate discursively upon those reasons*" (Giddens, 1984:3). Human beings are capable actors and constructors of their own life projects. To feel the ability of having influence on one's life, is one major aspect keeping things going in an individually satisfactory way. "*But terms such as*

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[3] The concept of the lifeworld orientation in social work was established in the 1970's by Hans Thiersch. It became for German theory and practice discourses in social work one of the most famous basic concepts.

'purpose' or 'intention', 'reason', 'motive' and so on have to be used with caution, since their usage in the philosophical literature has very often been associated with a hermeneutical voluntarism, and because they extricate human action from the conceptuality of time-space" (Giddens, 1984:3). Health is one of these constitutional elements of everyday life, which is more likely to be associated with individuals' responsibility, especially in neoliberal policies of activism and behaviour. But, it seems like limited attention is given to the role of health in the lifeworld and the shaping of inequalities in the environment. A more fruitful avenue is via the concept of wellbeing and the well-known capability approach (CA). This concept refers to the objectively given freedom to a good and healthy life, in which Nussbaum sets a vague but normative framework on basic freedoms. *"And that is my idea: the goals are plural and incommensurable, but they are also part of a set that needs to be realized as a whole"*, she says at the HDCA-Conference 2015 in Washington D.C. (Nussbaum, 2015). In just societies motives and relevances might differ, but not the practical freedom to a good and healthy life. States were asked to enhance opportunities for socially disadvantaged persons to realize this practical freedom. A key value remains in the potential for the concept of well-being to drawn attention to how the people's well-being is shaped by the social contexts in which individuals life projects are made (MacDonald, Shildrick, 2013:148). This approach pays attention to how social structural inequalities, not (just) personal behaviour, impact on health and ill health (MacDonald, Shildrick, 2013). On the opposite health promoting strategies are likely to demand the 'good' and 'capable' member of a society for health. This tension rather exerts pressure (ill health) than promotion (maintain health) – the option space to healthy behaviours is shaped by institutions and structures practices. They mediate *real* opportunities in everyday life in a subtle but widespread way, and in this provide or limit human options to health. To feel in control of life and live the life one individual has reason to value, while at the same time maintaining health in reality, is more like individual capacity and formats real health-related agency. This health-related agency is the real option space to heath in everyday life practices (Rademaker, 2017a, 2017b). Elements of the 'normal life course', such as opportunities for education, employment and personal growth, are on the one hand basic resources to maintain health and were on the other hand shaped by socio-cultural structures as well as the health situation of the people. The subjective construction of the individual's lifeworld, and to what extend this conglomerate of provided and available recourses to health, such as personal and socially *actually* offered functioning and socio-cultural limitations in the reality of the people, provide options to health in reality. These opportunities for health are emphasized in the living environment against the backdrop of the current living situation: in socialisation (Hurrelmann, Richter, 2016; Lareau 2011), in the environment (Vester, 2009) and real, lived everyday practice. The price of health, so Vester argues in the context of environment-specific lifestyle and health, is very high: Burdens, stress, living and working environment, professional and familial "catastrophes" and health misfortunes shake individuals to vastly different extents depending on their individual living situation and opportunities (Vester, 2009:49). Health is not only affected by individual abilities and opportunities to choose for or against a certain life and to decide actions in a certain context. Behaviour by itself is thought too narrow an influencing factor that can also be very disillusioning. In the worst case, one works steadfastly on one's own individual failures. This is disillusioning for both sides – the affected party and the helper(s).

The question of resources, that is to say abilities and opportunities to establish health on an everyday basis, is a central one. This is not sufficient by itself, however. What do we gain from health-promoting school breaks with fruit in Mensa if the pupils have no money to go to Mensa and eat a toast and Nutella instead? Or what do stress management courses for working mothers gain us if single parent, part-time working women can barely manage their everyday life between job(s), kindergarten, school and stress with their landlord?

Both offerings probably rather identify those who are already health-aware and also rather more likely increase the pressure on those who are already unable to measure up to the socially defined requirements of a healthy and good life by means of a *health diktat*. One possible response can be

analyzed for example in prejudges referring to the health promotion system, which in Crossley's research explore attitudes towards health and a theoretically postulated increasing 'resistance' to health promotion amongst the general public (Crossley, 2003).

Now, the Prevention Acts means health promotion in the lifeworld is being legally standardised for the first time. Living environments are defined in Sec. 20a Para. 1 PrävG as social systems meaningful and definable for health, in particular for living, learning, studying, medical and care provision as well as leisure activities, including sport. This is one great step in a substantial change towards a more effective and striking health promotion. But it is a long way and several more steps must be defined and undertaken. If one takes a focus on living conditions seriously, lifeworld-oriented health promotion must be conceived based on the real, everyday practice of living (Rademaker, 2017a). The implementation of the Prevention Act in the sense of living environment-oriented health promotion should thus clearly reference settings and, in addition to an ongoing drive in behaviour prevention be aimed at a change in relationships and thereby expand the real options for action available to socially disadvantaged persons. It seems worthless to continue measures and projects only with the label of offering them in living environments. How can disadvantaged members of society consequently be addressed? How can professionals know more about the subjective constructions of health of their target groups? How can the health-related agency be a main topic in health promotion – practically and precise? And how can individual capabilities be developed in measures of health promotion?

Health-related agency

Health promotion, which seems to be used in a demand for normative valuable 'healthy practices', has to shift to a broad perspective that goes beyond human capacities to act healthy, and works at the environmental limitations to health in the lifeworld of the people. Opportunities of health in everyday practices were shaped more by avoiding risky behaviour and strengthening health resources. To strengthen health agency following Emirbayer and Mische, the focus of promoting health has to shift to *"the capacity of human beings to shape the circumstances in which they live"* (Emirbayer, Mische, 1998:965). Referring to the CA, the state has to provide circumstances, in which all individuals have the practical freedom to shape their life projects in a satisfying way, but moreover in the normative given framework of human rights. To become more precise, the debate about agency links to the *"temporally constructed action by agents from various structural environments, temporal-relational action contexts, that equally reproduces as well as transforms such structures in the interplay of habit, perception and evaluation in order to respond interactively to problems that confront changing historical situations"* (Emirbayer, Mische, 2017:147). Agency describes people's *real* options for action to decide either for or against an action and locates these options in relation to the situational context in which a person finds themselves. Options are based on one's own abilities, possibilities, freedoms, but equally also on motives, acquired and prized behaviours, social norms and the spirit of the times independent of values. The complexity of agency can be linked back to the actors' living environment.

To strengthen health-related agency is a multidisciplinary approach in collaboration of all actors in the professionals and lay system, on the micro, miso, and macro level of communities (see Figure 1).

Figure 1: Strengthening health-related agency on the micro, miso, and macro level of communities
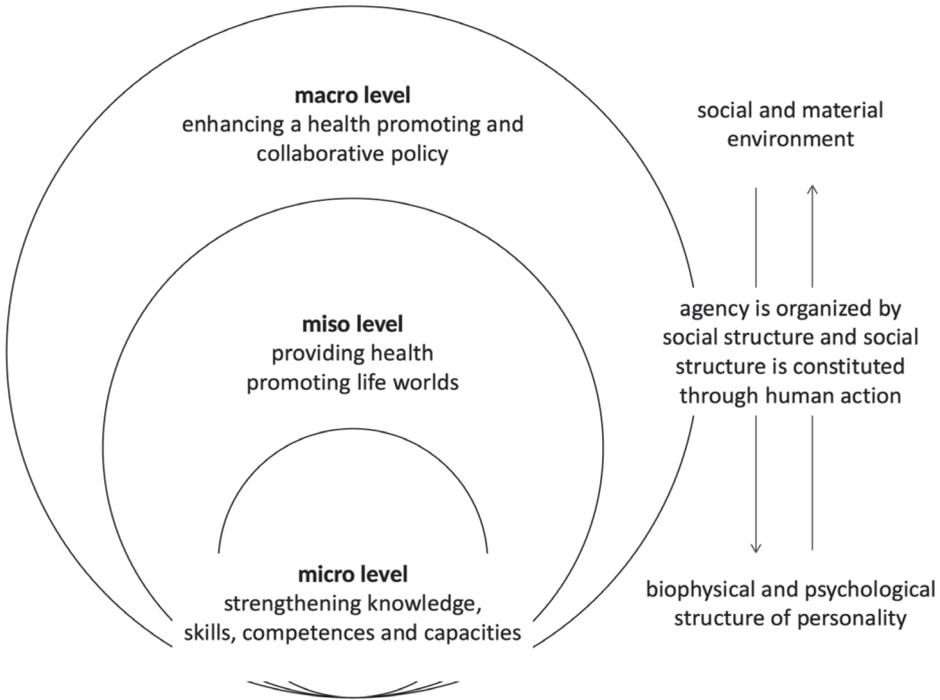
Source: Author's own figure based on Hurrelmann, Richter, 2016

On the micro level health-related agency can be boosted in strengthening knowledge, skills, competences and capacities, on the miso level in providing health promoting life worlds and on the macro level in a health promoting and enhancing collaborative policy. A renewed focus on health-related agency (Rademaker, 2017b) may significantly improve the locally oriented practice of health promotion among socially disadvantaged persons. It focuses less on the responsibility of the individual, but rather on the circumstances in which the opportunities for health are distributed in everyday life. This relates in particular to lived (health) routines, ideals and ideas as well as normative judgements of practical options to act in real everyday life (Löwenstein, 2017). Health-related agency describes humans' real opportunities to engage health in routinely incorporated practical activities, interactions, and institutions over time. These possible future trajectories of action, and the capacity of actors to make practical and normative judgements among his or her alternatives, provide health-related agency. Health-related agency responses to the emerging demands, dilemmas, and ambiguities of presently evolving situations (Emirbayer, Mische 1998:971). "Health does not occur in a vacuum." (Williams et al., 2008:15) It is not simply something one has or is, but a *"reiterative set of practices and ritualised performances by which one, literally and metaphorically, materially and culturally, socially and morally, becomes 'viable' […] in the sense that the performative aspects of health demonstrate the social and cultural legitimacy of the body, both to self and others […]"* (Williams, 1998:444). The reproduction of everyday life, like Lareau sums up in her ethnography about child rearing in US-American families is a pattern of environmental circumstances: everybody creates his or her life within a specific social context. We don't build the roads we ride on, hire the teachers who taught us in school, decide how rapidly the city would clear snow from the streets, or compose the racial, ethnic, or social class balance of our schools

or neighbourhoods; nor did we determine the availability of high-paying jobs in the area, set the education and skills required to fill those jobs, or pace the growth of the national economy (Lareau, 2011:14). Health-related agency is embedded in conceptions of time and action, involves varying degrees of inventiveness and reflectivity in relation to action and its temporal-relational contexts, and health-related agency is intrinsically social and relational, it *"centres around the engagement by actors of the different contextual environments that constitute their own structured yet flexible social universes"* (Emirbayer, Mische, 1998:973).

A connection to health-related agency promises success in the discourse around health promotion among socially disadvantaged persons (Rademaker, 2017b). This implies a practice of health promotion that not only implements initiatives in the living environment (the setting), but rather initialises this based on people's living environment together with these people. Institutional initiatives would tend to be planned more on the basis of the profession, the institution and their possibilities, and e.g. organise health promotion according to the socially imposed expectations of how people should stay healthy in everyday life. The situational approaches, individual need and specific interests of recipients run the risk of falling behind here. These are, however, frequently the cause of health restrictions, disorders and burdens and require a multi-perspective treatment of health in the living environment from the viewpoint of all actors involved. In understanding the motives and valued everyday practices of the people a unique chance to enhance health-related agency can occur, focusing on the strong tension between everyday patterns and opportunities to health: *"the specific forms of interplay between the qualities and capabilities of subjects with objectively given (social) conditions"* (Otto et al., 2013:210). This form of health-related agency refers to the "practical freedom" of real options for health and the people's perception of a good life (Otto et al., 2013).

Participation

If health is to be mutually established in the respective living environments, then this also requires an uptake in real participation. According to Wright, Block and Unger (2016) the participative practice of health promotion develops systematically in stages, starting with the pre-stage of participation through participation (see Figure 2) on to the highest possible degree of self-organisation (Wright et al., 2016).

Figure 2: Systematic steps of participation in health promotion
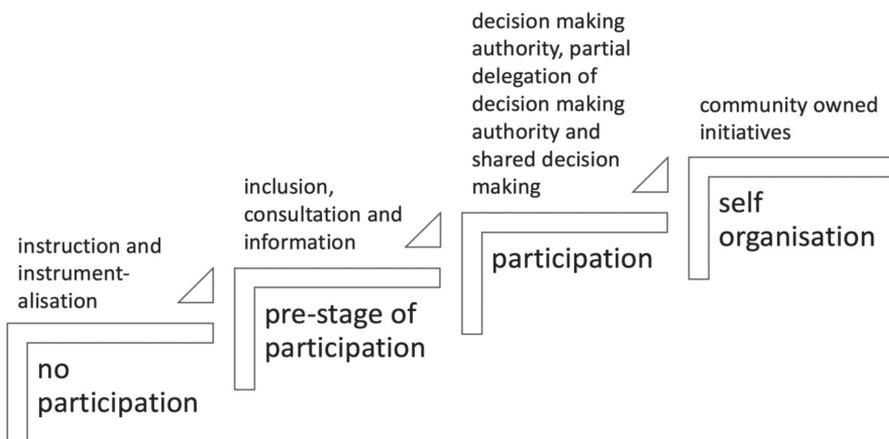
Source: Author's own figure based on Wright et al., 2016

In the context of this development process, the target groups must be empowered to recognise their own needs, to formulate aspirations derived from these and to introduce ideas or concepts. Professional practice changes to advisory and supporting work and acts in a less nominating way. Participation not only increases the needs-based focus, acceptance and uptake of initiatives, but rather even awakens health-promoting potentials: self-efficacy, conscientiousness, communication and interaction abilities and much more (Zeldin et al., 2009). For this reason, the Cooperation Network "Equity in Health" highlights participation as one of the twelve Good Practice criteria (Kooperationsverbund gesundheitliche Chancengleichheit, 2017) for health promotion among socially disadvantaged persons. Because, *"for what is largely ignored in the theoretical framework of egalitarian liberalism is the question of the extent to which the options opened up in principle by the provision of resources or basic goods can in fact be made use of by real people in their concrete life circumstances"* (Otto et al., 2013:210). People are participants, not just recipients. They are 'agents' of their life and have the ability to direct or influence health. Participation in health promotion includes to take their life seriously and analyze these subjectively valued life projects critically throughout the circumstances, struggles, challenges and needs they occur. This implies identification of health challenges out of the lifeworld, and not just in the lifeworld. To become precise: a drug prevention intervention in poor neighbourhoods is health promotion in a setting. Health promotion out of the lifeworld would primarily analyze the lifeworld of the people living in this neighbourhood, and however initialize the intervention together with the people of this area. The perspective is different, because it does not focus on risks, but on understanding and improving options in the lifeworld. It aims to enhance health as a whole, for all inhabitants in this neighbourhood – not only the drug users. Maybe the drug consumption has something to do with unemployment, less life satisfaction or moreover a lack of other options? So why not strengthening community resources instead of avoiding risks? Surely the people of this neighbourhood will be easier to reach by not blaming them as a victim.

Defining goals, planning a project and implementing interventions is a collaborative process, that depends on the structural participation of the people living in the environment. Participation in health promotion keeps direct and indirect effects on health. Moreover, being involved provides low-threshold accessibility of health promotion programmes, which has the potential to overcome the prevention dilemma. This is adapted in community-based participatory research (CPR) for health (Minkler, Wallenstein, 2011:9). The main aspects of this research strategy focus on participation in the whole process and cooperation of all actors, to engage community members and researchers in a joint process in which both contribute equally. It is a co-learning process, which involves systems development and local community capacity building. It is an empowering process which can increase participants control over their lives. And, it achieves a balance between research and action (Minkler, Wallenstein, 2011). Consistent participation at all levels (planning, implementation, evaluation) makes it possible to organise health promotion in real everyday life and thereby presents Social Work with new (old) challenges as the central actor in the living environment of socially disadvantaged persons.

CHALLENGES FOR SOCIAL WORK

The (new) challenges for social work, as mentioned in the title of this article, seem to be more or less old. Social work plays a key role in local health promotion among socially disadvantaged persons as well as in the development of health-related agency for affected target groups. This is well known and based on former social work pioneers, like e.g. Richmond refers in her "Social Diagnosis" to the relation of people's opportunities, social disadvantages and environmental circumstances (Richmond, 1917). However, the evidence and tradition show that health promotion and disease prevention is shaped by health care systems, which in fact tend to preventive practices. In neoliberal societies, the concept of health promotion habitually is subsumed under subject's

capacities: individuals have to actively maintain their health and be capable to become valuable for society. Health promotion and risk prevention were concepts for active and self-responsible people, and therefore, the welfare state offers particular benefits for those who were acting healthy in a neoliberal given framework.

The establishment of the Coordination Centres for "Equity in Health" in the German federal states enables stronger cooperation from actors in social and health services in the immediate local area as a significant mark of quality (Mielck et al., 2018). *"The collective co-production of local social order has (…) an empirically verifiable influence on the health and social possibilities of the people living and working in the neighbourhood"* (Bär, 2015:6). The formation of this cooperation offers both a challenge and chance for social work to involve itself in this interdisciplinary dialogue both consciously and professionally: one chance lays in a broad and an overcoming of the system borders opportunity for health promotion in the community, and in promoting the social work perspective. This social work perspective on health promotion in the lifeworld differs with the health care tradition, where the life world is located in 'settings'. Social work practitioners need support realizing lifeworld orientated health promotion such as chapter three outlines. But who could offer this kind of professional support? Therefore, community-based approaches offer a fruitful avenue for health promotion. There is strong evidence that people benefit when they actively contribute to local community development. On the other hand local professionals benefit to create change in a community, if they understand the community context. Every community has qualities that can be built upon to promote health. This strength-based practice, referring to Saalebey (2006), focuses on **C:** competencies, capacities, courage and character, **P:** promise, purpose, possibility, positive expectation and **R:** resource, resilience, relationships, resourcefulness, resolve, and reserves (Saleebey, 2006:10) in the community. Saaleby's CPR model improves the quality of life by helping the people to utilize their own capacities, identifying their options in the community, understanding structural barriers in the environment, and taking leverage on the hopes and aspirations of all actors. *"Healthy communities are those that, in part, view {young} people as partners rather than clients and involve them in positions where their contributions make a difference"* (Zeldin et al., 2009:4). Being involved gains a stronger sense of agency, belonging and connection to the community and develops personal and civic competencies (Zeldin et al., 2009). There should be consensus that this refers not only to youth: culture, structure and programming may be strengthened when actors in a community work together. The Public Health Action circle (National Academy of Science, Institute of Medicine, 1988) provides a baseline for strengthening health-related agency within participation (see Figure 3).

Figure 3: Model of strengthening health agency within participation
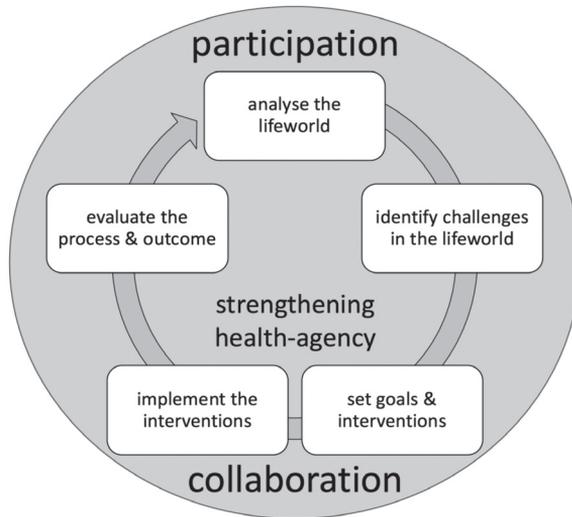
Source: Author's own figure based on the Public Health Action Circle of the National Academy of Science, Institute of Medicine, 1988

It is a challenge not to limit oneself to "easily" reachable living environments such as kindergartens, schools and businesses. Communities in particular with their largely complex structures are the living environments in which vulnerable groups such as the elderly, families or the unemployed can be reached (Altgeld, Sterner, 2017). The task here must be to develop participative projects and initiatives based in these groups' living environment that can develop effective health promotion for the reduction of health inequality (see Figure 3): The lifeworld of the people must be the core starting point of interventions to identify to what extent everyday challenges shape their health. Setting goals and the implementation of intervention as well as the process of evaluation are cooperative and participative processes that involve all actors in the environment. Moreover, the strengthening of health-related agency never ends. It is a procedural development that needs a critical analysis in its outcomes for the people, modification related to changing environments and good practices to be established. The national development of health promotion and prevention chains like the ones developed by the CN and the partner process "Growing up healthy for everyone!" for the target group of children can be a start for the German practice (Landesvereinigung für Gesundheit & Akademie für Sozialmedizin Niedersachsen e.V., 2013).

Finally, the realisation of participation opportunities should also be seen as a challenge. Health is a right for everybody, a right to be protected especially in the marginalized and socially discriminated society, and in this a main postulate for social work practice, standing for "social justice, human rights, collective responsibility and respect for diversities", aiming to "engage(s) people and structures to address life challenges and enhance wellbeing" (IFSW, 2014). Following completely in this tradition of social work as a human rights profession, we must advocate for the rights and needs of socially disadvantaged population groups and implement their right to participation in, and the mutual shaping of, their living environment. This theoretically constructed foundation, which on the one hand enjoys great consensus, must on the other hand be continually redefined and practically implemented on site locally. If the principle of participation is taken seriously,

this means comprehensive structural changes. Spaces must first be created for experimenting and reflecting so that the participants can learn how participation can best be realised. Participation challenges, because it demands time, flexibility, cooperation on an equal footing, the readiness to act even outside of hierarchies, the building of trust and continuity in collaboration (Wright et al., 2016).

Focusing on the health-related agency among socially disadvantaged people implicates a critical analysis of health in the environment and how societies provide structural opportunities to health. This refers rather to health promoting projects which in fact emphasize risk denial. Health promoting programmes are those which offer education, access to labour market, and all the other options humans need to live the life they have reason to value. *"One such major challenge is the issue of social exclusion, which underlies the issue of social equity. That is to say, the mechanisms that drive social exclusion are also the drivers of social inequity and, accordingly, are expressed as health inequities in a given society"* (WHO, 2015).

Three perspectives become important, which are based on the three mentioned levels (micro, miso, macro): First, people's life and health world and how they cope with challenges in relation to the 'normal' life course, second, to what extent well-being and health shape the people's patterns of coping with life challenges, and third to what extent health and well-being are shaped by these life challenges. Such analysis provides a fruitful framework to criticize activism in health promotion, which tends to ignore patterns of everyday life among socially disadvantaged groups. *"A better understanding of critical moments (their advent and outcomes) is one avenue for exploring individual difference and agency – in respect of wellbeing, the impact of well-known health inequalities, the shape of transitions, the experience of social exclusion – in shared contexts of social and economic disadvantage"* (MacDonald, Shildrick, 2013:159). Strengthening health-related agency within participation, following the International Collaboration of Participatory Health Research (ICPHR), "is not done "on" people as passive subjects providing "data," but "with" them to provide relevant information for improving their lives." (ICPHR, 2013) *"In participatory health research (PHR) the goal is to maximize the participation of those whose life or work is the subject of the research in all stages of the research process. [...] PHR is action research, engaging people in making change for the better, for example, by finding ways to make neighbourhoods safer, helping health professionals to know what patients need, and empowering citizens to take political action to improve their living conditions"* (ICPHR, 2013:online). The common distinguishing features of participatory approaches to health research are

- Participation, locality and collectivity in research and ownership.
- Aims for transformation and social change, promotion of critical reflectivity and production of local collective co-created dialogical and diverse knowledge.
- Striving a broad impact, producing local evidence based on a broad understanding of generalizability, following a specific validity criteria and dialectical processing (WHO, 2015).

Collaboration is an important element of strengthening health-related agency at the local level, but one of the most difficult pieces of work too. However, cooperation is one core strategy in social work practice: fundamental barriers caused by different status of participating actors, obligation in their working alliance, availability of resources and different reference systems of actors challenge the work together (van Santen, Seckinger, 2008). In the historical tradition health care and social services developed with fundamental differences that follow different concepts, approaches and strategies and create barriers to effective joint working thus far. Sometimes even common similarities in the practice were neglected or rather seen as collaborative tasks. The different 'languages' and system 'logics', e.g. within the various definitions of health and its function in everyday life, do not necessarily contribute to collaborative strategies. Unfortunately, the social work practice still struggles with its leading competence in health promotion and prevention.

For the work of the DVSG the lifeworld-oriented approach in health promotion becomes the basic framework, which focuses more on the equality-question in society, and aims to promote health promotion and prevention based on social works expertise in professional practice. To gain a precise theoretical understanding of health, the structural and particular subtle boarders in which people live and how their option space of real opportunities to health is limited in every day life, becomes the core focus for the work in the special working group 'health promotion and prevention'. This conceptualization of social justice is an advocacy health promotion approach, and builds the baseline for the working group in the DVSG. The new Prevention Act offers a chance to influence health promotion in a broad way and to overcome the *dilemma of prevention* within the social work profession. More than 500 million euros must be spent in local activities, which have to focus the living environment of the people and collaborative strategies at the local community level. The funding is mainly organized by the CC's in the federal states, at the heart of communities. The base to overcome health demands and to gain a more precise theoretical understanding of health in the lifeworld is set and social work is predestined to take over this job. In strategies like PHR the people were taken as serious and active actors, with individual life projects, struggles and needs, and the view expands on community resources rather than individual's risks. If the profession now takes the challenge and gains a more precise theoretical and professional answer on lifeworld orientation in health promotion, the promises of the new Prevention Act have the chance to be realized.

OUTLOOK

In order for health promotion and prevention to reach socially disadvantaged layers of society, there needs to be structurally anchored cooperation and participation on the part of all actors involved. Cross-sector collaboration at the community level in the federal states is not a question, but rather a clear and guiding response for a qualitative improvement of the structures for health promotion and prevention. The foundation of the Cooperation Networks "Equity in Health" in the states in Germany represents an opportunity that must now be qualitatively further developed. The social work profession is particularly called upon here to shape this process. Health Social Work makes a significant contribution here, and in fact does so in the form of theoretical as well as practical points of reference in the context of a lifeworld-oriented understanding of health. The structural and financial changes brought about by the Prevention Act in Germany are to be welcomed since they take a long necessary step towards the structural improvement and expansion of measures for prevention and health promotion. For this national perspective the DVSG network aims to promote social workers to find their place in this transformation. In collaboration of scientists, researcher, practitioners and politicians, social work might manage to make a significant impact in the debate surrounding the formation of lifeworld-oriented health promotion and convey its perspective at specialist conferences and in publications as well. Furthermore, social work can designate and occupy its own subject areas in the context of agenda setting and recognise its role as a policy-shaping profession within the context of policy practice. The fact that this development initiated by the Prevention Act is in many ways just getting started could also be an opportunity for social work[4].

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[4] The aim of the working group of "health promotion and prevention" founded in December 2017 is to take up the issue of socially defined health inequality in the German Professional Association for Social Work in Health Care (Deutsche Vereinigung für Soziale Arbeit im Gesundheitswesen, DVSG) and to act for the creation of lifeworld-oriented health promotion as part of social work practice. We understand health promotion to be the core duty of Health Social Work and want to bring together core elements from practice, research and scholarship. If you are interested in being a part of this, please contact: Dr Anna Lena Rademaker, Prof. Dr Katrin Liel. You can find more information at: http://dvsg.org/die-dvsg/fachbereiche/gesundheitsfoerderung-und-praevention/.

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The Concept of Self-Care, Work Engagement, and Burnout Syndrome among Slovak Social Workers

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Abstract
OBJECTIVES: This article focuses on the empirical verification of the connections between self-care, burnout syndrome, and the level of job satisfaction of Slovak social workers. THEORETICAL BASE: An essential part of working in the conditions of the provision of care is uncertainty, a risky environment, time pressures and the serious consequences of one's decisions. The area of self-care is essential in this context because it is comprised of self-care that enables one to increase the overall well-being in the work environment and can prevent negative phenomena in their work. METHODS: The author's questionnaire was used to evaluate the self-care performance among 405 social workers, which was used in combination with the MBI (Maslach, Jackson, 1981), and the UWES questionnaire (Schaufeli, Bakker, 2003). OUTCOMES: Four factors of self-care were identified. In addition, links between self-care and well-being at work, and burnout

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syndrome were identified. Self-care can therefore positively affect well-being and prevent burnout syndrome. SOCIAL WORK IMPLICATIONS: It is necessary to focus on improving self-care in professionals particularly through educational activities not only during their practice but also during the training of social workers. A prerequisite for the expansion of these activities is the fact that only a professional with a good level of self-care is sufficiently prepared to work for the clients.[4]

Keywords
self-care, performed self-care, work engagement, burnout, social workers, social practice

INTRODUCTION

Self-care is a technical term, used in many fields of science in a variety of ways. A person's ability to take care of themselves in areas of everyday life is considered a basic and natural disposition of the individual (Lovaš et al., 2014). Self-care represents an interconnected multi-dimensional concept consisting of mental and physical health leading to an improvement in the quality of life of an individual (Cameron, Leventhal, 2003). It includes several components, including physical, emotional, spiritual, social and recreational areas (Tartakovsky, 2015). The paradox of this phenomenon may be the fact that while one person classifies a situation as self-care, another person may classify it as a stressful one. For example, a team sport may on the one hand be regarded as a form of relaxation. On the other hand, it may be viewed as a kind of competition which may induce stressful, even frustrating feelings (Williams-Nickelson, 2006).

One of the characteristics of social work is also its dynamic nature and the need to respond to changes in society (Tóthová, Žiaková, 2017). An essential part of working in the demanding, dynamically changing conditions of the helping profession is uncertainty, a risky environment, time pressures and the serious consequences of one's decisions (Profitt, 2008; Monk, 2011). These circumstances underline the importance of the factors entering into the process of decision-making related to the emotional survival of persons in problematic situations (Gurňáková et al., 2013). However, it is important that the individual with a high level of self-care can effectively help other people, which is more than desirable in the field of social work (Filaroski, 2001). Self-care could become an essential part of good practice in the field of social work (Collins, 2005). Social workers, as well as workers in other assisting professions, encounter many problems in their day-to-day work that pose high demands on their psyche, so it is very important that they find time to care for themselves (Šlosár, Šoltésová, Plavnická, 2017). Self-care is also important for social workers in the field of performance and personal growth. Murphy and Dillon (2003) point to the stressful environment to which social workers are exposed to every day. Therefore, it is important to focus on the behaviour, survival and inner well-being of a social worker in the context of his/her work activities. On the contrary, Cunningham (2004) considers further training of social workers in the area of self-care important. By that he means organising of a variety of lectures to teach the correct use of self-care strategies, which can significantly improve the physical, psychological, occupational, spiritual and interpersonal areas of social workers.

An expert working in the field of helping professions is not only a professional but also a balanced individual. He/She focuses on the consistent fulfilling of his/her obligations, has a positive impact on the social environment he/she lives or works in, improves the situation of the client and may even contribute to the higher status of their profession in society (Saakvitne, Pearlman 1996;

Profitt, 2008). In this respect, personal growth and development are especially important because an expert is considered part of a greater whole. Therefore, an expert is a real authority, which ultimately increases the feeling of personal responsibility. It is assumed that they will approach their profession as well as the problem solving from the perspective of the general good and ethics (Naagarazan, 2006). If the above particulars are aligned in the life of a social worker he/she is able to focus on him/herself, manage his/her personal and professional growth. This is also a key competence of social workers (NASW, 2009). They are able to properly decide, collaborate with clients or other professionals, focus on reaching their goals in due time and contribute to positive changes in social work as a profession. An essential tool of each social worker is in the vast majority of cases themselves, therefore it is important that this instrument functions efficiently and effectively, thereby increasing their potential in the work with clients. The self-care involves psychological, personal and also organisational activities (Lovašová, 2017).

Social determinants are also very important, such as the conditions in which the individuals are living, the environment into which they are born, where they grew up, but most importantly in the context of this paper, where they work. According to several theories (e.g. systemic theory, life model), social work is a profession where personal maturity, experience, ethical attitude and training are expected (Brnula, et al. 2015; Šlosár, et al. 2017). This is work with a special position in relation to clients, including creating trust-based relationships, but sometimes shouldering problems of one's clients (Hricová, Nezkusilová, Mesárošová, 2017). Teamwork, quick and right decision making, emotional balance, personal effort in solving the clients' problems, responsible and effective approach in fulfilling the social tasks, independence as well as practical and theoretical erudition are expected from a social worker (Strieženec, 2005).

Helping professions include a variety of positive and negative consequences. In general, positive effects of helping are called compassion satisfaction, the negative called compassion fatigue (Köverová, Ráczová, 2017). However, if self-care is not sufficient, a person may experience adverse socio-pathological phenomena (e.g. burnout syndrome, fatigue from helping, work dissatisfaction) (Šiňanská, Kočišová, 2017). The report will further focus on a burnout syndrome. According to literature (Gillespie, 1987; Kim, Ji, Kao, 2011), it is a phenomenon that often appears in conjunction with social work, particularly work with clients. It occurs on the basis of activity level at work, administrative burden and bureaucracy. Although the burnout syndrome is spoken of as a group of specific symptoms, in the majority of clinical practice it is not seen as a diagnostic category in the sense of a separate nosological unit, despite the fact that there are demonstrable negative effects on the performance (Bianchi, Schonfeld, Laurent, 2015; Kebza, 2005). The burnout syndrome can be described as a state of drought when an individual feels overloaded, immobilised and blocked. Among the first signs is a change in one's behaviour. The concerned person is involved in everything, but they are always restless, short-tempered and cantankerous. They keep a distance from other people, who are perceived as a disruptive element. They have a growing pile of work, feel disgust towards other people and often respond gruffly and crudely (Grün, 2014). According to Prieß (2015), the inability to perceive oneself, one's own limits and needs that according to them do not exist at all, or only marginally, is a strong prediction of burnout syndrome. The link is suggested by recommendations in the field of prevention mentioning a diverse work regimen, good social background, realistic expectations on oneself, rigorous separation of professional and private life, optimal degree of personal involvement in relation to the client, satisfactory assertiveness, setting of priorities and delegating tasks to other people (Švingalová, 2006).

MATERIALS AND METHODS

Participants and procedures

The research sample consisted of 405 respondents who work in the position "social worker" in the public (includes social workers includes social workers in Office of Labour, Social Affairs and

Family, retirement houses, social services, etc.) and non-public sphere in Slovakia (males = 76; females = 329), who participated in the research by filling out a questionnaire; the average age was 40.25 years (SD = 0.525, Min-Max = 18-65). In terms of the type of educational attainment, 340 respondents had a higher education qualification (social science specialty = 269; technical specialty = 71), 64 secondary education (vocational school = 59, gymnasium = 5), and 1 respondent did not indicate their education. The length of the practice among the respondents was inquired about as well. The average length of a practice was 10.36 years (SD = 9.416; Min-Max = 0-40). The research sample was made up of Slovak social workers working in various types of facilities and variety of clients. The only criterion was the daily performance of social work and the daily contact with the client. The administration of the questionnaire was carried out in person. The social workers filled out the questionnaires after the agreement with the management of the facility or organization. Filling of the questionnaire was not financially compensated.

Measures
MBI – Maslach Burnout Inventory (Maslach, Jackson, 1981; Ráczová et al., 2018, uses under license TA-763) is a methodology consisting of 22 items in which the respondents evaluate the intensity of feelings caused by work or work environment on a scale (0 = not at all; 7 = very much). The questionnaire was originally prepared for monitoring the burnout syndrome in helping professions. It identifies the syndrome in three factors, two of which are negative (emotional exhaustion, depersonalisation) and one is positive (personal satisfaction from work). Through the exploratory factor analysis, the same 3 factors were identified in this questionnaire, which covered 56.04% of the variance. Reliability through Cronbach's coefficient alpha reached values of 0.782 (personal satisfaction from work), 0.803 (depersonalisation) and 0.904 (emotional exhaustion)
UWES – Utrecht Work Engagement Scale (Schaufeli, Bakker, 2003) is originally a methodology consisting of 17 items quantifying the degree of involvement in work or well-being at work. Respondents evaluate the frequency of subjective feelings and experiences from the work environment on a scale of 0-6 (0 = never; 1 = hardly ever/a couple of times a year; 2 = seldom/once a month or less; 3 = sometimes/a couple of times a month; 4 = often/once a week; 5 = very often/a couple of times a week; 6 = always/every day) The authors presented an abridged methodology of 9 items as well (Hakanen, Bakker, Schaufeli, 2006). This research worked with the original methodology of 17 points that identifies 3 factors of well-being -spirit, self-sacrificing devotion, and captivation. Through explorative factor analysis, 3 factors were identified, which cover 64.19% of the variance. However, according to this analysis, some items loaded several factors, the inner consistency of the entire methodology reached a value of =0.931. Similar to the original methodology reaching good inner consistency in the individual factors, reliability of this research also reached satisfactory values (factor spirit 0.75-0.83 in the original questionnaire, 0.784 in this research; factor self-sacrificing devotion 0.86-0.90 in the original questionnaire, 0.913 in this research; factor captivation 0.82-0.88 in the original questionnaire, 0.799 in this research).
VSSv.2 – Questionnaire of performed self-care in the helping professions. This author's methodology is used to quantify the performed self-care in helping professionals. It is an adjustment and extension of the VSS Questionnaire of performed self-care (Lovaš, Hricová, 2015), which is the original format of 21 items used to capture the activities that belong under the topic of self-care. The respondents evaluated the frequency of performing specific activities which fall within the area of self-care in the original questionnaire through a 5-point scale (1=never; 5=always). Through explorative factor analysis the entries were divided into three factors, according to the areas of self-care – physical well-being (e.g. "I look for information on how to take care of physical health", "I exercise to obtain a good figure"); activities in health problems (e.g. "In case of health problems I follow the doctor's advice," "I visit a doctor to address health problems", "I avoid situations in which I run the risk of a disease ") and positive attitude (for example. "I create a good atmosphere in relationships with my friends", "I suppress a bad mood"). The overall reliability of

the questionnaire reached value of 0.83 for the whole methodology and range of 0.78-0.85 for each of the factors. The Questionnaire VSSv.2 (the questionnaire of performed self-care in helping professions) was created by author's own modification of the original VSS questionnaire. It was extended and modified in order to capture the level of activities that belong to the area of self-care in the work environment. The questionnaire was designed for helping professionals – social workers, who come into daily contact with the clients of social work in Slovakia. The editing of the questionnaire took place on the basis of the 2-phase qualitative analysis of performed self-care activities. 1/ the determination of self-care in social workers (Lichner, Lovaš, 2016); 2/ content analysis of performed activities through active accredited supervisors (Halachová, Lovaš, 2015). The modified questionnaire VSSv.2 that was used contained 37 items aimed at capturing the performed self-care activities in the work environment. The respondents indicated the intensity of performance of individual self-care activities on a 5-point scale (1 = not at all; 5 = definitely yes). The total reliability of the questionnaire reached a level of 0.912. Since this was the first use of the author's questionnaire aimed at self-care in helping professions, this analysis had a quality of a validating study. Through explorative factor analysis, 4 factors explaining 44.3% variance (Table 1) were identified in the accordance with the Scree-test through Oblimin rotation. The reliability of the factors was between α = 0.785-0.885. Out of the full questionnaire containing 37 items, 6 items were excluded due to low charge. The overall high reliability of the instrument indicates reliable use for identification of the overall degree of performed self-care in the work environment. In terms of the structure of individual factors, the first factor (F1 – psychological self-care) is made up mainly of items indicating the individual effort to create a good social climate in the workplace (e.g. "I create a good atmosphere in the workplace") and the individual coping with pitfalls created by the work, or the contact with clients through some self-care activities (e.g. "I use my own strategies of coping with workload while working with clients"). The second factor (F2 – professional self-care) is loaded mostly by items falling under self-care aimed at professional area of workers (e.g. "I prepare myself for work", "I regularly switch between work activities") and professional growth relating to better managing one's workload (e.g. "I use education to cope with the workload ", "I use supervision to cope with the workload"). The third factor (F3 – health self-care) consists mainly of items related to the professionals' care of their own health (e.g. "I visit a doctor to address my health problems"), and the principles of psycho-hygiene at work (e.g. " I go on breaks (lunch break, coffee break…"). The fourth factor (F4 – physical self-care) is loaded with care for physical health, physical activity and a healthy lifestyle at work (e.g. "I exercise for the fitness and figure", "I follow the principles of a healthy lifestyle at work").

Table 1: Items and factors of self-care questionnaire (VSS v.2)

Item of the questionnaire	F1	F2	F3	F4
21. I am positive in contact with my co-workers	0.816			
19. I create a good atmosphere in relationships with people I am close to	0.733			
4. I create a good atmosphere in the workplace	0.689			
9. I am nice to my colleagues so as to create a good atmosphere in the workplace	0.681			
7. I create a good atmosphere in contact with the clients	0.677			
22. I respect the expected role in relation to my colleagues	0.647			
16. I think positively	0.643			

	F1	F2	F3	F4
26. I use my own coping strategies to manage workload while working with clients	0.616			
5. I suppress bad mood	0.600			
20. I use my own coping strategies to manage workload created by the work	0.588			
25. I avoid dark thoughts	0.567			
27. I care about my appearance	0.538			
14. I try to create a good impression when in contact with other people	0.536			
18. I regularly observe personal hygiene at work	0.512			
32. I use professional growth to cope with workload		0.738		
13. I look for information on how to feel good at work		0.732		
17. I use education to cope with workload		0.722		
15. I regularly switch between work activities		0.636		
29. I prepare myself for work		0.629		
6. I use supervision to cope with workload		0.574		
31. I visit a doctor in case of health problems			0.727	
33. I go on breaks (lunch break, coffee break)			0.723	
35. I schedule my tasks so that I never have too much work in one day			0.670	
34. I use free time at work (outside of work with clients) to speak with colleagues			0.651	
23. In case of health problems I follow the doctor's advice			0.633	
30. I always have enough sleep			0.567	
10. I regularly get medical checkups (dental, gynaecological...)			0.514	
11. I play sports				0.835
1. I exercise for fitness and figure				0.809
3. I follow the principles of a healthy lifestyle at work				0.669
8. I look for information on how to take care of physical health				0.618
Cronbach's α=	0.81	0.89	0.82	0.79
F1: psychological self-care; F2: professional self-care; F3: health self-care; F4: physical self-care				

RESULTS

Level of performed self-care in workers of helping professions

The analysis of performed activities of self-care through the author's methodology demonstrated average and above average performance of these activities through comparison of their gross and average scores (Table 2). The highest loaded factor was, in this case, the first factor of performed self-care in the work environment. In a further analysis of possible connections between demographic variables (gender, age, length of practice, level of education) of the respondents, no significant correlations between performed self-care and these variables were recorded.

Table 2: Level of performed self-care in workers of helping professions

	VSS overall score	VSS F1	VSS F2	VSS F3	VSS F4
Gross score	118.06	59.14	19.41	26.97	12.54
SD	17.04	7.63	5.26	5.26	4.30
Min	38	15	6	7	4
Max	155	70	30	35	20
X	3.81	4.22	3.24	3.85	3.14
SD	0.55	0.55	0.88	0.75	1.07
VSS: performed self-care F1: psychological self-care; F2: professional self-care; F3: health self-care; F4: physical self-care					

Analysis of the burnout level in social workers

Three levels of burnout were analysed through the questionnaire. Emotional exhaustion, which reached an average of 20.07 (SD = 12.06; Min-Max = 0-54) and depersonalisation, which reached an average of 7.41 (SD = 6.15; Min-Max = 0-28) as negatively oriented subscales, and personal satisfaction from work (X = 32.38; SD = 8.25; Min-Max = 8-48) as a positively oriented subscale. Identified values were compared with reference values for this methodology. On this basis there were three levels of burnout identified in the sample of social workers working in the social sector in Slovakia. The highest level of burnout was identified in the subscale of emotional exhaustion. Other possible links between burnout syndrome and demographic indicators (gender, age, length of practice, level of education) were additionally analysed. In this way, weak statistically significant positive connotations between the level of emotional exhaustion and depersonalisation were identified in the context of lengthening of the practice of respondents.

Table 3: Level of burnout

	Emotional exhaustion		Depersonalisation		Personal satisfaction	
Level of burnout	f	%	f	%	f	%
Low	181	44.7	222	54.8	185	45.7
Average	114	28.1	102	25.2	128	31.6
High	110	27.2	81	20.0	92	22.7

Level of well-being at work in social workers

Work involvement and well-being at work quantified through the UWES questionnaire reached above average values according to the arithmetic average (Table 4). The most loaded factor was self-sacrificing devotion, the least loaded factor was captivation. According to the other demographic characteristics, the analysis showed weak statistically significant positive correlations between age, total score and all the factors of the UWES questionnaire about well-being at work.

Table 4: Average values of well-being at work

	Well-being at work – overall score	Well-being at work – spirit (VI)	Well-being at work – self-sacrificing devotion (DE)	Well-being at work - captivation (AB)
Gross score	69.73	24.65	21.00	24.09
SD	15.48	5.34	5.78	5.67
Min	18.00	7.00	5.00	6.00
Max	102.00	36.00	30.00	36.00
X	4.10	4.11	4.20	4.01
SD	0.91	0.89	1.16	0.94

The identified results were compared with the reference standardised values defined for this methodology (Table 5). According to this analysis, the research body was on the average level a majority of the time in the overall score of well-being at work as well as in individual factors. The highest average values were recorded on the subscale captivation.

Table 5: Level of well-being at work

	Well-being at work – overall score		Well-being at work – spirit (VI)		Well-being at work – self-sacrificing devotion (DE)		Well-being at work - captivation (AB)	
Level	f	%	f	%	f	%	f	%
Very low	8	2.0	12	3.0	13	3.2	5	1.2
Low	40	9.9	54	13.3	54	13.3	36	8.9
Average	242	59.8	247	61.0	216	53.3	212	52.3
High	98	24.2	73	18.0	87	21.5	132	32.6
Very high	17	4.2	19	4.7	35	8.6	20	4.9

Analysis of the links between performed self-care in the work environment, burnout syndrome, and well-being at work in social workers

The author's intention was to describe the level of individual constructs of self-care, burnout and well-being at work, as well as the analysis of mutual links between these variables. First, the focus was on the relations inside the individual constructs. Based on this analysis (Table 6), it can be established that the mutual relations inside individual constructs suggest their justified use in accordance with how the individual research methodologies were originally construed and validated. The strongest inner correlations were recorded in the case of the methodology identifying well-being at work (UWES; $r=0.716 – 0.932$). There was special interest in mutual links in the author's questionnaire of performed self-care in the workplace, which was identified in a sample of Slovak social workers. Close, positive statistically significant relations on an average and high level were identified here, while the total score correlated the strongest with individual factors. However, the overall relations between subscales in the methodology VSSv.2 can be assessed as satisfactory ($r=0.336 – 0.803$).

An important aim of the analysis was the identification of relations between self-care, burnout and well-being at work. According to the assumptions, self-care, as well as well-being at work, may

work preventively in relation to the negative work phenomena (e.g. burnout).   Similarly, well-being at work may be an indicator of a good level of performed activities of self-care in the work environment. According to the analysis (Table 5), statistically significant positive close relations between the overall score of performed self-care and well-being at work in the overall score as well as the individual dimensions were (r = 0.405-0.491) identified. In the case of performed self-care and well-being at work, similar relations were measured in the context of the burnout (positive statistically significant correlations in the case of subscale personal satisfaction from work and negative statistically significant correlations in the case of emotional exhaustion and depersonalisation).

Table 6: Correlation matrix – performed self-care, well-being at work and burnout

	1	2	3	4	5	6	7	8	9	10	11
1 - VSS overall score	-										
2 - VSS F1	0.803 ***	-									
3 - VSS F2	0.762 ***	0.473 ***	-								
4 - VSS F3	0.724 ***	0.475 ***	0.381 ***	-							
5 - VSS F4	0.666 ***	0.336 ***	0.484 ***	0.349 ***	-						
6 - Well-being at work – overall score	**0.490** ***	**0.482** ***	**0.509** ***	**0.292** ***	**0.175** ***	-					
7 - Well-being at work – spirit	**0.455** ***	**0.470** ***	**0.447** ***	**0.289** ***	**0.148** **	0.911 ***	-				
8 - Well-being at work – self-sacrificing devotion	**0.491** ***	**0.493** ***	**0.475** ***	**0.324** ***	**0.152** **	0.932 ***	0.803 ***	-			
9 - Well-being at work – captivation	**0.405** ***	**0.368** ***	**0.480** ***	**0.192** ***	**0.193** ***	0.896 ***	0.716 ***	0.753 ***	-		
10 - Burnout – emotional exhaustion	**-0.297** ***	**-0.307** ***	**-0.160** **	**-0.272** ***	**-0.133** **	-0.419 ***	-0.474 ***	-0.462 ***	-0.214 ***	-	
11 - Burnout – personal satisfaction	**0.441** ***	**0.503** ***	**0.310** ***	**0.267** ***	**0.185** ***	0.447 ***	0.462 ***	0.469 ***	0.322 ***	-0.328 ***	-
12 - Burnout – depersonalisation	**-0.322** ***	**-0.383** ***	**-0.207** ***	**-0.222** ***	**-0.112** *	-0.396 ***	-0.388 ***	-0.429 ***	-0.279 ***	0.548 ***	-0.463 ***
* p<0,05; ** p<0,01; *** p<0,001											

DISCUSSION AND CONCLUSION

Self-care can be understood in a variety of dimensions. Recently, a gradual transition is being recorded from the traditional understanding of self-care in the context of healthcare professions, in particular to some kind of a wider understanding – theoretical, as well as practical understanding in the form of actual performed activities. There are a lot of works being recorded in the theoretical field that relate to self-care not on the side of client, but on the side of the professional (e.g. Jones, 2006; Napoli, Bonifas, 2011; Lee, Miller, 2013; Newell, Nelson-Gardell, 2014). In spite of this shift, the attention of empirical studies is still devoted mainly to the medical area of self-care

(oriented on patients and their self-care skills supporting medical therapy of diseases) (e.g. Poote, French, Dale et al., 2014; Dietz, Bombard, Mulready-Ward et al., 2014; Lenander, Bondeson, Midlöv et al., 2015; Haun, Patel, Lind et al., 2015). The intention was to focus on the area of self-care realized by those people that come into daily contact with social clients. A sample of Slovak social workers was addressed for research. One of the objectives of this report was to describe and verify the factor structure of the proposed author's methodology capturing the level of performed activities linked to the work environment of the target group – social workers. The methodology was designed on the basis of the questionnaire analysing the level of general self-care activities (Lovaš, Hricová, 2015). Specific activities, which meet the definition of self-care as an activity tied to the area of healthcare among others, were identified in the workplace. In the work environment it is important to take care of the individual level of self-care along with the work level and level of organizational self-care (Cox, Steiner, 2013). All of these levels are captured by the author's questionnaire.

In addition to the above, the intent of this paper was to describe the mutual relations between performed self-care, level of burnout and level of well-being at work. In this context, it was assumed that the identified relation between self-care in the work environment and well-being at work would be positive, which was confirmed by the analysis. Self-care and well-being at work correlated positively in all three factors, which demonstrated the common features of these constructs, which corresponds with the results introduced by Vinje (2007) on a sample of health care professionals. The question is to what extent does self-care in the work environment affect well-being at work, or to what extent does well-being at work affect activities of self-care. According to Schaufeli and Bakker (2003), it is well-being at work by its nature that is related to burnout. While burnout is considered a negative effect resulting from the work environment or as a result of performing a certain work, a high level of well-being at work should lower the burnout. These correlations were confirmed as highly significant by this research (Table 6). This is assumed to be the case with self-care as well. At present, several authors have confirmed the links between self-care and burnout (e.g. Oser, Biebel, Pullen, et al., 2013; Thompson, 2014; Salloum, Kondrat, Johnco, et al., 2015). According to Hricová and Vargová (2014), self-care can have a salutogenic effect on burnout and some other negative phenomena (individual self-care activities which include positive mood, thinking, regular physical activities, etc.). In this research these assumptions were confirmed between burnout and well-being at work, as well as in the case of performed self-care. This is seen as a confirmation of the nature of self-care methodology, in which it is assumed that a high level of self-care may aid in prevention of negative phenomena resulting from the work environment.

Therefore it is necessary to raise the degree of active self-care in workers who are in daily contact with many problems of their clients mainly in the area of social work, psychology or health care. It is appropriate to extend the educational, supervisory and socio-psychological activities in particular during the course of practice as well as during training at universities.

In terms of specific programs implemented to support self-care as well as the prevention of negative phenomena arising from the exercise of profession, we must state that in the Czech and Slovak Republics this area is weakly covered. Part of self-care (one that is focused on improving working capabilities) can be covered by supervision as it is about ensuring a certain quality and level of employee's work through a normative, formative, restorative and mediation function (Vaska, 2014). Inspiration could include specific programmes implemented abroad. During university education, training on work-life balance, with practical preventative implications for negative phenomena can already be realised (Dittmann, 2005). Other specific measures include increasing the level of self-knowledge, self-regulation, coping with stress as well as working with one's own expectations and interests. All of these areas fall under the competence of self-care (Baker, 2003). Specific activities are based on the assumption that self-awareness of ideas, limitations, needs, and even working with them is part of self-care, helps improve work engagement, and thereby contributes to reducing negative work-related effects such as stress or burnout (Shapiro, Brown,

Biegel, 2007). Other activities that are effective in preventing work-related burnout include those based on cognitive-behavioural training. These appear to be more effective than those working with a supervisor (Mesárošová, 2017). According to other research, burnout interventions focused on social support appear to be less effective compared to those that are oriented directly to the stressor. This includes mutual cooperation, strengthening teamwork in the organisation and co-operation. Specific examples include, in practice, self-training programmes that focus directly on tackling burnout, secondary stress or other stressful situations. At the same time, they strengthen the level of work engagement, thus meeting the definitions of self-care (Kačmárová, Kravcová, 2011). To increase self-care, to prevent burnout and to improve work engagement, the self-care plan seems to be effective (Butler, 2017). This can be individualised for each worker and should contain components that create work-life balance for each individual. The self-care plan includes activities that help the worker to prevent a negative phenomenon such as a burnout syndrome, while on the other hand, increasing work-engagement. The self-care plan obliges an individual to its conscious implementation.

A prerequisite for the expansion of these activities is the fact that only a qualified worker who has a good level of self-care is sufficiently prepared to work for the benefit of other people – clients.

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Civil and Forensic Patients: Comparing Demographics, Risk Factors, and Negative Life Events

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Abstract
OBJECTIVES: This investigation centres on how the mentally ill with a forensic admission compare to the mentally ill with a civil admission, and investigates who inpatients with a forensic and civil admission are, and how the risk factors and negative historical events they have experienced compare or differ. THEORETICAL BASE: Using a risk and resilience framework, risk factors that are deleterious to healthy development are used as variables. METHODS: The records of all adult inpatients both forensic and civil, aged 18 to 89 at admission in two U.S. mountain region public psychiatric hospitals were included in the sample (n=1768). All patients are assessed using the Colorado Clinical Assessment Record (CCAR) which, measures a diverse set of variables including Current Issues, History of Issues, Demographics, and Disabilities. OUTCOMES: Civil and forensic patients have more in common than differences. Both samples compare more closely to risk factors and negative historical events than they do to the general population. However, this begins to break down once the sample is separated by gender. SOCIAL WORK IMPLICATIONS: Social Workers who work in prison systems need to become more familiar with mental illness interventions. Additionally, social workers should both educate law enforcement about de-escalation tactics with the mentally ill and intervene on mental health related police calls. On the macro level, social workers should advocate for the mentally ill to be housed in psychiatric hospitals rather than be imprisoned where they will often not receive inpatient psychiatric care.

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INTRODUCTION

In the United States, it has been suggested that there are greater numbers of mentally ill persons in the prison system than in psychiatric hospitals (Ditton, 1999; Lamberti, Weisman, Faden, 2004; Schnell, Leipold, 2006; James, Glaze, 2006; Daniel, 2007; Torrey et al., 2010). Prisoners serving short term sentences or those awaiting trial have the highest rate of mental health disorders (60%), followed by State inmates (49%), and Federal prisoners (40%) (James, Glaze, 2006) with very few receiving mental health services while incarcerated. Additionally, cost cutting measures at private prisons have further eroded psychiatric care for forensic patients including being prescribed current psychiatric drugs for mental illnesses (Daniel, 2007). There is such a dearth of mental health services in prisons that it has been found that suicide is the 3rd leading cause of death in prisons (#1 natural causes, #2 AIDS; Daniel, 2007).

Prisoners with a mental illness in the U.S. were more likely than other inmates to be imprisoned for violent offences and much less likely to receive a prison sentence for drug-related offences (Ditton, 1999; James, Glaze, 2006; Schnell, Leipold, 2006; Torrey et al., 2010). However, mentally ill prisoners were often under the influence of drugs or alcohol when they committed the offence that brought them into the criminal system (Ditton, 1999; James, Glaze, 2006). Thus drug and alcohol dependency contributed to or exacerbated their mental health needs (Torrey et al., 2010). However, mental health treatment, including substance abuse treatment, in the prison system does not occur for most prisoners with mental health needs; only 33.8% of state prisoners with mental health needs received treatment, 24% of those in federal prisons, and 17.5% of those in local prisons (James, Glaze, 2006).

Throughout the U.S. prison system, female prisoners had higher rates of mental illness than their male counterparts (James, Glaze, 2006; Schnell, Leipold, 2006). Additionally, mentally ill inmates were disproportionately affected by a trauma history. Nearly 8 in 10 female forensic patients reported physical or sexual abuse (Ditton, 1999; James, Glaze, 2006). Male prisoners with mental health needs were more than twice as likely in comparison to other male inmates to report an abuse history (Ditton, 1999; James, Glaze, 2006). Thus, both female and male prisoners with mental illnesses had trauma and abuse histories that were vastly different than inmates without mental illness.

Additionally, U.S. mentally ill prisoners are spending more time incarcerated than their non-mentally ill counterparts. Prisoners with a mental illness were sentenced to serve on average a year longer for offences than non-mentally ill inmates (Ditton, 1999; James, Glaze, 2006; Torrey et al., 2010). They were also more likely to be charged with breaking the rules in prison, often increasing prison time, as compared to other prisoners (Ditton, 1999; James, Glaze, 2006; Schnell, Leipold, 2006; Torrey et al., 2010). Thus prisoners with mental illnesses are spending more time in the prison system because their untreated symptoms cause further barriers to regaining their freedom. Prison staff often lack knowledge and are ill-equipped in how to intervene with mentally ill prisoners (Torrey et al., 2010). Generally, U.S. prison and jail staff have not been trained on how to safely intervene with a triggered, psychotic or delusional inmate and thus mentally ill inmates are more likely to be abused in jail or prison (Torrey et al., 2010) and more likely to spend time in solitary confinement (ACLU, 2013). Thus, the mentally ill are being further traumatized and victimized in the prison system. Additionally, prisoners with a mental illness have a recidivism rate reported from nearly 90% (Torrey et al., 2010) to 58% (Schnell, Leipold, 2006). Thereby, U.S. jails and prisons are becoming a revolving door for the mentally ill.

The U.S. state in which the research was conducted showed the odds are four times more likely that a mentally ill person would be imprisoned rather than placed in a psychiatric hospital (Torrey

et al., 2010). Additionally, in the state the research was conducted less than 1% of forensic patients were transferred to a psychiatric hospital (Schnell, Leipold, 2006). Thus the mentally ill who commit crimes will less likely receive any sort of psychological or psychiatric intervention to reduce the likelihood that they will commit future crimes and thus are more likely to return to the prison system upon release.

The high rates of mental illness within the prison system is largely a consequence of the deinstitutionalisation of the mentally ill and the debacle of the state psychiatric hospital system in the United States (Daniel, 2007; Torrey et al., 2010). In 2004, in the United States, there were 100,439 psychiatric beds available in public and private psychiatric hospitals and in the psychiatric units of general hospitals, which made approximately one psychiatric bed available for every 3,000 people (Torrey et al., 2010). In comparison in 1955, there was one public psychiatric bed available for every 300 people (not considering private psychiatric hospitals; Torrey et al., 2010). Thus doing the math, an individual with a severe mental illness was ten times more likely to receive treatment in 1955 than in 2004 (Torrey et al., 2010). Sadly, this scenario continues today.

It can not be more succinctly stated that the U.S. prison system is overrun and ill-equipped to deal with the mentally ill in their midst. In response, many states are beginning to use Mental Health Courts that give offenders a choice between following a treatment plan often in a psychiatric hospital or being imprisoned (Torrey et al., 2010). Thus, most recently, there has been an increase in beds allocated for forensic patients in psychiatric hospitals, for example California has an increase of 80%. In Colorado, from July 1, 2010 to June 30, 2015 the forensic legal status of discharged patients has gone from 26.2% to 51.9% having had a forensic legal status during their visit, with increases each fiscal year. But the creation of forensic beds in psychiatric hospitals does not begin to stem the tide, due to the fact that forensic patients generally have longer stays (Davoren et al., 2015). However, it improves the likelihood that people with a mental illness who commit a crime will receive mental health treatment and not simply be punished for wrongdoings.

Furthermore, the rates of recidivism for forensic patients returning to psychiatric hospital care are far lower (28.2%; Green et al., 2014) than mentally ill criminals returning to the prison system (90%–58%; Schnell, Leipold, 2006; Torrey et al., 2010). Therefore, creating a system where criminals with a mental illness receive care in a psychiatric hospital seems to be a preferred method from a cost-benefit analysis (Torrey et al., 2010), as well as being more effective and more humane. Thus, there needs to be a change in how we understand people with mental illness who commit crimes in that the common denominator should not be their criminal activity, where thereby they are punished by imprisonment for wrongdoings, but rather their mental illness, and as such they receive treatment in psychiatric hospitals.

As the pendulum begins to move towards a greater number of forensic patients in psychiatric hospitals, we wanted to investigate how the mentally ill with a forensic admission compare to the mentally ill with a civil admission. It is clear that psychiatric hospitals are a better inpatient treatment option for mentally ill individuals who commit crimes than prisons. However, how do these two populations housed in psychiatric hospitals resemble each other or differ? Are they distinct populations or is it simply that mental illness is expressed in criminal or non-criminal outcomes in these populations? There is very little research comparing the two groups. The literature primarily has focused on demographic differences of forensic patients with particular commitment statuses (e.g. sexual offenders tend to be older and Caucasian; Vess, Murphy, Arkowitz, 2004). Specifically, we wish to learn who the patients with a forensic and civil admission are, how they compare demographically and how the risk factors and negative historical events they have experienced compare or differ.

METHODOLOGY

Sample

The records of all adult inpatients both forensic and civil, aged 18 to 89 at admission, with discharges from July 1, 2014 to June 30, 2016 in two U.S. mountain region public psychiatric hospitals were included in the sample (n=1768). The sampling timeframe was chosen to maintain consistency between the two hospitals in terms of data collection methods. These two hospitals were selected as they are generally considered to be the last line of inpatient treatment for individuals with the most severe mental health needs within the state they are located, with no other equivalent options available to the general public. We are cognisant that other treatment options for patients with less severe mental health needs exist, but suggest this sample gives the greatest parity between civil and forensic entries.

If a patient had multiple visits during this time period the last visit was used to prevent those who had repeat visits from skewing the data. The mean number of visits by patients in the sample was 1.19 (SD = .48).

Sample demographics

The sample was 27.1% female (56.8% civil, 43.2% forensic) and 72.9% male (39.4% civil, 60.6% forensic), as compared to the state, 49.8% female and 50.2% male (United States Census Bureau, state quick facts, 2016). In Colorado from July 1, 2010 to June 30, 2015 the forensic legal status of discharged patients has gone from 26.2% to 51.9% having had a forensic legal status during their visit, with increases each fiscal year.

In comparison to the rest of the inpatient population individuals who identified as Asian/Pacific Islander ((1, N = 1997) = 8.06, p <.05) or Latino/Hispanic ((1, N = 1997) = 13.00, p <.001) were less likely to have had a forensic legal status while those who identified as African American/Black ((1, N = 1997) = 8.81, p <.05) were more likely to have had a forensic legal status.

Table 1: Ethnicity/race of sample in comparison to state

Ethnicity/Race	In Hospital Civil (N =780)	In Hospital Forensic (N=988)	In State+
American Indian/Native Alaskan	0.6%	0.9%	1.6%
Asian/Pacific Islander	2.3%*	0.9%*	3.1%
African American/Black	11.6%**	17.0%**	4.5%
Latino/Hispanic	16.1%***	9.6%***	21.2%
Caucasian/White	43.0%	57.0%	69.0%
Other	0.9%	0.3%	0.6%

*p≤.05., **p≤01., ***p≤001
+Source: United States Census Bureau, state quick facts, 2016

Generally, the level of education within the hospital patient population was low, with 70.5% of the civil patients and 72.9% of forensic patients having a 12th grade (equivalent to the British GCE advanced level) education or less ((1, N = 1997) = 1.20, p = .294) as compared to the state where only 36.3% had a 12th grade education or less (Census 2000 Profile, State Census Profile, 2002). Additionally, the income of the patient sample was low with 98.8% of civil patients and

99.0% of forensic patients ((1, N = 1627) = 1.20, p = .815) earning less than $25,000 (£17,500) per year as compared to 23.1% of the state population that earn less than $25,000 (Census 2000 Profile, State Census Profile, 2002). Most inpatients (76.9% of civil patients and 89.9% of forensic patients ((1, N = 1997) = 54.59, p < .001)) had never been married. Both forensic and civil patient's primary diagnoses fell mostly into three categories; Schizophrenia/Psychotic, Bipolar, and Substance Abuse/Addictive, with no other category making up five percent or more of the primary diagnoses (see table 2).

Table 2: Primary diagnosis of sample

Diagnosis Category	Civil Patients (N =780)	Forensic Patients (N=988)
Schizophrenia/Psychotic	50.7%	54.0%
Bipolar***	16.2%	20.3%
Substance Abuse/Addictive***	23.2%	7.8%
Other***	0.9%	19.9%

*p≤.05., **p≤01., ***p≤001

INSTRUMENTATION

At admittance or at discharge from the hospital, all patients are assessed using the Colorado Clinical Assessment Record (CCAR) (Colorado Department of Human Resources, 2014). The CCAR was developed in 1976 and implemented in 1978 by the Colorado Division of Mental Health. It is commonly used in a handful of U.S. states and Canada. The most recent version of the CCAR is seven pages long and measures a diverse set of variables including Current Issues, History of Issues, Demographics, and Disabilities. The assigned social worker completes the CCAR using a combination of patient records, interviews with patient's family and friends, and discussions with the patient. The majority of variables are measured dichotomously. The results are maintained in a secure database. The last completed CCAR was used for the purposes of this study under the assumption that the last CCAR would be more complete and accurate than previous ones. In addition to the CCAR, databases maintained by the hospitals were also used to collect data. These databases contain information commonly accessed during treatment such as primary diagnosis and demographics. The legal status of an inpatient was considered to be *forensic* if at any time during an inpatient stay they had a forensic legal status, which required reporting the progress of the patient to a court and/or permission from a court to release the patient. A lack of a forensic legal status at any time during an inpatient stay resulted in the patient being classified as a *civil* patient.

Information was aggregated from all sources. If any source indicated the presence of a risk factor or historical event it was considered to be present. For example, if it was indicated that a patient has a diagnosis related to a learning disability in the hospital databases, but it was not recorded on the CCAR it was considered to be present.

RESULTS

The results first presented are the risk factors and negative historical events experienced by both civil and forensic patients, then separated by gender and then compared to the general population. As indicated in Table 3, many historical experiences of the sample differ from the general population. In regard to risk factors and negative historical events, civil and forensic inpatients

are very similar to each other and different from the general population. However, there are some instances where they differ from each other.

Table 3: Historical risk factors and negative events by legal status

Risk Factor/Event	Civil Patients (N=914)	Forensic Patients (N = 1083)	Total Hospital Population (N=1997)	General Population
History of Trauma				
Yes	80.2%***	63.8%***	71.3%	
No	19.8%	36.2%	28.7%	96.0%
Suicide Attempts				
Yes	31.9%	30.4%	31.1%	
No	68.1%	69.6%	68.9%	95.4%
History of Sexual Misconduct				
Yes	1.8%***	4.7%***	3.3%	
No	98.2%	95.3%	96.7%	99.8%
Property Destruction				
Yes	11.7%***	5.1%***	8.2%	
No	88.3%	94.9%	91.8%	99.9%
Fire Setting				
Yes	2.5%	1.9%	2.2%	
No	97.5%	98.1%	97.8%	99.0%
Animal Cruelty				
Yes	1.2%	0.8%	1.0%	
No	98.8%	99.2%	99.0%	95.0%
Danger to Self				
Yes	35.0%*	30.2%*	32.5%	
No	65.0%	69.8%	67.5%	96.0%
Danger to Others				
Yes	10.8%***	17.2%***	14.1%	
No	89.2%	82.8%	85.9%	90%
Mental Illness in Family				
Yes	48.6%***	30.6%***	39.2%	
No	51.4%	69.4%	60.8%	80.0%
History of Neglect				
Yes	19.2%	15.8%	17.4%	
No	80.8%	84.2%	82.6%	92.9%
History of Physical Abuse				
Yes	41.4%*	36.7%*	41.4%	
No	58.6%	63.3%	58.6%	83%
Developmental Disability				
Yes	9.2%	9.0%	9.2%	
No	90.8%	91.0%	90.8%	85%
Traumatic Brain Injury				
Yes	8.9%	8.1%	8.9%	
No	91.1%	91.9%	91.1%	91.5%
Learning Disability				

Yes	6.3%***	14.3%***	10.7%	
No	93.7%	85.7%	89.3%	90.0%
History of Sexual Abuse				
Yes	31.3%***	24.2%***	27.6%	
No	68.7%	75.8%	72.4%	92.0%
*p≤.05., **p≤01., ***p≤001				

Sources: [a] (Briere, Dietrich, & Agee, 2015), [b] (Kessler, Borges, Walters, 1999), [c] (http://www.worldatlas.com/articles/state-by-state-numbers-of-registered-sex-offenders-in-the-us.html, 2016), used number of registered sex offenders/ US population

There was a significant difference ((1, N = 1997) = 47.75, p <.001) in the legal status of males and females with male patients having higher rates of forensic status. As a result it was considered worthwhile to explore the differences in risk factors and negative historical events within legal statuses as characteristics associated with gender. As can be seen in Table 4, female inpatients are more homogeneous than male inpatients in Table 5.

Table 4: Comparing risk factors and negative historical events between legal statuses in females

Event/Risk Factor	Civil Patients (N=272)	Forensic Patients (*N*=207)
History of Trauma		
Yes	88.5%	83.3%
No	11.5%	16.7%
Suicide Attempts		
Yes	34.9%	35.2%
No	65.1%	64.8%
History of Sexual Misconduct		
Yes	2.3%	1.0%
No	94.3%	95.9%
Property Destruction		
Yes	7.6%	4.3%
No	92.4%	95.7%
Fire Setting		
Yes	1.6%	2.9%
No	98.4%	97.1%
Animal Cruelty		
Yes	0.7%	1.0%
No	99.3%	99.0%
Danger to Self		
Yes	33.9%	33.3%
No	66.1%	66.7%
Danger to Others		
Yes	10.9%	7.6%
No	89.1%	92.4%
Mental Illness in Family***		
Yes	52.6%	64.8%
No	47.4%	35.2%
History of Neglect		

Yes	25.0%	23.3%
No	75.0%	76.7%
History of Physical Abuse		
Yes	56.6%	56.7%
No	43.4%	42.3%
Developmental Disability		
Yes	10.3%	10.0%
No	89.7%	90.0%
Traumatic Brain Injury		
Yes	9.0%	7.2%
No	91.0%	92.8%
Learning Disability ***		
Yes	5.4%	14.5%
No	94.6%	85.5%
History of Sexual Abuse		
Yes	52.3%	48.1%
No	47.7%	51.9%

*p≤.05, **p≤01, ***p≤001.

Table 5: Comparing risk factors and negative historical events between legal statuses in males

Event/Risk Factor	Civil Patients (N=508)	Forensic Patients (*N*=781)
History of Trauma***		
Yes	75.9%	58.8%
No	24.1%	42.1%
Suicide Attempts		
Yes	30.3%	29.1%
No	69.7%	70.8%
History of Sexual Misconduct***		
Yes	1.6%	5.7%
No	98.4%	94.3%
Property Destruction***		
Yes	13.9%	5.3%
No	86.1%	94.7%
Fire Setting		
Yes	2.9%	1.6%
No	97.1%	98.4%
Animal Cruelty		
Yes	98.4%	0.8%
No	1.6%	99.2%
Danger to Self*		
Yes	35.5%	29.4%
No	64.5%	70.6%
Danger to Others***		
Yes	10.7%	26.4%
No	89.3%	70.6%
Mental Illness in Family***		
Yes	46.4%	19.8%

No	53.6%	80.2%
History of Neglect		
Yes	16.1%	29.3%
No	83.9%	70.7%
History of Physical Abuse		
Yes	33.4%	13.6%
No	66.6%	86.4%
Developmental Disability		
Yes	8.6%	31.2%
No	91.4%	68.8%
Traumatic Brain Injury		
Yes	8.8%	8.8%
No	91.2%	91.2%
Learning Disability ***		
Yes	6.8%	8.4%
No	93.9%	91.6%
History of Sexual Abuse		
Yes	20.3%	14.3%
No	79.7%	86.6%

*p≤.05, **p≤01, ***p≤001.

DISCUSSION

First of all, forensic patients vary significantly by race and gender from civil patients. Forensic patients were more likely to be male, and African American. Civil patients were more likely to be female, Asian/Pacific Islander or Latino/Hispanic. There was not a significant difference between Caucasian/white admissions. Some of these results were not surprising as historically, both in the state this study was conducted and the United States as a whole, those imprisoned have been disproportionately male and African-American (U.S. Department of Justice, 2018a, 2018b). However, the lower rates of Latino/Hispanic forensic patients, both in comparison to the rate of this population in civil patients and in the general population of the state, was unexpected by the researchers as it is contrary to incarceration rates. No simple explanation for this finding was available to the researchers of this study, although it was speculated that cultural differences in how this population addresses mental health and mental health care may be responsible for this finding. Further research is warranted in this area.

There was no difference between forensic and civil inpatients in obtaining education over the 12th grade level. While the literature indicates that education reduces crime (Hernandez, 1998; Steurer, Smith, 2003; Malkin, 2010), research (Mojtabai et al., 2015) suggests that those with mental disorders have less educational attainment than those without, which may be a more dominant factor in the education level of this study's sample. There was no difference between the two groups on income, with neither earning more than 25,000 per year, which is not surprising since it is estimated that only 10-20% of persons with severe mental illness are employed (McGurk, Mueser, Pascaris, 2005). Forensic patients were statistically less likely to have ever been married. It is generally understood that the status of being married improves psychological functioning (Holt-Lunstad, Birmingham, Jones, 2008). Thus forensic patients had fewer academic or emotional resources than civil patients.

Most (95%) forensic and civil patients' primary diagnoses were one of three categories: Schizophrenia/Psychotic, Bipolar, and Substance Abuse/Addictive. Forensic patients were

significantly more likely to have been diagnosed bipolar than civil patients. In addition, a link was found between bi-polar diagnosis and criminality, especially when there is comorbid substance abuse/use (Quanbeck et al., 2004; Fazel, Lichenstein, Grann, 2010). Civil patients were significantly more likely to have been diagnosed with Substance Abuse/Addictive than forensic patients. With the majority of both groups (50.7% civil and 54% forensic) diagnosed with Schizophrenia/Psychotic disorder. Thus the majority of both inpatient samples were grappling with the same mental illness.

With regard to risk factors and negative historical events, civil and forensic inpatients were often very similar to each other and very different from the general population. History of trauma, suicide attempts, history of sexual misconduct, property destruction, fire setting, danger to self, family mental illness, history of neglect, history of physical abuse, and history of sexual abuse occurred much more frequently in both forensic and civil samples than in the general population. It has been found that individuals with a severe mental illness were 11 times more likely to experience a trauma or violent crime than the general population (Teplin, McCelland, Abram, 2005). However, animal cruelty and developmental disabilities happened more frequently in the general population than in the inpatient samples. Interestingly, there were some instances where the forensic and civil differed from each other. Forensic patients had significantly greater histories of sexual misconduct than civil patients, and both had much greater histories than the general population, which concurs with the literature on sexual misconduct and mental illness (Belluardo-Crosby, 2011). Civil patients had significantly greater histories of property destruction and danger to self than forensic patients and both had much greater histories than the general population. Forensic patients had significantly greater histories of danger to others and learning disabilities than civil patients or the general population. Traumatic brain injuries were similar across both samples and the general population. In general, forensic and civil patients looked more like each other than the general population.

By separating both samples by gender, some differences were found. In general, female civil and forensic patients were very homogenous, differing only in that female forensic patients had higher levels of mental illness in the family and learning disabilities.

However, there were more differences between male forensic and civil patients. Male civil patients had significantly higher levels of trauma, property destruction, danger to self, and mental illness in the family. Male forensic patients had significantly higher levels of sexual misconduct, danger to others, and learning disability. Thus male civil patients can be seen as exhibiting greater internalising behaviour and male forensic patients exhibiting greater externalising behaviour.

Interestingly, both female and male forensic patients had significantly higher levels of learning disability. It has been suggested that learning disability exacts a major influence on externalising behaviours since it is learned at a young age that it is better to be the "troublemaker" than to be considered "stupid" (Hernandez, 1999). Thus many externalising behaviours act as a coping mechanism to cover feelings of intellectual inadequacy. This may be a core difference between why the mentally ill become either civil or forensic patients, though more research is warranted.

In general, civil and forensic patients have more in common than differences. Both samples compare more closely to risk factors and negative historical events than they do to the general population. However, this begins to break down once the sample is separated by gender. Female inpatients have two differences in risk factors and negative historical events associated with legal status, but males have six differences (history of trauma, history of sexual misconduct, property destruction, danger to others, mental illness in the family, and learning disability) associated with legal status. Interestingly, in females the presence of a risk factor or negative historical event is a predictor of a forensic legal status while this is not necessarily true in males. In males the presence of four of the six risk factor or negative historical events that are associated with legal status predict a civil legal status including one, a history of trauma, that is a predictor of forensic legal status in females. This would suggest that males and females may have very different paths to mental health inpatient

placements in regards to how they interact, or not, with the legal system. Further study regarding this may be warranted.

CONCLUSIONS

This research advances the understanding of who civil and forensic patients are. It also underscores that though there are some differences between civil and forensic patients, there are many more similarities. Thus mental health interventions should take place for these two populations in psychiatric hospitals and not subject forensic patients to the prison system where they are less likely to receive treatment. Most recently, social workers have begun to take the lead in creating psycho-education programs for law enforcement officers (Arvesen, 2018). These programs educate the police about mental illness, strategies for intervening with individuals that may be psychotic, under the influence of substances, or severely triggered and behavioural interventions to help the individual de-escalate. Additionally, a co-responder model of criminal justice diversion has just begun to be implemented in California and Colorado (Arvesen, 2018). The co-responder model has a social worker embedded with a law enforcement officer to respond to calls when there is a suspected mental health issue. The social worker has the authority to divert the mentally ill individual to an immediate behavioural health assessment if it seems warranted or can intervene with the individual to de-escalate the situation. Having the social worker alongside a police officer will hopefully help the mentally ill individual get the mental health care they need instead of entering the prison system. On the macro level, social workers should advocate for the mentally ill to be housed in psychiatric hospitals rather than be incarcerated where they will often not receive treatment. We believe that social workers have a major role that they can fill to improve the lives of the mentally ill, so that they receive the services that they need instead of languishing in the prison system.

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Outcomes from a Compassion Training Intervention for Health Care Workers

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Abstract

OBJECTIVES: To investigate how compassion training may help support health care workers do their jobs well, maintaining positive states of mind without being overloaded by empathic distress. THEORETICAL BASE: Recent findings from neuroscience suggest that compassion is a positive mind state and can be trained. Compassion is found to be different from empathy which, unlike compassion, can lead to empathic distress and burnout. This finding has led to the development of a range of compassion training programs. METHODS: A single session compassion training intervention including: (i) information defining compassion, (ii) research information from neuroscience demonstrating that compassion is a positive mind state and different from to empathy, (iii) scenarios emphasising common humanity and (iv) a slogan for health care workers to use to help them hold a compassionate stance towards their patients. OUTCOMES: The compassion training intervention was delivered to 100 health care workers at a major inner city private healthcare organisation in Australia in October 2017. A survey

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administered post-training session indicates that the health care workers found the compassion training useful and further training would be beneficial. SOCIAL WORK IMPLICATIONS: As a result of the positive findings from this research, a web-based compassion training module is being developed for all staff at the healthcare organisation.

Keywords
compassion, training intervention, hospital, health care workers, empathic distress, burnout

INTRODUCTION

Research into compassion
Compassion is not new, and has been mentioned for centuries. It appears to be an innate part of being human. Children as young as 18 months old exhibit natural helping behaviours towards others (Warneken, Tomasello, 2006). Humans cannot survive without compassion. Compassion enables the caregiver to be able to recognise when their offspring is suffering and be motivated to alleviate that suffering. Even animals have this capacity towards their offspring. Compassion is widely regarded as a virtue in all cultures and is essential for a society that flourishes and extends care and concern for one another. One has to value the other to feel concern for them (Ricard, 2015). A widely held definition of compassion is that it is a sense of concern that arises when we are confronted with another's suffering and feel motivated to see that suffering relieved (Jinpa, 2016). Until recently there has been little scientific research into compassion. That is now changing with the evidence from functional magnetic resonance imaging research over the last two decades that mental training has positive effects.

There is now considerable research interest in training people in positive mind states such as compassion. There has been significant worldwide research into compassion over the last two decades (McCaffrey, McConnell, 2015; Strauss et al., 2016; Kirby, 2017;). Major research institutes that are investigating compassion include The Center for Compassion and Altruism Research and Education at Stanford University, Greater Good Science Center at the University of Berkeley, Center for Investigating Healthy Minds at the University of Wisconsin-Madison and the Max Planck Institute for Human Cognitive and Brain Sciences. Compassion training programs have been developed including the Stanford University Compassion Cultivation Training program and the Emory University Cognitively Based Compassion Training. These compassion training programs are being delivered to health care workers, school teachers and children. It is early days in compassion research and these compassion training programs require evaluation regarding their effectiveness. Compassion is a complex phenomenon. It is important to have a clearer understanding of the factors which support the emergence of compassion and those which are barriers to compassion. Compassion training programs may play an important role in helping people cultivate and maintain more compassionate stances towards others.

Compassion and empathy have important differences
One of the key findings in compassion research has been by Klimecki and Singer (2012) who found that compassion is other-focused, a positive mind state and can be trained. This highlights an important distinction between compassion and empathy which are often confused with one another. Empathy is an important core skill for relating to others and understanding how they feel. Empathy encompasses being affected by and sharing another's emotions (Gilbert, 2010). Compassion, on the other hand, is always centred on another's suffering (Schantz, 2007; Goetz, Keltner, Simon-Thomas, 2010). One can have empathy for any emotion that another is feeling, including positive emotions such as joy and happiness. In fact, empathy which leads to an overidentification with another's suffering has a downside.

Neuroscience suggests there are two types of empathy: first there is one which is empathic concern or compassion. Compassion, or empathic concern, has positive neural pathways, leading to feelings of warmth, concern, reward and affiliation (Stickle, 2016). Even if the suffering of the other is very great, if one can have compassion towards them, the neural pathways are positive. One *wishes* for the other to be free from suffering: it is a positive mindset. One does not have to be successful in freeing the other from suffering; it is the wish that is important. Compassion is the motivation that prompts acts of altruism. The second type of empathy is focused on the self and can lead to empathic distress; it registers in neural networks related to pain (Klimecki, Singer, 2012). In the second type of empathy, the person overidentifies with the suffering of another and becomes overwhelmed by their own feelings of distress.

An example of the difference between the two types of empathy is shown by a situation where an ambulance officer and a distressed onlooker arrive at a car accident scene at the same time. Both the ambulance officer and the distressed onlooker are aware there are injured people. The ambulance officer has empathic concern or compassion: he wishes to alleviate the suffering of the injured people and leaps into action as he is trained to do. The distressed onlooker sees the injured people's injuries, *imagines what it would be like to feel their pain* and becomes faint and has to walk off. The distressed onlooker is now overwhelmed by their own feelings of distress: they are no longer focusing on the injured people. At this point, the compassion process has ended, since compassion is defined as a concern in response to the suffering of another. The perspective one takes is key, *imagining how another would feel* (can lead to empathic concern) versus *imagining how you would feel to experience the suffering* (leads to empathic distress) (Batson, Early, Salvarani, 1997). For example, a surgeon can operate on a patient's broken arm to alleviate their suffering. The surgeon does not have to feel the same pain as the patient who has the broken arm. In the case of compassion, it is sufficient to become aware that another is suffering; one does not have to suffer oneself (Ricard, 2015).

The second type of empathy, empathic distress, bears no relation to compassion because one is no longer concerned with the suffering of the other. One has become concerned about one's own suffering. Compassion is always about the other, it is not about oneself. Several authors have spoken about this distinction of other-focus versus self-focus. Eisenberg (2002:135) calls the empathic distress response of the distressed onlooker a 'self-focused, aversive emotional reaction to another's emotion or condition'. Batson (2009) says that 'personal distress' or 'empathic distress' is the opposite of 'empathic concern'. Distress over one's own suffering is a valid experience, but it cannot be called compassion. Some definitions of compassion hold it to contain elements that are focused on the self, for example distress tolerance (Gilbert, 2010; Strauss et al., 2016). Compassion does not contain self-reference items. Compassion is a virtue because it is a selfless concern for another who is suffering.

Klimecki and Singer (2012) suggest that the term 'compassion fatigue' is a misnomer and it should be called 'empathic distress fatigue' instead. Compassion has been shown by neuroscience to be a positive state of mind. Ledoux (2015) says that an examination of the literature on compassion fatigue shows that compassion fatigue does not match with the definition of compassion. Ledoux (2015) suggests that what is called 'compassion fatigue' is really burnout or overloaded workloads, not compassion. Compassion research needs greater clarity regarding definitions of what constitutes compassion and the differences between compassion and empathy. It is important to distinguish between concern for others, which makes compassion noble and a virtue, and concern for self. This is not to say that concern for self is unimportant, but once one's attention is taken off the other, it changes the situation completely. Hospitals do not promote their core values as 'we make sure we are feeling good'; they always promote their core values as 'we care for you'. Sinclair et al. (2016:14) say 'there is the need to reset the empirical foundation of compassion research by establishing its conceptual specificity, thereby providing a scientific base to conduct future research on the topic that is marked by validity and rigor'.

Compassion and common humanity as core values for health care workers

Compassion is a core value of hospitals and enshrined in the codes of practice of professions such as social work, nursing and medicine. The National Association of Social Workers Code of Ethics (1996) emphasises that social work practice is founded on respecting basic human needs and recognising the dignity and worth of the person. Several authors suggest that the perception of common humanity is the foundation of compassion (Von Dietze, Orb, 2000; Jinpa, 2016). Compassion recognises the universality of human suffering (Feldman, Kuyken, 2011; Strauss et al., 2016). All humans share the desire for happiness and the wish to be free from suffering (Ricard, 2015). The social work profession is founded on the principles of common humanity, respect for all persons and human rights. Radley and Figley (2007:207) state, 'In the most basic sense, clinical social workers are guided by compassion for humanity and an altruistic desire to improve individual and societal conditions'. Morley and Ife (2002) suggest that social work is based on sharing a common humanity and that the value of humanity is central. These values of compassion and common humanity are shared by all helping professions; their ethical principles are built on international conventions such as the United Nations Universal Declaration of Human Rights (1948) which states 'All human beings are born free and equal in dignity and rights'. An example of this is staff working in accident and emergency departments. They treat all inpatients, irrespective of whether the patient caused the accident or was an innocent victim. Hospitals do not make judgements as to who is worthy of admission and who is not; the only criterion is whether the patient needs medical attention and care.

The reality is that providing compassionate care on a day in day out basis is not always easy. Compassion is a complex multidimensional construct (Jinpa, 2016). There are many factors that can easily disrupt compassion such as excessive workloads or viewing the other through a biased lens that emphasises difference instead of similarity. When one can recognise that all humans share the same basic needs, one is able to feel compassion towards any other person. Common humanity recognises the universality of suffering (Feldman, Kuyken, 2011; Strauss et al., 2016). All people struggle with experiences of suffering, injustice, mortality and death (Canda, Furman, 2010). All humans share the desire for happiness and wish to be free from suffering (Ricard, 2015; Jinpa, 2016). Social workers know that difficult circumstances can come upon anyone. Furthermore, Gray and Stofberg (2000) make the point that even if one brings suffering upon themselves, it is still suffering nevertheless.

An important point to note is that respect for the person does not mean one has to condone what they do (Adams, Dominelli, Payne 2009). One can still respect the humanity of another but accept that justice is required. For example, a social worker working with prisoners acknowledges the prisoner has committed a crime but works with them to assist with their rehabilitation and integration back into society. Unfortunately, it is common for blame to be focused on the person as a 'bad person' rather than focusing on their negative actions. Social work is a profession that believes in people's potential, capacity to change and the possibility of transformation. Social workers can be found working both with the victims of crime and with the perpetrators of crime. Jinpa (2016) points out that stereotyping and biases can led to exclusion, objectification and in the worst cases, dehumanisation and genocide.

The opposite of this is when people risk their own lives to save strangers. Monroe (1998) interviewed people who rescued Jewish people in Nazi-occupied Europe. The critical element was the perspective that people held. Monroe (1998:206) says for others to help strangers they had a 'particular perspective…in which all living beings are entitled to a certain humane treatment merely by virtue of being alive…deeply felt recognition that all share common characteristics and are entitled to certain rights, merely by virtue of our common humanity.' Compassion depends on our identification with the person we are concerned about (Jinpa, 2016). Compassion training, with its emphasis on common humanity, has an important role to play for health care workers.

METHODS

Compassion training intervention

The health care organisation in the current study is the largest not-for-profit private health care group in Victoria, Australia. Victoria has a population of approximately 6 million people. The health care organisation comprises 8 hospitals and 4 specialist centres. The health care organisation employs 7,770 staff and holds compassion as one of its 6 core values, alongside respect, integrity, excellence, community and accountability. The decision was made to trial a single session compassion training intervention to gauge staff interest and gather feedback from them regarding the effectiveness of this approach. Health care workers usually have multiple demands on their time and a heavy workload. They may not be able to attend a 6-week program of compassion training whereas a single session training program with a low time commitment may be more readily accessed.

The compassion training intervention was promoted across the health care organisation and 100 health care workers attended. Eighty health care workers attended in person and another twenty watched the training session via remote video link. The compassion training intervention was of one hour duration and was presented by the lead author of this paper. After the session the health care workers were emailed a survey to complete to provide feedback on the session. The compassion training intervention included: (i) information defining compassion, (ii) information from neuroscience research indicating that compassion is a positive mind state and different to empathy, (iii) scenarios emphasising common humanity and (iv) a slogan for health care workers to use to help them hold a compassionate stance towards their patients. These will be examined in more detail below.

(i) Information defining compassion

Health care workers were given education on the difference between compassion, pity, empathy and sympathy. These terms are often used interchangeably in compassion research (Goetz, Keltner, Simon-Thomas, 2010; Sinclair et al., 2016). They are not the same. Pity involves the giver having a condescending view towards the receiver (Von Dietze, Orb, 2000; Perez-Bret et al., 2016). Empathy involves one being affected by and sharing another's emotions (Gilbert, 2010). Empathy is not specific to suffering in the way that compassion is. Sympathy involves feeling kindly to another but not necessarily wishing their suffering is alleviated (Ricard, 2015). Compassion involves feeling concern in response to another's suffering and wishing them to be free from that suffering.

(ii) Research information from neuroscience indicating that compassion is a positive mind state and different from to empathy

Health care workers were shown recent research findings which indicate that compassion and empathy use different neural pathways (Klimecki et al., 2013). Compassion is now shown to be a positive mind state leading to feelings of warmth, concern, reward and affiliation (Stickle 2016). Excessive empathic resonance where one is overwhelmed by empathic distress can lead to burnout, whereas compassion is a positive mind state (Klimecki et al., 2012).

(iii) Scenarios emphasising common humanity

The perception of common humanity has been proposed as fundamental to being able to cultivate compassion for all others. Health care workers were shown a number of scenarios (4 real life and 1 constructed) where common humanity was emphasised. The scenarios were:

(a) A Danish television advertisement called 'All that we share'. The people in the TV advertisement were initially grouped under headings 'those who wear suits', 'those who save lives', 'those who exercise' and then gradually the groupings were changed into common human experiences such

as 'those who are lonely', 'those who are step parents, 'those who have been bullied'. The final message was that people have much more in common than they realise when they get beyond superficial differences.

(b) Footage of an Australian lifeguard talking about why he volunteered to rescue men, women and children who were fleeing the war in Syria on fragile inflatable boats in the Mediterranean which often sank. He said 'As a lifeguard, you help people irrespective of race, religion or creed. You don't look at them as a label or agenda. You look at them as human.'

(c) Prison inmates who saved the life of their prison guard who had a heart attack. They used his mobile phone to call an ambulance and removed his gun and bullet proof vest to help him breathe more freely. One of the prisoners said in an interview afterwards 'It wasn't the case of us being the prisoners and him being the prison guard. It was just 'man down' and you go and help.'

(d) Homeless men who rushed to help victims of a bomb attack. In an interview after the event, one of the homeless men said 'I might be homeless and living on the streets but I still have feelings. I saw women and children screaming and bleeding and I went to help.'

(e) Father of two young children who leapt onto train tracks in front of an oncoming train and lay down on top of a man who had fallen onto the train tracks and was having an epileptic fit. The train ran over the top of them both and they both survived unharmed. The father, who was from Harlem said, 'I've always been about helping people, this guy was going to die unless someone helped him.'

(iv) Slogan for health care workers to assist in holding a compassionate stance

The Compassion Cultivation Training (CCT) course developed by Stanford University Center for Compassion and Altruism Research and Education uses the slogan 'Just like me, this person wishes to be happy and to be free from suffering'. People can use this slogan to adopt an attitude towards anyone they meet, even people who may be exhibiting challenging behaviours. The slogan helps promote the sense of common humanity and the commonality of basic needs.

RESULTS

Twenty-two health care workers responded to the survey link. Their response rates were as follows (Table 1).

Table 1: Health care worker responses regarding compassion training

Statement	Response rate (N=22)
Was it useful to have information on the neuroscience behind compassion?	16 respondents said yes (73%)
Was it useful to have information on compassion being a positive mind state whereas too much empathy can lead to burnout	22 respondents said yes (100%)
Was the slogan 'Just like me, this person wants happiness and does not want suffering' useful?	18 respondents said yes (82%)
Was it useful to view video material on common humanity?	18 respondents said yes (82%)

Health care workers were asked 'How important is it to you to have access to information that can boost compassion?' A total of 81% said 'Very Important' and 19% said 'Somewhat Important'. Health care workers were asked for an idea or strategy from the training session that might help them have more compassion. Responses included:

'That all of us just want to be loved and live happily'
'Put yourself in their place'
'Find the commonality between myself and another'
'To remember 'they are just like me' with same hopes and fears'
'Try to imagine other's perspective, we are all human'
'Looking at common human traits'
'Reflecting on others' feelings and others' points of view'

DISCUSSION

The results from the compassion training intervention demonstrated that the health care workers found several aspects of the intervention helpful. Although only 22% of the health care workers who attended the compassion training session filled in the post intervention survey, they rated the usefulness of the segments very highly. In particular the health care workers found information on compassion being a positive mind state and too much empathy leading to burnout being important. The slogan 'Just like me this person wants happiness and does not want to suffer' and the video material on common humanity was rated as useful by 82% of the respondents. It appears that the slogan and common humanity material are helpful in reducing 'in-group'/'out-group' differentiation: everyone becomes the 'in-group', sharing a common humanity. Von Dietze and Orb (2000) consider this to be essential for the development of compassion.

It is important to note that no research has been conducted to investigate whether the perception of common humanity impacts on people's levels of compassion. As noted in the introduction, several authors have suggested that the perception of common humanity appears to be the core component of compassion (Feldman, Kuyken, 2011; Jinpa, 2016; Strauss et al., 2016). Pommier (2010) suggests that the perception of common humanity involves realising that one could find oneself in the position of the sufferer if one were less fortunate. One has a level of identification with the person suffering and recognises human vulnerability as a general phenomenon (Van Der Cingel, 2009). The perspective of perceived similarity leads to concern for the other. More research urgently needs to be undertaken to test this notion because if it is found to be correct, then future compassion training interventions will be made more effective by incorporating the perception of common humanity into their core training.

These results, combined with the strong interest from the staff at the health care organisation, have led to the health care organisation management deciding that it will benefit staff to have access to the compassion training material as a permanent web based module. This will be developed, trialled and evaluated over the next 2 years.

Limitations
There were several limitations to the study:
1. Data was not collected on respondent demographics. This would be helpful to ascertain whether there are differences between sex, age and professional discipline.
2. The survey was administered at one time point only, emailed to health care workers the day after the compassion training intervention. Most completed the survey within the first 3 days after the session. It would be interesting to see what the results might be at 3, 6 and 12 months mark.
3. There was a fairly low response rate at 22% and it appears this cohort found the compassion training very useful. It is unclear how the 78% who did not respond found the training.
4. Five scenarios that emphasised common humanity were used (4 real life and 1 constructed). It is not clear whether some scenarios were more effective than others. It would be helpful to gather feedback on each scenario to see if the health care workers found some scenarios easier to relate to than others.

CONCLUSION

The reasons for developing and promoting compassion training programs for health care workers are compelling. Compassion is a positive mind state; it helps health care workers maintain a caring and concerned attitude towards every patient they work with and protects the health care workers against empathic distress and burnout. The compassion training intervention held at the health care organisation attracted significant interest from staff and the results indicate that the health care workers found the content useful. Health care workers were particularly interested in learning about the difference between compassion and empathy. The health care workers also found viewing material on common humanity and being given the slogan 'Just like me, this person wants happiness and does not wish to suffer' helpful. The perception of common humanity is an area where very little research has been conducted to date. More research needs to be done investigating the perception of common humanity as it appears to be fundamental to people's ability to have compassion for others. It is recommended that further research be conducted on compassion training interventions to gain clarity regarding which components of the training are most useful and whether the training effect is constant and holds over a longer time.

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Melissa Petrakis (Ed.): **Social Work Practice in Health: An Introduction to Contexts, Theories and Skills.**
Australia: A&U Academic, 2018.

Introduction

The book Social Work Practice in Health is an introduction to social work practice in Australian contexts. The authors of this book discussed the theories applied in different health settings with examples from their field of practice, and also highlighted the skills required for social work practitioners for their effective intervention in a specific segment in the field of health. The book consists of 24 authors who are experts in particular areas and have strong and higher achievements in their educational background. The book editor Dr. Melissa Petrakis has more than twenty years of experience in public health and mental health services in Australia, and today is a mentor for clinicians and management in clinical and community rehabilitation. She is also the coordinator of the Health and Mental Health Unit and a senior lecturer at Monash University in Melbourne, Australia and a senior research fellow at St Vincent's Hospital, Melbourne.

The targeted readers of this book are students who are interested or plan to work as social workers in the health setting and the academics who are teaching and supervising students' health settings in Australia and New Zealand, as well as social workers who are already engaged in health related social work practice. To some extent, it could be of interest to international readers as well. Although written for the Australian context, there is useful information and practical experience to be shared with students, academics and professionals who work in health and a health related setting in the different parts of the world.
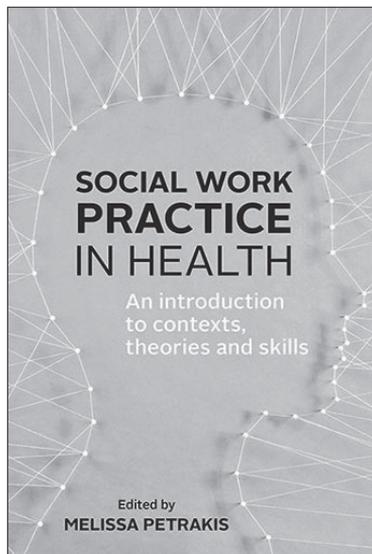
The book discusses some common health related issues such a as the importance of well-being of mothers, working with children, domestic and family violence of women, disability, refugees and aged care. These are shared fields of practice and some of the approaches and frameworks presented would be suitable to be adopted and modified according to the local context, for enhancing practice. For example BUMP is a mentoring programme based on a socio-ecological approach to understanding violence and has been developed for pregnant women, and is based on a socio-ecological approach to understanding violence. The Australian clinical guidelines for early psychosis, the strength model to treat people with mental illness, framework for recovery-oriented practice, the stress vulnerability model, and dual diagnosis are other examples of approaches that would be of interest internationally.

Organisation of the book

This book seeks to articulate the nature of social work practice in health and health related field in Australia and New Zealand and is organised into three major components: Part I is entitled "What is health social work? Role, values and principles for practice", Part II presents Health practice and practice contexts, and Part III focuses on Politicised issues in health practice. Each chapter in this book integrates the concepts and discusses social work practice in different segments in health settings with relevant case examples. The chapters also present some theoretical approaches and perspectives that are helpful for social work practice.

The opening chapter sets the background by defining health and illness and also setting the context of an essential understanding of social work in a health setting as evidence base practice which requires appropriate knowledge and specific skill, and ability of conducting research. This discussion forms the basis for the remaining chapters. This is especially important because of the recent upsurge of interest in the health related field.

The remaining chapters then spell out what is involved in a health setting. They examine how social workers might engage with the discursive construction of evidence-based practice in the respective field, and how social work practice can work to realise and safeguard vulnerable groups with health related challenges. This applied practical focus has been maintained throughout, and it is hoped that the book will therefore retain a relevance and utility for practitioners, academics and the potential students who especially have interest to work in a health setting.

The concluding chapter focuses on portraying the existing indigenous practices in New Zealand and briefly explains the indigenous peoples' health related issues and government's health programmes. The role of the social worker is appropriately explained. The author's intention must be appreciated because in this globalized world the richness and the importance of indigenous practices are often ignored in other sectors. There is a need of research to bring the indigenous perspective to

light and the responsibility of social workers to give voice to the voiceless is well emphasized. The book is organized meaningfully and has a flow from the beginning to end.

Briefing each chapter

The first chapter mainly consists of two articles contributed by three authors. Both articles focused on describing the terminology based on the relevant literature and briefly explain potential health related issues and social work interventions in general. It provides useful general information on health and social work practice. The authors attempted to distinguish health and illness and further gave emphasis to the determining factors which greatly impact the health status of human beings and where social workers' involvements are required. The role of social worker and the specific skills need are discussed within the the Australian context. The authors also acknowledge the challenges confronted by social workers, and the pressure created changes that emerged in last few decades. Another article specifically looks at the necessity of research based social work practice in a health settings and it motivates social work practitioners to conduct research and build their practice based on the evidence which will be more scientific in nature. Further, the discussion stresses the importance of knowledge as a foundation for practice in any given field of practice.

In the second part, the importance of child-centered and strengths-based social work practice in the health domain is discussed citing relevant areas where children with long term or chronic illness face numerous physical and psychological challenges. Based on their experience the authors reflected on the necessity of updating the knowledge on different approaches to work with children and families suffering from substantive illness.

Further, an article on hospital-based trauma social work explains the role of social worker in the acute trauma setting and specific single-issue interventions to more complex ones required work in this setting.

The well-being of Australia's mothers explains the relationship between the well-being of mother and health, social and behavioral

outcomes of the child. This article attempted to explore the concept of well-being of mothers in the Australian context. The author stresses the importance of addressing the needs of mothers of children within the autism spectrum disorder, mothers with mental illness and young mothers. This particular article quite impressed me as rarely is research conducted in these areas. The well-being of mothers is a global consideration which can greatly influence all other aspects of life.

Western explanations about the domestic and family violence against women are provide through an historical analysis for understanding violence against women. The author highlights the complexities, dynamics and myriad influencing factors in domestic and family violence in the Australian context. Though the theme is well researched the authors discussion will help readers to understand the violence against women in a more specific angle.

The unique early intervention role of social workers in mental health settings is outlined together with the challenges to distinguish the social work approach within the multidisciplinary team is discussed by an expert from the field. The authors also encourage social workers to conduct research in this field of health care practice, which will enhance the social work practice in a clinical setting.

The discussion on forensic social work emphasizes importance of social work intervention in the correctional setting and goes into applicable theories in the field of forensic social work with appropriate case examples. The author also included her reflections on her experience. She clearly explained the application of theories with the brief and informative case examples proving good insight for those who work in the forensic setting. Another article brought attention to the interdisciplinary team where all the relevant intellectuals work together to optimize the quality of the intervention by enhancing knowledge and skills required to work in a particular setting. The need of multidisciplinary team work is very recently acknowledged in the health setting in Sri Lanka, and after reading this article I could realise that adoption of the concept of interdisciplinary team work in social

work practice extends the scope of social work in the future.

Initially, I had a thought that the book would be directly talking about social work practice in a health setting and I never expected that such experts in the field be authors of the book. While I was reading the book first there was a bit of confusion to understand the motivation of the authors, and later could realize the effort of each author to contribute to this book and make it worthy to read. Some of the articles are not from the direct practice of social work but the authors linked the discussion back to the field. The strength of the book is that it is written by the authors who are not just researchers but they are authorities in their fields. This part ensures the quality of the book.

Conclusion

The overall impression of this book is that it is general in relation to information and can be a resource for beginners in the field of health social work. It offers introductory knowledge and preparation for practice. Academics who engaged in teaching and supervising students can also make use of the practical examples and the reflections of authors who are truly experts in their field of practice and relevant field of knowledge. The book may also be the source for other professionals such as doctors, lawyers, caretakers, and professionals in the field of social services. The argument outlined demonstrates the need of social workers and the impact of social work interventions. In countries like Sri Lanka, social work is still seen as charity work and other profession have difficulty acknowledging the professional status of social workers. This book contributes to social work practice, research, knowledge and skill development in the fields of forensic social work, women and childcare, elderly and disability care, indigenous practice and refugee health. The book is relevant to the current social work practice in health and health related settings.

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Beáta Balogová, Eva Žiaková (Eds.):
Vademecum sociálnej práce. Terminologický slovník [Vademecum of Social Work. Dictionary of Terms]. Košice: University of Pavol Jozef Šafárik, Faculty of Arts, 2017.

Nowadays, social work is focusing on its development in the levels of theoretical and academic, as well as empirical and application. The origin of encyclopaedias and dictionaries was and has been a reflection of the degree of completion of the given field. They are representatives of the actual level of theoretical and scientific thinking. For this reason, a terminological dictionary is not only a reaction to the lack of professional literature, but it is, as well, a proof of an increasing importance of a scientific field and a manifestation of the soundness of its scientific base. The editors of the publication *Vademecum sociálnej práce (Vademecum of Social Work)*, Prof. PhDr. Beáta Balogová, PhD., and Prof. PhDr. Eva Žiaková, CSc., together with a numerous author team, transcend the usual dimension of a unilateral vision of specific areas of social work. The Latin term "vademecum" is translated as a handbook, handle, guide book, in a vast number of terms and professional expressions, which also corresponds to a wide range of key terms and concepts. Therefore, this publication is also the result of a longer-term project of the Association of Social Educators in social work in Slovakia and offers an expert work to the experts and to the student community in which the knowledge gained in social work in the interdisciplinary context was assessed.

The book after the first browsing attracts a reader by its good arrangement and content. It is obvious that the structure of the book is encyclopaedically well arranged and systematically elaborated. The composition of the author team, which consists of more than 60 graduate experts in the field of social work, has contributed to the total quality of the publication. The intent of the author team was to start working on the entries for eleven areas that respect scientific discussion of the social work development. These entries are in alphabetical order and have a fixed structure: 1. term in Slovak, 2. term in English, 3. linguistic roots of the origin of an entry, 4. definition of a term, 5. professional dimension of the performance, 6. institutional scope of solving of the given issue – the application dimension, 7. legislative scope of the addressed issue. The selected approach of the processed entries lays stress especially on the social relations and social environment. Every entry has its specifics but all of them find the understanding of a client and a social worker important in relations and by means of relations. Considering the quality and the level of processed terms to one whole, it is not simple to focus exclusively on certain terms. This is the reason why we will evaluate individual chapters from the point of view of their specialty.
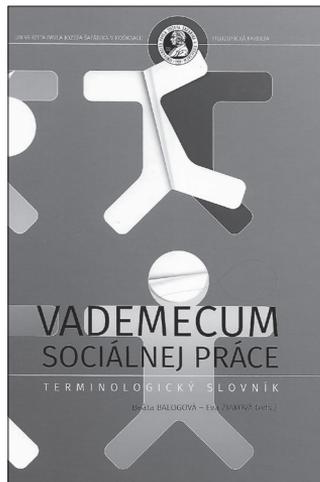
The first three chapters define the terms from the field of ethics of social work, theories and methods of social work which are important in the relationship of a social worker and a client. As the chapters describe many variables, it is important to use specific approaches, methods and techniques while working, and within them to apply professional skills to solve problems which result from the social situation and individuality of every client. Mentioned chapters present these issues in a constructive and precise way.

From a practical perspective, chapter 4 might be interesting in that social workers may find there a wide range of terms connected to the social work consultancy. The authors succeeded in elaborating the consultancy in social work systematically and comprehensively. Positive evaluation is completed by a note that *basic social consultancy and specialized social consultancy,* which is nowadays defined by the legislation as an expert activity, were delimited in the book by a term *Levels of social consultancy.* Therefore, from a practical point of view, it would be a benefit to give individual attention to these expert activities. It is more than probable that the experts will, in compliance with the legislation, look exactly for these terms in the terminological dictionary.

The authors covered the topic of supervision in social work in the fifth chapter. It offers initiatives to find new ways, perspectives and possibilities for the solving of social problems of the clients. This chapter treats a highly topical subject which is an impulse for the practice because it will enable the improvement of the work of social workers, for example, to prevent burn-out syndrome.

The sixth chapter focuses on the field of social politics and social security. Even though this field is very complex, the authors have put together the entries in such a way in order to secure good arrangement and fast orientation to the complex problematic of this chapter.

The seventh chapter focuses its attention on social pathology. The authors – in connection with a social situation that brings many changes reflected in the social functioning of an individual, family and entire society – included entries defining the problem of poverty, unemployment, homelessness, delinquency, substance and non-substance addictions, criminality, bullying, cyber-bullying and other socio-pathological phenomena.

Parts eight to eleven of the publication offer the overview of many key terms in which there are represented theoretical findings from the fields of family as a client, social services and social rehabilitation, social work in public administration but also the field of research.

A view on the overall direction of social work and the diversity of its understanding plays an important role in the conception of the dictionary. However, to choose from such a huge number of the terms considered important by experts and laymen, was not an easy task; it was successful in creating an extensive terminological dictionary that is beneficial for practice. An important message of the author team consisting of the experts from Slovakia (in their own words): *"The choice of entries that have been chosen has no ambition to be exhaustive. The ambition of the author's team was to offer to the experts a terminological dictionary that would define individual terms, point out the direction of further possible scientific development and at the same time become an inspiration for those who will, today and in the future, devote themselves to this field of social work."* (p. 358).

The mentioned approach of the author team and elaborated content predestine the publication to be a benefit not only for the students of the field of social work but as well for the experts who need to be oriented in many areas of social work and quickly look up the most important information. *Vademecum of Social Work* is as well a significant act which shows the right of social work as a confident position of an established scientific discipline and, certainly it should not be missed not only in university libraries but also in workplaces focused on a daily professional experience in a social field.

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Research Report from the Research Institute for Social and Economic Sciences, Vorarlberg University of Applied Sciences

In cooperation with the Children and Youth Welfare Organisation in Vorarlberg (Austria) investigations were carried out in a master's degree thesis entitled "The Use of Social Diagnostic Instruments in the Youth Welfare Service Practices in Foster Placements of Vorarlberg." This research work consisted of analyses relating to social diagnostic instruments and skills implemented for the clarification processes in children and youth welfare in Vorarlberg, and examined various aspects of the involvement of children and their legal guardians in these clarification processes. The relevance of both of these issues stems from the fact that relatively few investigations have been made into the approaches and methods of social workers in the area of children and youth welfare regarding possible threats to young persons' welfare. On the other hand, these inquiries have societal implications, since the well-being of a child, as well as the rights of parents and children in general, are concerns of society as a whole. And finally, the increased institutionalization of children and the youth has aroused the interest of the media, a trend which must be dealt with judiciously in empirical research (Ackermann, 2017:7).

Assessing welfare risks is increasingly becoming a complex process, leading to uncertainties among social welfare professionals. In addition, the number of cases has been rising, coupled with a reduction in competent personnel. All this has led to a scarcity in time resources when a quick assessment of a possible threat to child welfare is needed most (Lüttinghaus, Streich, 2008:39).

Social diagnostics can contribute to quality improvements of support measures by assuring participation in transparent decisions and by serving as a documentation basis. A "multi-perspective case interpretation" needs "hypothetical, reflexive and dialogical" diagnostics during the support planning (Röh, 2016:5).

On the individual case, family, and network levels there are well-developed diagnostic instruments, as for example the "resource map, inclusions chart, multi-perspective grid, network map, or genogram" (Röh, 2016:9–20). Using qualitative document analysis, 100 case files in which foster care had been decided upon were investigated with respect to the efficacy of social diagnostic procedures and instruments – from a bio-psycho-social perspective. The most current case files, dating back to December 2016, were given priority. Because of their larger populations, the towns of Bregenz, Dornbirn, Feldkirch and Bludenz (all in Vorarlberg, Austria) were accorded primary consideration.

The results show that the Children and Youth Welfare Organisation in Vorarlberg places substantial emphasis on bio-psycho-social perspectives, using preferably multi-level and multi-perspective diagnostics. There is a standardized procedure in the clarification process using threat inquiry, threat assessment, support planning talks and support planning appointments. The Welfare Organisation evaluates threat assessment in any individual case using the cooperative efforts of two experts. This procedure is based on the concept of resource-oriented, cooperative consultations according to the methodologies of Maria Lüttringhaus and Angelika Streich. The Welfare Organisation implemented genograms as a social diagnostic instrument in 78 of 97 cases. Furthermore, in 52 cases home visitations were used as an instrument to determine the care needs of the child. Following the concepts developed by Lüttringhaus/Streich, case discussions within the team took place in 11 out of 97 cases. In addition, use was made of visual assessments (five times), resource maps (3 times), a child protection survey, a clarification plan, a client record and an instrument for determining a child's care needs. Additional social-diagnostic instruments, as

known from specialist literature, were not evident. The diagnostics of the Children's and Youth Welfare Organisation Vorarlberg can be ascertained primarily in the form of cohesive continuous texts.

The participation of the legal guardians and the minors/children occurs within the context of the threat assessment, in the form of talks. These are recorded in summarised, continuous text form in the threat assessment. The support planning is also carried out with the participation of all those involved. In the support planning discussions the initial situation and the objectives, from the points of view of the legal guardians and of the underage person, are summarised in writing. However, there is seldom an exact recording of the child's perspective.

In six cases the efforts of the expert in charge of the case could be determined explicitly, in order to comprehend the child's perspective views. In specific talks with the child attempts were made to precisely diagnose his/her needs, goals, family situation, and state of mind. In none of these six cases was a diagnostic instrument used.

This research work demonstrates that, in the area of resource activation and empowerment/participation of the persons involved, there is much more potential to be achieved. Solid diagnostics can be of assistance, together with discourses among other experts, to achieve competent results, which become an important basis of documentation in confronting criticisms or making decisions transparent and comprehensible. But this is only one side of the issue. It is much more important, in the area of young persons' welfare, to aid and support clients as best possible with the help of social diagnostics. Social diagnostics can no longer be stigmatized and criticized, since they provide an incredibly valuable fundamental approach in our society, specifically in the field of clinical social work.

The interest of the Children and Youth Welfare Organisation Vorarlberg in empirical research, and the Organisation's openness for further developments, deriving from this master's thesis, have led to the follow-up project "Core Processes and Custom Support by the Children and Youth Welfare Organisation in Foster Care Procedures in Vorarlberg," extending from September 2017 to September 2018. Within the scope of this research the core processes (threat clarification, support planning, case management) are to be evaluated. In addition, it will be determined to which degree the support choices in Vorarlberg are sufficiently customized. Aside from the qualitative re-analysis of the documentation of the 100 case studies, two focal groups, consisting of management personnel and social works in the children and youth departments, will be established. The results of all these investigations can be expected in September 2018.

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5/2018: 100 Years of the Czechoslovak Social Work (Czech and Slovak edition)
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2/2019: Social Work Education (Czech and Slovak edition)
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3/2019: Influence of Changes in the Society on Social Work (Czech and Slovak edition)
The editor of this issue is Oldrich Chytil (Czech Republic).
The publication date is planned for June 2019.

4/2019: ERIS Journal – Summer 2019 (English edition)
The editors of this issue are Doris Böhler (Austria) and Karen Mills (United Kingdom).
The publication date is planned for August 2018.

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Public commitment to the Journal

The journal for theory, practice and education in social work

The mission of the journal "Czech and Slovak Social Work" is:
- to support the ability of Czech and Slovak societies to cope with life problems of people through social work,
- to promote the quality of social work and professionalism of social work practice,
- to contribute to the development of social work as a scientific discipline and to the improvement of the quality of education in social work,
- to promote the interests of social service providers and users.

In the interest of achieving these objectives, the Journal will, across the community of social workers and with co-operating and helping workers from other disciplines, promote:
- attitudes which regard professionalism and humanity as equal criteria of social work quality;
- attitudes which place emphasis on linking theoretical justification of social work practice with its practical orientation on clients' problems and realistic possibilities;
- coherence among all who are committed to addressing clients' problems through social work;
- open, diversity-understanding, informed and relevant discussion within the community of social workers;
- social workers' willingness and interest in looking at themselves through the eyes of others.

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There is also space for all reviewers who want to introduce an interesting book in the field of social work and its related fields in the journal. We require making arrangement about the book review with the editors in advance. When sending the text please attach a scan of the front page of the reviewed book. (in 300 DPi resolution).
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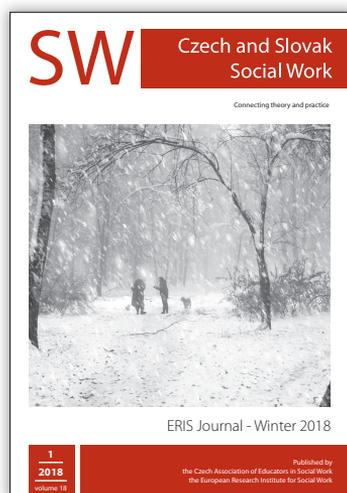
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