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## Editorial



## Articles



## Book Reviews



## You have written

# Does research into ourselves help promote social work and client interests well?

Research into helping interventions may consist in the study of "contexts", "agents", "methods and processes" and "targets" of these interventions. It seems remarkable that five of the six articles included in this volume pay attention to "contexts" or "agents" and only one addresses the "methods and processes" and "targets", i.e. clients of social work intervention. Hence, the authors are more interested in social workers themselves than in their clients and ways of helping them.

Musil and Prinzová both focus on the dilemmas experienced by social workers, the former in the context of organisation and the latter on the sites of armed conflicts. Vávrová and Polepilová deal with the training needs of social and other helping workers. Špiláčková corrects the misinterpretations concerning social work practice at the time of the communist regime. Plasová reflects on the conditions for reconciling work and family under the current Czech Childcare Policy Model. The focus on the capacity of current community care services to help elderly people live in their home environment by Kubalčíková and Havlíková seems to be the exception that proves the rule.

What does this mean?

It is doubtless important to understand the cultural, educational, social policy and political contexts of social work. The same seems to be true of the experiences, problems and views of social workers. However, one should take into account that social workers are unsuccessful in persuading Czech society that their help can be useful and its professional status should be enhanced so that they have a chance to try their best in following their mission. From this perspective, both the lack of attention to the "methods and processes" of help through social work and inadequate focus on "clients" seem to be harmful.

The status and the expected mission are context-dependent. Social workers therefore need to understand this context in order to be able to change the legitimacy of social work and the conditions for doing their job. However, for promoting these interests, social workers also have to display capability to help both people in need and the mainstream population to cope with their mutual tensions and the accompanying problems. Hence, social workers need to know the difficulties their clients experience when interacting with various actors in the majority population. Moreover, social workers should manifest their ability to apply an adequate scale of methods so that they can help their clients and other people in their social environment to deal with the problems that they encounter in their mutual interactions.

The collection of articles included in this volume indicates that researchers mostly do not focus on the promotion of the above-mentioned capabilities of social workers.

It is an honour to me to express my thanks to Malcolm Payne for help with preparing this volume.

*Libor Musil*

# Towards Staying at Home. Could Domiciliary Care Services be a Possible Way?

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**Abstract**

Population ageing as well as the change in the approach towards the clients of personal social services impact on stated social services policy in many European countries. Likewise to support elderly people in their natural social environment is the strong point of the official policy of social services in the Czech Republic and the role of field-based assistance increases as opposed residential care. In the context of these national priorities of elderly care policy, the purpose of this study is to report on the position of the domiciliary care services as the typical means of field-based social services providing. European and national priorities regarding the policy of elderly care are presented in the first part of the text. After that using case study results of selected domiciliary care service agency extended by quantitative data (SHARE) we investigate both the current aim of the domiciliary care services and its importance to the service users themselves. Above all we focus on the possibilities and risks of the domiciliary care services providing and the potential of this kind of service to ensure suitable care of elderly in their place. We discuss this issue from the viewpoint of the different actors: service users, service workers and service managers as well.

**Key words**

Elderly, social services policy, domiciliary care services, nature social environment, case study

### 1 Current strategy of European elderly care policy

Ageing is a demographic feature of all European countries as fertility has declined and life expectancy improved. Today the countries in Europe face economic and political obstacles to finding the tax revenues necessary to support significant growth in publicly funded services and benefits for older people. The impact of ageing on health and social care expenditure arises because older people tend to need care more frequently as they develop chronic, principally cardiovascular and respiratory, disease (Blackman, Brodhurst, Convery, 2001:12). But ageing brings an increasing risk of enduring difficulties such as physical disability, depression or dementia, and of stressful life events such as loss of effective relationships. These changes affect individuals at different rates and with different patterns, and individual older people respond to them in different ways: they could have different degrees of vulnerability and different coping styles.

In the light of population ageing, changes in family structures, an increase in women's labour market participation rates and the perceived unsuitability and high cost of institutional care, the challenge of providing adequate community care as well as care in the home has become a policy concern of great importance (Doyle, Timonen, 2007). Concern about the future affordability of social service providing has arisen out of number of aspects of ageing in Europe. First, the number of "older old" people - those aged 80 and over – are projected to rise even faster than the numbers of "older" people. This is significant because it is among the "older old" that long-term care needs are greatest. Second, there are concerns about rising dependency ratios. The Economic Policy Committee (EPC) estimated that by 2050 the EU-15 would move from having four people of working age for every older person to only two. Third, there are concerns that there could be a future decline in family support for older people with potential increases in demand for formal services and long-term care expenditure (Pickard *et al.*, 2007).

In many European countries is now a strong stated policy preference for care in the home as opposed to institutional care and policies on the local level are (increasingly) bearing out this preference. This shift to care in the community and in the home has been slow to evolve but is now commonly and firmly promoted by policy makers and experts as well as the older person who, for the most part, have a preference for home care. Most countries have made decision at least in principle that, whenever possible, such care should take place in the older person's home.

### 2 What is the domiciliary care service?

Due to composition of the services provided, domiciliary care services have the potential to support the elderly to "age in place" as it is able to compensate for lots of the old peoples' limitations in daily living activities. According to Walker (2005) staying in well-known place is a very important aspect of the quality of life of the elderly. Halvorsrud and Kalfoss (2007) found out that all classic conceptualizations of the quality of life have among others included such domains as physical health, social relationships and support and environment. Moreover, Bowling *et al.* (2002) found out that the quality of area residence and the rate of social support (measured as the number of areas of life with which they could ask someone for help) and social activities had strong influence on self-evaluations of quality of life among the older people.

The importance of environmental context for the quality of life has its roots in the strong association of place with individual and family biographies in minds of Europeans and, therefore, place is imbued with meaning and aspects of identity. "It is also the location where older people spend much of their time and the proportion of time spent at home rises in old age" (Walker, 2005:10).

Doyle and Timonen (2007) point out that the generic term "home care" is often used interchangeably with the term "domiciliary care". However, "domiciliary care" and "home care" have different meanings in different social service systems. A distinction can be made between medical and non-medical social care service. The focus of this text is non-medical domiciliary care (or non-medical home care), i.e. social assistance to the people in their natural social environment.

The parameters of domiciliary care services were defined by Cullen *et al.* (2004). According to their typology, care can be broken down into four categories:

***Practical:*** for example, domestic tasks such as preparing a meal, cleaning the house and doing shopping;

***Personal:*** for example, washing and bathing, help with getting dressed and providing continence care;

***Monitoring/Supervision***: for example, of persons with dementia who may be confused when using appliances or in danger of wandering;

***Care management:*** providing support through management activities such as liaising with health professionals and coordinating care services.

Individuals who require domiciliary care services usually meet a limitation in "basic activities of daily living" (BADL) e.g. washing, dressing or eating, and/or in "instrumental activities of daily living" (IADL) e.g. shopping, cleaning, or meal preparation. Domiciliary social service staff typically work in a dual capacity. They deliver light domestic care (assistance with IADL) including food preparation, light housework and companionship services such as accompanying clients to medical appointments. They also provide personal care (assistance with BADL) such as helping the older person in and out of bed, assistance with dressing, prompting medication, showering, bathing, grooming, etc.

## 3 Demographic situation in the Czech Republic and the strategy of social services provision

The population of the Czech Republic is ageing at a rate similar to that in other European countries. In spite of a temporary increase in fertility over the past few years, steady growth in the proportion of persons over 60, or 65, to the total number of inhabitants is apparent. As the demographic forecast (in its mean value version) implies, in the year 2050, approximately one third of the country's population may generally be expected to be older than 65. As in other European countries, by the year 2050, the number of persons over 80 (the so-called "older-old") will have almost quadrupled. Some of the factors responsible for the ageing of the Czech population may have been a long-term decline in fertility, or, significantly, the extending life expectancy. In the year 2008, the span of longevity in newly-born men was estimated at 74 years, and that of newly-born women, at 80.1 years.

### 3.1 The ageing society and the growing expenditure on social care provision

The demographic trends described above have significant implications for the country's expenditure[1] on social care of the aged. While in 1997, the expenditure costs amounted to CZK 123,576,000, in 2006, public funds released a total of CZK 225,545 million for the same purpose, and in 2007, the amount increased to CZK 252,990,222, so the expenditure costs have almost doubled during this decade.

Similarly, the ageing of the population is evident in the social services sector. Social services are provided to approximately 700,000 clients, i.e. approx. 7% of the population of the Czech Republic. According to the Czech Statistical Office records, it is the senior citizens that constitute more than one half of the social services clients. Social services are financed by more than one source. In 2008, the total cost of the social services system was approximately CZK 20 billion, i.e. approx. 0.65 % of GDP. Clients' contributions account for 35% of the total cost, with territorial self-governing authorities contributing 25%, the state budget 30% and the funds of the public health insurance contributing 3% (usually where health and social care is provided concurrently in homes for the elderly or homes for people with disabilities) (Social services and Care Allowance in the Czech Republic, 2009). From the financial point of view, residential care services in the Czech Republic can be considered rather too costly a way of help provision. For example, in 2008, the annual expenditure on the care provision per client in the Homes for the elderly[2] amounted to approximately CZK 2 million and in Special regime homes[3], to CZK 2.1 million. In domiciliary care services, in comparison, the expenditure costs per client were CZK 15,280 per year. (Social services and Care Allowance in the Czech Republic, 2009).

### 3.2 The system of social services for the elderly in the Czech Republic

Help for and care of the elderly are regulated by Act No. 108/2006 Coll., on social services and by the Ministry of Labour and Social Affairs Decree No. 505/2006 Coll. Social services are by this Act classified into three basic areas: *Social counselling*, usually specialised for a certain target group or situation, with basic counselling being

an integral component of all social services; *Social care services,* the main objective of which is to arrange for people's basic needs, which cannot be provided without another person's care and assistance. *Social prevention services*, namely serve to prevent the social exclusion of persons who are endangered by socially adverse phenomena. Social services are also classified according to the place of their provision: *Field-based services* are provided at a person's place of residence, i.e. in his/her household, at the place where he/she works, studies, or spends his/her spare time. To receive *out-patient service*, the person must visit specialised facilities such as care centres for disabled people or contact centres for people at risk of becoming dependent on addictive substances. *Residential care services* are provided in facilities where a person at a certain stage of his/her life lives all year round.[4]

### 3.3 Domiciliary care service as part of the system

Within this classification scheme the domiciliary care service is part of the social care services. The domiciliary care service is then defined as a field-based or out-patient service provided to persons with reduced self-sufficiency due to their age, chronic illness or disability, and to families with children, where their situation requires that they be assisted by another person. This service is provided at a specified time in persons' households or in out-patient facilities and it is provided to the client for a fee.

Besides domiciliary care service there are two other commonly used types of social care services intended for older people, i.e. homes for the elderly and special regime homes, however, these are provided as part of the residential care classification.

### 3.4 Current strategy of Czech elderly care policy

The issues of the ageing of population, along with the increasing expenditure costs of social services provision, are also reflected in a number of policy documents approved by the Czech government.

Of particular interest among these is the document *National Report on Strategies for Social Protection and Social Inclusion 2008-2010*, and the document *Quality of Life in Old Age: National Programme of Preparation for Ageing for 2008-2012*. Both texts contain principles underlying the provision of help and support to the elderly, with particular focus on active ageing and promoting an active old age, integration of the elderly into, and their involvement in, common daily activities within community life, and thus promoting, inter alia, the concept that older persons with care needs (recipients of long-term care) should remain living in the place which they know well, i.e., in their own homes. Two other key documents, a government resolution of 2006 *The concept of transition from residential service to different types of social service provided to users in their home environment and promoting social integration of the user into society,* and *Priorities for the development of social services for the period of 2009-2012*, contain arrangements and methods for achieving these goals. The pivotal issue in the field of development of long-term care for older people in the Czech Republic is strengthening the role of field-based services with the care provided in the client's own home, and the related question of promoting cooperation between formal and informal care providers. Voiced this way, the strategic visions and the steps projected towards their implementation underline the importance of domiciliary care services, which is meant to form the main pillar of the whole system of social services for the elderly.

The government policy described above corresponds with older persons', or their relatives', views as observed in research conducted in the past decade (cf., for example, Veselá, 2002; Kuchařová, 2002; Kubalčíková, 2007). According to this elderly people would generally prefer to remain living in their own homes, should they become dependent on care provision due to a worsening state of health or living conditions, and receiving help therein carried out by professional carers or their relatives. The persistent myth that the elderly people's needs are virtually limited to securing the basic necessities of life is contradicted by their demands for non-material help (such as personal contact with other people, the feeling of security and the availability of help, etc.).

On the other hand, it is necessary to reflect on the strategies that the Czech elderly use when considering their own preferences as to the suitability of the care arrangements in case of health deterioration or reduced self-sufficiency. In 2008, the utilization of accommodation capacity

in Homes for the elderly amounted to 95.3 per cent in total, in some regions even 100 per cent. If the capacity is not fully utilized, as is sometimes the case, it is generally a temporary situation or emergency beds. Almost every residential home has a waiting list of applicants. According to the Czech Statistical Office records, in 2008, there were in total 52,953 unsatisfied applicants for placement in an elderly people's home. In many cases, applications are submitted even though the applicants' immediate physical or living conditions do not require it – they do so to guarantee that they are secure in future if their health suddenly worsens. The waiting time for placement is relatively varied, depending on the type of service, and it ranges from several months up to five years. In other words, the elderly signal considerable distrust of domiciliary care services and its potential to ensure help in case of considerably reduced self-sufficiency.

With regard to the demographic development described, the government's strategy of long-term care organization and mainly to elderly people's personal goals, it is legitimate to ask: *What are the risks and opportunities of domiciliary care services provision in the Czech Republic in connection with support of the elderly people to stay in their natural social environment?* Using a qualitative case study design we focus mainly on the extent to which the domiciliary care service is able to ensure the provision of needs of older people with reduced self-sufficiency.

## 4 Methodology

With the aim of answering the question above, we will use data obtained by combining qualitative research methods. According to Shawn and Gould (2001), qualitative research can be considered optimal in the area of social work or social policy if we are concerned with themes such as understanding service user and social behaviour, representing service users' voices, organizational culture and change management or understanding and evaluating complex policy initiatives. Specifically, we will use data from a large case study of a representative organization providing domiciliary care services, which was carried out in the years 2009-2010 as part of a multi-year project conducted by Research Institute for Labour and Social Affairs, and focused on the impact of national social services policy on immediate practice of help provision and the social workers' attitude to clients.

A case study is a distinctive research concept within a qualitative strategy. It can be regarded as most effective where the questions "why" and "how" are the main concern in the problem given, while we are not in control of the course of events and focus on the phenomenon within the framework of its context (Yin, 2009).The theme of the research focused on the culture of provision of this type of social service and the attitude of social workers to clients. The theme framework set this way enabled us to pursue a number of connected research themes, inter alia, the risks and opportunities of the present-day form of domiciliary care services provision, from the perspective of the provider, workers and users.

For the research purpose, a municipality domiciliary care services agency was chosen, located in a medium-sized town with a population of 20,197, out of which, at the beginning of 2010, more than 18 per cent were aged 60 and over. The service is primarily provided to the elderly citizens of the town. At the time when the survey was conducted, the number of service clients was 475. There were 21 front-line workers, eighteen of whom were social service employees (carers) and two were social workers; the part of the duties of a social worker that involved paperwork was carried out by the head of the service, who was also engaged in management.

Data collection was carried out with the help of semi-structured interviews, which, in some cases, were conducted repeatedly. As communication partners, representatives of the local municipality, the service management, over half the front-line workers and seventeen client representatives were involved. The sample of clients was chosen according to previously specified criteria: age, sex, marital status, range of service provision, degree of dependency and type of housing. Clients were interviewed in their homes, and field notes on the respondent's living conditions are included in the research findings. The data gathered were analysed with the assistance of the Atlas/ti software.

The case study outputs focusing above all on the supply of services are framed by the quantitative data analysis which provides information about the demand for help. For studying the

composition of the Czech elderly population from the viewpoint of their health, housing and social situation and with a special respect to their need of outer help and care we used the Czech sample from the second wave of the *Survey of Health, Ageing and Retirement in Europe* (SHARE). The data collection was carried out 2007 and the Czech sample included 2,827 respondents aged 50 and over.

Further information on the service-in-question practice was obtained through studying relevant documents, such as service provision regulations, house regulations in special regime homes for the elderly, data stored in the register of social services providers, leaflets for the service applicants, forms relating to service provision, agreements with clients, worksheets and job specifications. Other sources of written information comprised municipal conceptual materials, specifically the domiciliary care service scheme.

## 5 Results

In this section, we firstly illustrate the potential need for provision of help to the elderly in the Czech Republic in their daily activities using the SHARE database. Then in this context, we present main outcomes from the case study of the selected domiciliary care service agency. Attention is paid to methods of domiciliary care services provision, drawing on the parameters defined by Cullen *et al*. (2004) which were described in the previous part of the text.

### 5.1 The level of managing IADL and BADL by the elderly in the Czech Republic

From analysis of data representative of the Czech population aged 50[5] and over gathered within the scope of the European project SHARE, it is evident that the need for outside help with daily living activities increases with age. As shown in tables 2 and 3, it is mostly activities relating to IADL that cause difficulty to the elderly, namely doing work around the house or garden, using a map, shopping for groceries, and preparing a warm meal. Even though it is obvious that problems with BADL activities do not affect such a high percentage of the elderly as those in the case of IADL, the importance of help with these activities cannot be denied as the performance of these is closely related to maintaining their self-esteem and dignity, or, in some cases, even health of the persons in question.

**Tab. 1 Proportion of respondents in three age groups who claimed to have everyday problems with the following BADL, given at percentage point rate**

| | Age category | | |
|---|---|---|---|
| | 50-64 | 65-74 | 75+ |
| Dressing, including putting on shoes and socks | 2.9 | 5.4 | 11.2 |
| Walking across a room | 0.4 | 1.8 | 6.1 |
| Bathing or showering | 1.4 | 3.6 | 13.2 |
| Eating, such as cutting up your food | 0.1 | 0.9 | 1.6 |
| Getting in and out of bed | 1.7 | 2.8 | 8.7 |
| Using the toilet, including getting up or down | 0.7 | 1.4 | 4.7 |

**Tab. 2 Proportion of respondents in three age groups who claimed to have everyday problems with the following IADL, given at percentage point rate**

| | Age category | | |
|---|---|---|---|
| | 50-64 | 65-74 | 75+ |
| Using a map to figure out how to get around in a strange place | 3.9 | 8.7 | 20.3 |
| Preparing a warm meal | 0.7 | 2.1 | 10.4 |
| Shopping for groceries | 1.4 | 4.3 | 17.1 |
| Making telephone calls | 0.4 | 1.4 | 7.1 |
| Taking medications | 0.4 | 0.4 | 3.0 |
| Doing work around the house or garden | 6.2 | 11.8 | 29.9 |
| Managing money, such as paying bills and keeping track of expenses | 0.9 | 1.7 | 7.1 |

The proportion of residents who claim to have no problems with the activities listed falls dramatically with age. While as many as 88.8 per cent of respondents under 64 do not experience any permanent obstacles in performing activities related to BADL and IADL, in the oldest age group, 75+, only 57.3 per cent of persons

interviewed do not encounter obstacles. Analysis outputs also reflected that the elderly in the age group 65+ claim to have some difficulty obtaining external help with the activities described. Only 60 per cent of those who had problems with at least one of these activities, or with mobility or load transportation (e.g. a five-kilo-weight of shopping bag) claimed to have someone in their environment who was able to help them.

These findings show that, in the light of the need they declared, at present, help with managing BADL and IADL provided to the elderly by either informal or formal providers can be seen as insufficient. The possibility of solving the problem of reduced self-sufficiency by placing the person in question in a home for the elderly – ignoring the reality that these are permanently full – is an alternative not even preferred by the elderly themselves, the signs of which can be seen from the results of SHARE analysis, where a strong attachment of the elderly to their own homes and localities can be traced (90 per cent of respondents aged 65+ had lived in their homes for at least 20 years, and in the same localities for as many as 36 years and more).

From these trends in demographic development – increasing demand for care, decreasing capacity of informal providers – it is clear that it would be the domiciliary care service that would enable continued residence at home of older persons with care needs, regardless of their capacities. In the light of the elderly people's needs described, we shall next deal with the possibilities of providing this type of help through domiciliary care services.

## 5.2 Parameters of domiciliary care services provision in the Czech Republic

In this part, we will try to reconstruct the conceptualisation and methods of domiciliary care services provision to the elderly in the Czech Republic, utilizing data from the case study described in Methodology. Concurrently, we will look at the parameters anticipated in this type of social service by Cullen et al. (2004) as they were carried out in the social service agency studied – i.e. practical help, help with self-maintenance, monitoring/supervision, and care management. In addition to these, we discuss also the institutional context in which the chosen domiciliary care service agency operated, e.g. the funding and local government social policy.

### *5.2.1 Practical help*

This parameter is relatively widely available in domiciliary care services and explicitly defined in legislation. According to law, the term "practical help" involves providing food or help to service users in providing food, which in practice means ensuring a supply of food corresponding to the specific diet needs of people in old age, also delivery of hot meals, help with preparation of meals or drinks or preparation and serving of meals and drinks. Another form of practical help is assistance given to client in the maintaining of their household, namely light housework, routine maintenance and upkeep, help with all-round or seasonal cleaning, cleaning up the house following decoration jobs, everyday shopping and running errands, heavy shopping or shopping for clothes and household equipment, washing and ironing.

This assistance is provided by the domiciliary care services agency examined. Interviews with the service representatives and management showed that the service has the potential to ensure the full range of such help to a wide spectrum of clients. Of the total number of 475 clients, almost 59 per cent demand solely the delivery of warm meals less than 10 per cent a combination of warm meal delivery and help with housekeeping and self-maintenance, and approximately 31 per cent of clients demand solely ensuring help with housekeeping and self-maintenance without delivery of hot meals.

Provision of these activities is covered by the employees of the provider organization, namely the front-line workers – carers. The one exception to this arrangement is the preparation of warm midday meals, which are supplied by an external firm. The delivery itself, however, is carried out by social service workers in two cars once a day, with special attention to keeping the delivery time around noon, including weekends.

### *5.2.2 Help with self-maintenance*

This parameter of domiciliary care services help is also explicitly defined in legislation. It involves activities such as assistance with serving food, dressing and transfer from bed to wheelchair, help with spatial orientation and unsupported movement. Similarly, domiciliary care services include assistance with personal hygiene, hair and nail care and continence care.

The forms of help described were also part of the official service offer of the domiciliary care services agency examined. In comparison with the practical help in the clients' homes, however, the real range of assistance concerning self-maintenance was considerably poorer. Self-maintenance services represent less than 17 per cent of the whole range of help provided by domiciliary care services agency workers. According to the head of the agency, in such situations clients usually receive help from a relative or other close person, and consequently, demand for their provision by a formal provider is relatively low.

The exception to this is a group of clients who reside in the domiciliary care services home. They occupy separate housing units designed for individuals or couples. This arrangement is a form of protected housing, particularly special purpose flats allocated by the municipality, which means that, on the one hand, the rent level of the flats is guaranteed, on the other hand, the municipality determine the allocation of flats to applicants on the basis of an assessment of their living situation. The assessment criteria are not defined by a legal norm, the managing organization usually determining these at their own discretion. A standard prerequisite for flat allocation is the use of domiciliary care services by the applicant. In other words, the flats are designed for persons with reduced self-sufficiency, conforming with the national policy on development of this type of housing. It is necessary to point out, however, that the users of the protected housing scheme are regarded (not only from the legal point of view) as people dwelling in their own home.

At the time of the research, two houses with this type of protected housing were available in the town. House A was inhabited by 49 elderly people. House B had 69 beds and its bed availability was filled. It cannot be concluded, though, that the use of protected housing scheme is related to the wider range of services provided for assistance with self-maintenance. While the residents of House A were in this respect similar to the elderly using other forms of housing (their own, municipal or cooperative flat or their own house), House B residents represented the target group requesting this type of housing to a larger extent than other recipients of the domiciliary care services agency. In the next part, we will present further factors which are likely to influence the clients' decision-making concerning the ways of help utilization.

***Intermezzo I: Funding of Domiciliary care services***

In connection with the two above discussed parameters of service provision, it is necessary to mention the question of funding. Considering the fact that food provision, assistance with housekeeping and self-maintenance are from the point of view of the Social Services Act regarded as standard part of the domiciliary care services offer, by rule of law, maximum prices are stipulated that the client can be charged for provision of this type of help. Most items of services are expressed at time rates, where one man-hour is calculated at CZK 85, or by a level amount per single operation such as shopping for heavy goods, at CZK 100. A main meal is charged CZK 70, its delivery CZK 20. If the client requests assistance with laundry, the price is stipulated at CZK 50 per kilogram.

In addition, clients can choose the range of services relevant to their needs and financial situation. Accordingly, they make a contract with the domiciliary care services. Items of help provided are recorded and filed by the service employees, and the service cost is charged on the basis of a monthly summary and monthly settlement. It is assumed that clients may use their care allowance to cover the cost nonetheless, the service can be used even by people who are not entitled to draw care allowance, in which case they pay for the service from their own resources.[6]

It is also important to note that client payments cover only part of the total operation costs of the domiciliary care services. To ensure the complete running of the service, further subsidy is inevitable, either from the municipal budgets, or by application to the local department oof the Ministry of Labour and Social Affairs. (Such subsidy, however, cannot be legally claimed, and at the time of reduction in public expenditure costs, its provision is restricted). In the domiciliary care services agency, in 2009, the annual operational expenditure totalled CZK 5,948,000. Client payments comprised less than 32 per cent, the contribution from the Ministry of Labour and Social Affairs amounted to approx. 20 per cent, and the remaining 58 per cent of expenditure was covered from the municipality's own budget.

### *5.2.3 Monitoring/Supervision*

Provision of help in the form of supervision or regular monitoring of the client's life situation is not explicitly defined in legislation as a projected parameter of domiciliary care services in the Czech Republic. Some items of service, such as accompanying clients to medical appointments or public institutions etc., could be regarded as a kind of supervision as these are included in legislation, and the remittance is stipulated at the standard rate of CZK 85. Long-term supervision of clients with reduced self-sufficiency, for example, can be provided by domiciliary care services in the form of the so-called discretionary activity. In other words, it is not part of the service by legislation, but it can be offered to clients at the establisher's discretion, in this case at the same hourly rate of CZK 85 stipulated by law.

In the domiciliary care services agency, supervision represented only 2 per cent of the total range of help provided. The head of the service mentioned, in this respect, the high expenditure costs which supervision demanded. As such, these have further negative impact on the provider, i.e. the municipality. There are two reasons for such high costs. In case of supervision, the worker's capacity is used by a single client over a long period of time, whereas the stipulated hourly rate paid by the client does not correspond with the real price of the job per hour. The difference between the two items requires additional expenditure which is covered from municipality budget. The other reason for a certain reluctance to provide help in the form of monitoring or supervision can be ascribed to the schedule of the domiciliary care services agency, which operates all week, the provision of services other than food delivery is generally carried out on working days from 7 a.m. till 4 p.m. Expenditure costs connected with supervision beyond the schedule must be covered from the provider's own budget.

Apart from the issue of covering the service costs, there are other aspects connected with supervision and monitoring, although these are more or less related to funding. As mentioned above, the problem lies in the personnel capacity, which is strongly reduced when a worker spends a fairly long time with one client. No less important is the front-line workers' qualifications. In today's practice, elementary education is sufficient in the social area, at the level of a 200-hour course (at the time of research, all the workers attended and completed this course or another course of equivalent value). Work with clients with extensive care needs is therefore beyond the capacity of an ordinary care worker. In the case of systematic supervision of clients and monitoring their life situations, the practice of the domiciliary care services agency examined encounters the problem of insufficient number of social workers, whose responsibilities include activities such as formulating agreement on the service aims, intervention scheme, ensuring client feedback etc. For the total of 475 clients, only two positions of social worker were set up in 2009 and the paperwork and other job content was partly carried out by the head of the service.

Although we noted earlier that monitoring and supervision are not defined by a legal norm, and in the practice of the domiciliary care services agency examined this parameter is dismissed for being too costly, it is still possible to view it as at least partly implicitly present. A minimal contribution towards monitoring the clients' situation can be traced in the practice of food delivery. The care workers providing the delivery have to give the food to the client in person, and thus they are in regular contact. In case of any extraordinary situation, if for example the client responds otherwise than usual - (s)he is not available at the time given, or if there is an apparent change in his/her health condition – the delivery person has to comply with work protocols, i.e. call for help like in emergency and keep the social worker informed about the client's immediate state of health. The head-of-the-service's aim is to create functional ties between the client, the front-line worker and social worker. This vision, however, encounters serious problems in the form of the already-mentioned capacity limits. According to front-line workers, food delivery is generally carried out under considerable pressure. They do pass the food to clients in person but they can hardly talk to them or discuss matters. The clients themselves described the practice of food delivery in a similar way. They had already got accustomed to the image of a front-line worker as of being in constant hurry, and mentioning any request would therefore be viewed by many of them as inappropriate disturbance. Apart from that, there is still the aspect of the front-line worker's insufficient level of qualification. From the interviews conducted, some of them find the

question of monitoring rather incomprehensible because they generally view the clients as "mostly the same".

As for supervision of clients with extensive care needs for physical or mental reasons, there is an apparent effort on the part of the domiciliary care services agency to respond to the demand for such service. As shown above, this service is also provided to clients residing in two homes with specific purpose housing designed for the target group of elderly people. In House B, part of the service is nonstop monitoring, which in practice means all-night presence of one of the carers. This care worker does not provide any medical service, nevertheless, she is available in case of emergency and calls for help. Similarly, where residents are chronically ill, she monitors medication (her presence is essential when the severe form of diabetes means that clients are dependent on insulin doses during the night). Generally speaking, most clients – residents in House B interviewed within the research, appreciated the principle of monitoring and claimed that without this service, their only alternative would be placement in the home for the elderly.

### *5.2.4 Care management*

Like monitoring and supervision, care management is not a codified part of domiciliary care services. As the concept of care management is beyond the framework of this type of service, it is important to note that generally, this concept is not part of Czech legislation in the area of social service provision. The concept of domiciliary care services provision explored in the research does not primarily draw on care management principles. During the research, we were able to identify certain attempts to coordinate help provision to clients One example of these attempts is the management's effort to cooperate with a non-governmental organization, which operates in the same town and whose services are aimed at elderly people with extensive care needs and dependency on another person's help. This non-governmental organization has the potential to provide social help of a nature similar to that of domiciliary care service, and, in addition, in combination with home care (i.e. medical help services). This cooperation, however, is not set up within a formal context, or as a result of negotiations at the level of official representatives of the municipality and the management of the non-governmental organization. Rather than that, it is a kind of „ad hoc" cooperation with a focus on seeking solutions for urgent needs of a particular client which are difficult to cover using the range of services offered by the domiciliary care services agency. An interesting piece of information was obtained from the head of the domiciliary care services agency in question, who participates in the process of community planning concerning social services. This process in the given town is virtually at its starting point; nevertheless, the question of facilitating services to families caring for an elderly person in their home environment was discussed as one of the priorities on the agenda. The incentive for the discussion was, inter alia, the absence of a more systematic monitoring provision by the existing organizations. In both of the given examples, it is not utilization of care management, but mutual cooperation, as well as reaching certain agreement on the concept of social services that the providers of social services to elderly people in town call for.

Within the scope of research, attention was also paid to the question of cooperation between domiciliary care services agency and the client's family or people in some other close relationship, which can be regarded as a significant element in the concept of care management. As in the case of cooperation with further provider organizations, not even in this area was cooperation with people in close relationships as would-be informal help providers conceived systematically. In the spirit of the contemporary thinking of the Social Services Act, the representatives of domiciliary care services agency management repeatedly emphasized that it is the elderly person who is a client, and therefore it is necessary to reflect his/her ideas and demands when negotiating the aims and range of help. On the other hand, they appreciated the families' effort to participate in care provision and communicate with the representatives of domiciliary care services agency. On the contrary, the front-line workers, who have to solve a number of unforeseeable situations in everyday practice, tend to turn to family members immediately in case of a conflict, or they are forced to take decisions concerning the client's personal arrangements which they consider problematic or urgent. They are likely

to use this strategy especially with regard to their own protection against any prospective complaints and conflicts with the client's family, which some of them openly admitted during the interviews. The elected representatives of the municipality directly referred to the family as the key element in care provision to elderly people and they assumed cooperation between the family and social service workers. On the other hand, they disapproved of the idea of increasing personnel for financial reasons. Paradoxically, their own expectations cannot be achieved due to the fact that, with the present-day number of social workers (i.e. two in total), the notion of planning cooperation with the family is inconceivable.

***Intermezzo II: Contrasting priorities of the local governance, service users and service managers***

From the provider's perspective, i.e. the municipality, it is definitely most effective to offer such activities through the domiciliary care services agency which covers the greatest possible demand for help with the lowest possible expenditure costs. According to the representatives of municipality, the indisputable priority should be given to ensuring assistance with housekeeping and shopping. During interviews with the mayor and his deputy (who is responsible for the administration of the social area), the notion of domiciliary care services was reflected as a primary form of help aimed mainly at clients with a higher level of self-sufficiency. Neither of them rejected the possibility of using the service to deal with complicated life situations, nonetheless they assumed the involvement of a functional family who would closely cooperate with the domiciliary care services agency. To be more explicit, in such cases, the roles of domiciliary care services and the client's family, which is looked upon as the predominant element, ought to be complementary to one another. Most representatives of front-line workers – the carers – shared this opinion, although they thought that domiciliary care services had no potential to provide help to clients with a high level of dependency on outer help. The most frequent arguments in this respect were insufficient service personnel and equipment, as well as insufficient equipment in clients' households (such as lack of space for bed assistance, lack of basic bathroom equipment etc.). The front-line workers saw some value in extensive family participation in the care. The clients themselves, interestingly, did not generally share the view that domiciliary care services would have the potential to provide help in case of a considerable reduction in their self-sufficiency. Their expectations in this regard were rather vague, partly due to the lack of detailed information concerning the range of services provided by the domiciliary care services agency, and, possibly, due to their reluctance to think about the details of any prospective reduced self-sufficiency.

A slightly different perspective was observed in interviews with mid-management, namely the member of the municipality responsible for the area of domiciliary care services and particularly the head of the service. Clearly, both of them were aware of the demographic change and its considerable impact on the conditions of the service provision: because of the ageing of population described above, an increased demand for social services can be expected; extending life expectancy implies demand for the service from people with a combination of social and health problems, which calls not only for the basic satisfaction of needs but also systematic help; the process of ageing also affects the present-day clientele of domiciliary care services agency, and therefore today's clients may need a more demanding care in future.

## 6 Conclusion and discussion: domiciliary care services in the Czech Republic – risks or opportunities?

Viewing the present trends in ensuring long-term care, and the government policy of social service provision to the elderly in the Czech Republic through the parameters of domiciliary care services defined by Cullen *et al*. (2004), we can point out certain disparities.

First of all, it is evident that the elderly with reduced self-sufficiency are expecting more from social services than basic practical help with their households, shopping or laundry. The key need in this respect is ensuring their security. Domiciliary care services have the potential to cover this need on the condition that it meets the parameters connected with non-material help provision, defined by Cullen *et al*. as continuous monitoring of the client's needs, supervision and application of principles of care management. The research results in the domiciliary care services agency

examined in the research confirm that, at present, these parameters are not explicitly included in the policy of this type of service, although it would be a potential role for social workers. Both the management and the employees of the service do not keep records of this type of demand, they only assume it implicitly and, to some extent, respond to it.

The first type of response emphasizes the importance of the role of the family, when domiciliary care services agency is, in the case of clients with a more extensive care needs, presented as a complementary provider of help. This approach might imply some risks. The employees and management of the agency, on the one hand, assume the existence of a functional family with sufficient potential to ensure care provision to the elderly person. This assumption, however, may prove erroneous, for example in case of the family members' increased necessity to travel or move house due to a different place of work, or the necessity to solve a family member's own health handicaps (the elderly people's children may themselves be old-aged), some housing problems etc.

Another type of response is to transfer: clients with extensive needs to another provider of social services. Also in this case we encounter a range of problems. First of all, it is important that the new provider is based in the client's locality, especially in the case of a non-governmental provider dependent on subsidies from public funds, the allocation of which is generally very uncertain. In such cases, consequently, the long-term viability of the provider cannot be ensured, particularly if such cooperation is not backed by a written contract or other kind of formal agreement with the municipality, as it is the case of the domiciliary care services agency examined in the research.

The response in the approach to protected housing practised in House B seems to be the most imaginative of all the options. The clients are provided with a non-stop service involving a social worker in around-the-clock attendance. Even this arrangement, however, may bring certain risks. Primarily, the increasing number of elderly people demanding long-term care brings a problem of the impossibility of meeting the demand, despite the municipality's plan to build another home within the protected housing scheme, as suggested by the head of the domiciliary care services agency. No less important is the aspect of social integration of the elderly person in need of long-term care, as this strategy practically implies, on the part of the client, the inevitability of leaving their home.

The elderly people's strategy of ensuring that they are provided with help in case of prospective reduced self-sufficiency is understandable in the context of the understanding of domiciliary care services provision explored in this study. Homes for the elderly offer parameters that are absent from domiciliary care services, such as the possibility of assistance in case of considerably reduced self-sufficiency.

As the research results show, within the scope of present-day strategies in the area of social services for the elderly, we can consider as an "opportunity" the start of systematic formulation of social services in the town, with the use of the method of community planning. This process might bring a dual benefit. Firstly, as a starting point for building up communication between services providers, and dialogue between services providers and the elected representatives of the municipality, which, in its effect, leads to setting out priorities and the approach to help, and, consequently, gives an ample scope for making formal agreements on mutual co-operation both between providers and between providers and municipality as the prospective benefactor. Secondly, it is a platform for the elderly – the prospective service users. The process of community planning is open to demands of prospective service users and their relatives for services which are not available in their locality, namely facilitative services. Furthermore, community planning comprises a potential platform for gathering, and providing the elderly with, more detailed information concerning the whole range of social services on offer, as well as services providers, in their locality. Thus the problem of the low degree of overall public familiarity with the above facts, as observed during interviews conducted with the domiciliary care services users, might be solved. Public ignorance or poor familiarity with the details imply rather low expectations of service provision on the clients' part, which consequently creates false impression on the part of the service employees that their offer is ample.

Considering the demographic change, it is imperative that social service policy objectives, as well as those of ensuring long-term care to

the elderly, are reformulated. Viewing the goal of deinstitutionalization, or transformation, of residential care services from the perspective of the case study results concerning domiciliary care services, it is necessary to point out the risk of inadequate resources in field-based services to ensure help to the projected number of elderly people in foreseeable future. Efforts to achieve this goal should be combined with concurrent extension of material and personnel capacity of this type of service, i.e. field-based service. Otherwise, it may be assumed that providers and, possibly, elected municipality and community representatives likewise, are likely to aim at the least financially costly solution, which means building special high capacity homes for the elderly in the form of protected housing, with waiting lists based on prior application sent well in advance. Another alternative is transferring more responsibility to the client's family, in which case it is also inevitable that there will be a need to support the informal providers both financially and – primarily – in the development of their skills and knowledge necessary for care provision, and offer them help in the form of systematic co-operation with formal providers.

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**BIBLIOGRAPHY**

Blackman, T., Brodhurst, S., Convery, J. **Social Care and Social Exclusion: A Comparative study of Older People's Care in Europe.** London: Palgrave, 2001.

Bowling, A., Banister, D., Sutton, S., Evans, O., Windsor, J. **A multidimensional model of the quality of life in older age**. *Aging and Health*, 2002. 6 (4): 355-371.

Cullen, K., Delaney, S. & Duff, P. **Caring, Working and Public Policy.** Dublin: The Equality Authority, 2004.

Doyle, M., Timonen, V. **Home Care for Ageing Populations: A comparative Analysis of Domiciliary Care in Denmark, the United States and Germany.** Cheltenham - Northampton: Edward Elgar, 2007.

Halvorsrud, L., Kalfoss, M. **The conceptualization and measurement of quality of life in older adults: a review of empirical studies published during 1994-2006**. *European Journal of Aging,* 2007, 4: 229-246.

Kubalčíková, K. **Předvýzkum potřeb pro cílovou skupinu "Senioři"**. Brno: ASVSP, 2007

Kuchařová, V. **Život ve stáří.** Praha: VÚPSV, 2002.

Pickard, L. at all. **Modeling an entitlement to long-term care services for older people in Europe: projections for long-term care expenditure to 2050**. *Journal of Social European Social Policy*, 2007, 17 (1): 33-48.

Shaw, I., Gould, N. (eds). **Qualitative Research in Social Work**. London: Sage, 2001.

**Social services and Care Allowance in the Czech Republic**. Prague: Ministry of Labour and Social Affairs, 2009.

Veselá, J. **Představy rodinných příslušníků o zabezpečení péče nesoběstačným rodičům.** Praha: VÚPSV, 2002

Walker, A. **Quality of life in old age in Europe**. In A. Walker (ed.). *Growing Older in Europe.* London: Open University Press, 2005, pp. 1-29.

Yin, R.K. **Case study research: design and methods**. 4th edition. Los Angeles: Sage Publications, 2009.

**Endnotes**

1 Data produced according to Eurostat methodology for the Core system of ESSPROS (= European system of integrated Social Protection Statistics).

2 In homes for elderly residential care services are provided to persons with reduced self-sufficiency due to their age, where their situation requires that they be regularly assisted by another person. This service is provided to the client for a fee.

3 In special regime homes, residential care services are provided to people with reduced self-sufficiency due to their chronic illness or dependence on addictive substances, and to persons with Alzheimer's disease and other types of dementia, with reduced self-sufficiency due to the above illnesses where their situation requires that they are regularly assisted by another person. When providing these social services, the regime of these facilities is adapted to these persons' specific needs. This service is provided to the client for a fee.

4 In this section the terminology and definitions were adopted from the MoLSA official document *Social services and Care Allowance in the Czech Republic* (2009).

5 Representation of respective age groups in the samples was as follows: 50-64 years – 57%, 65-74 years – 25% and 75+ years – 18%.

6 The average amount of old age pension in the Czech Republic by 31/3/2010 was CZK 10,043, the average amount of social care allowance in 2009 was approx. CZK 4,800 (www.czso.cz, www.mpsv.cz).

# Constancy of concepts of desirable social workers' actions and experiencing their dissimilarity in an organisation

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**Abstract**

The article notes the inappropriateness of a "consensual approach to the culture of an organisation" in a situation where the individualisation of identities makes differentiation of concepts of desirable actions by the personnel of social service organisations an inevitable necessity. It points out that, in this situation, the consensual view, which is accompanied by emphasis on "uniformity" and understanding dissimilarities as "deviations", leads to a dilemma between conformity and authenticity in social workers, thereby giving rise to stress. As an alternative, the author offers the "perpetual concept of organisational culture", which rejects the idea that co-operation is based exclusively on consensus and builds on the thought that co-operation presupposes constancy of concepts, which makes it possible to anticipate the actions of people with different concepts of the desirable way to handle clients. From this angle, dissimilarities cease to be "deviations" and may be at the heart of discussions on meaningful responses to the actions of people who have dissimilar concepts of desirable actions.

**Keywords**

organisational culture, experiencing dissimilarity, co-operation, social work

Social workers encounter the expectations of superiors, fellow workers and clients whose concepts of the desirable way to handle clients differ from their own (Lipsky, 180: 40–48, 145–147; Hasenfeld, 1983: 9) within social work service organisations. They therefore experience dilemmas (see Musil, 2006), that is, irresolvable choices between their ideals and the expectations of other participants helping through intervention (Lipsky, 1980: 140; Musil, Nečasová, 2008). Simultaneously, the dissimilarity of concepts and perception of dilemmas does not tend to be an obstacle to co-operation within an organisation. Social workers know how to cope with dilemmas (see Musil, 2006), thanks to which they even co-operate with people[1] whose concepts of work with clients are different and expectations of what can be expected from social workers are hardly acceptable. Obviously, co-operation with them is not based on consensus.

Contrary to this finding, the superstitious notion that "consensus is a precondition for co-operation" is widespread in social work service organisations. True to this superstition, people from these organisations often complain that they "are not united", "do not work according to a uniform methodology", etc. In the words of one such worker[2], *"everyone should proceed in the*

*same way, but, unfortunately, this is not the case. One of us is the 'bad guy' and another one the 'good guy'."* Clients *"tell each other"* and *"abuse this"*. It is normal for social workers to co-operate with people who have different concepts of desirable actions, but this provokes resentment in them. They appeal to unity or consensus that would rid relationships in the organisation of uncertainty and tension. This, I believe, is the origin of the popularity of the "consensual approach to organisational culture" (see Martin, 1992: 46–48, 54), which, by emphasising consensus, validates the above superstitious notion and brings its advocates to believe that dissimilarities in opinions are "deviations" from a desirable state of "unity".

The consensual view seems to overestimate the superstition of "unity of thought" and prevents people from noticing that – inside organisations – culture generates conditions for co-operation in that it enables people to anticipate the actions of others. From the consensual angle, it seems important to recognise "deviations", to feel guilt if I myself "deviate", to bring those who "deviated" to the right path or to eliminate their influence. The above approach to dissimilarities implies the expectation of conformity and sameness within an organisation. Seeing their own dissimilarities as "deviations", social workers are disturbed by the dilemma between conformity and their authentic concepts of the desirable way of interacting with clients. Thinking of dissimilarities and disagreements in terms of consensual perspective precludes acceptance of dissimilarities in the concepts of desirable actions and the ensuing expectations as a fact and diverts attention away from anticipating other people's actions and from decisions on how to respond to their anticipated conduct. These processes draw attention to the "perpetual[3] approach to organisational culture" which considers that "constancy of concepts" of desirable actions, rather than consensus, is a prerequisite for co-operation in an organisation. From the perpetual angle, constancy of concepts makes it possible to anticipate the actions of others and to respond to them (Keller, 1992: 59), whether they have an identical or different concept of desirable actions.

Hence my aim is to put forth and to present for discussion the assumption that social workers can use the perpetual approach to organisational culture as a perspective helping to cope with the dilemma between conformity and authenticity they experience in "consensually thinking" and conceptually dissimilar organisations[4]. Following this aim, I will attempt to play down the importance of the aspect of "deviations" and draw the attention of social workers to their decisions on how to respond, in their work with clients, to the expectations and actions of people with dissimilar concepts. To this end, I will outline the contours of the perpetual approach to organisational culture. First, I will briefly explain how the dissimilarity of concepts of desirable actions in an organisation is substantiated by the theory. I will define the "perpetual approach to organisational culture" and clarify the notion of "adjustment of decision-making and actions to the established concepts of other people", on which the understanding of co-operation relies if we take this perspective. Finally, I will describe various types of cultural bonds that, from the viewpoint of the perpetual approach, enable people to anticipate the actions of others and co-operate with them, no matter if they "think identically" or "think differently". In doing so, I will introduce "consensus" as one of many types of these cultural bonds. In the Conclusion, I will outline the differences in the way dissimilarity is experienced in concepts of desired actions from the consensual viewpoint and from the perpetual approach to organisational culture. I will propose the use of the perpetual perspective as an instrument of overcoming social workers' feelings of being not sufficiently conforming when they follow their authentic concepts of the desirable way of interacting with their clients.

## Dissimilar concepts of desirable actions in contemporary organisations

The possibility of unifying concepts among the personnel of an organisation in contemporary society is questioned by sociology, which refers to "individualised identities" (Giddens, 1991; Beck, 1992 and others). According to Giddens, individuals are confronted with the *"plurality* […] *of alternative lifestyle options"* and personal *"strategic life-planning* […] *of the* […] *trajectory of the self"* (Giddens, 1991: 82–85) is therefore important for each individual. This changes the way in which people satisfy their need to perceive personal experience and the world they live in as an organised whole[5]. People today do not seek to satisfy this need as members of a large social

entity unified by some general vision (Lyotard, 1993: 53). They distrust ideas of a marvellous future for whole large groups (nations, classes, branches of economy or an organisation, etc.) and are surrounded by an enormous range of alternative options and visions of personal life. They are forced to satisfy the need to feel individual experiences as part of an integrated order through personal visions and by organising individual, disarranged experiences according to a personally formed plan of the direction and meaning of their own lives.

After World War II, many (although not all) people still had no difficulty in identifying themselves with the idea of a "car factory worker", "municipal official" or "link in some other major machinery". Concepts of this type lack credibility today and collective identification with the vision of a well-functioning chain in the "mechanism" of an organisation is far less probable than it was at times when the visions of a lifelong career "in the family" of a single employer or continuous career in a single domain were popular. Thus, the personnel of organisations do not make decisions under the dominant influence of a role model embodied in a member of a large social group (firm, social class, trade, nation, etc.), but rather on the basis of personal experiences that they themselves construct through the prism of their individualised life strategies.

This favours dissimilarity of individual orientations in social work service organisations, which leads managers to regard subordinates as unreliable and makes them feel uncertain. According to Dustin (2007: 15–19, 27–30), managers attempt to cope with this uncertainty through formalisation (proceduralisation and routinisation) of social workers' decision-making. They believe that formalisation will allow them to predetermine the course and result of frontline workers' actions. However, many authors[6] point out the conflict between formalisation of decision-making and autonomous thinking of frontline social workers. They dispute the managerial belief that they can use formalisation of decision-making to rid themselves of the uncertainty which accompanies the individualisation of personal strategies.

Lipsky and Howe respond to the question of whether unification of the decision-making and actions of social workers can guarantee predictability of their conduct. In doing so, Lipsky (1980) relies on the term *"street-level workers discretion"*, while Howe (1986) uses the term *"ideological hegemony"*. Both assume that uniform thinking cannot be anticipated in social work service organisations. They therefore consider it unlikely that the entire personnel of an organisation would follow a predetermined and generally accepted scheme of actions and mutual interactions.

Lipsky (1980) explains that *"street-level bureaucrats"*[7] apply their own strategies in contact with clients. They have a margin for using their own judgment, which is also true in a situation where they are officially bound to observe strictly set rules. Citizens whose requests and problems are dealt with by street-level bureaucrats act in an individual manner, and hence erratically. The method of handling requests and resolving problems prescribed by rules must therefore be adapted case-by-case according to specific circumstances that managers cannot fully predict. The resulting margin for autonomous decision-making is used by street-level bureaucrats to cope with the tension between their own concepts of ideal service and the expectations of others that prevent their implementation. I consider that implementation of autonomous strategies as postulated by Lipsky is unavoidably manifested in differences in the ideas of workers in public organisations concerning the desirable handling of clients.

Howe (1986) claims that the powerful elite determines the rules in an organisation, and implementation of these rules leads social workers to use the language of the elite. The obligation and, subsequently, the habit of using this language for communication leads social workers to adopt the ideas expressed by the elite in its language. In the course of everyday routine work, they perceive working events from a perspective which embodies the ideas and interests of the elite. Howe describes this condition as "ideological hegemony", which is manifested in uniform thinking of personnel, conditional on the routine use of the language of the elite in routine situations. This uniformity, according to Howe, is disturbed when the "hegemonic individual" realises that he is unable to programme the resolution of a task himself in such a way as to ensure that his subordinates proceed in support of his interests. Therefore, in

resolving the task, he waives control in favour of autonomy of the frontline social workers. In this way, frontline workers gain scope for exercising their autonomous concept of the desirable way of dealing with clients. These concepts, as Howe has shown, often differ from the hegemonic individual's concepts.

**Constancy of concepts of desirable actions and anticipation of other people's actions**

The above premises concerning individualisation of identities, conflict between formalisation and autonomous thinking of frontline social workers, autonomous strategies of street-level bureaucrats and delegation of autonomy to frontline workers by the hegemonic individual are based on the assumption that individual persons or individual groups in social work service organisations co-operate even though they "do not think the same way". If this premise is valid, the consensual approach has only limited ability to explain how co-operation comes to exist. However, the question of how organisational culture promotes co-operation among people with dissimilar concepts of desirable actions can be answered using a different approach to organisational culture, one which I will call "perpetual".

This approach is based on the idea that co-operation depends on the ability of the parties involved to anticipate the actions of others and that the ability to anticipate them is derived from "constancy" of concepts of desirable actions (see Keller, 1992: 54–64), rather than necessarily from consensus. From the viewpoint of this idea, the term "organisational culture" can be used for those social bonds[8] among people in an organisation that consist in recognition of constant concepts of how and why the personnel of an organisation should interact among themselves and in relation to other people, e.g. clients, personnel of other organisations, etc. Constant concepts make it possible to anticipate the actions of other personnel, not only for those who think the same way, but also for those who build on different but repeatedly applied concepts of desirable actions. If a person acts repeatedly in the same way in a certain situation and if his colleague, thanks to previous experience with that person, understands his concepts and expectations, he can anticipate and adapt to the person's reactions. Hence, people in an organisation do not need to respond to others "blindly" or "experimentally", because they can act purposefully, taking into consideration the anticipated response.

The terms "constant concepts", "recognition of concepts" and "adapting decisions and actions to other people's concepts" are essential for the above definition of organisational culture and its effect on co-operation.

I use the word "constant" in referring to those concepts to which the members of a group adapt their decisions and actions either repeatedly, i.e. regularly and under all circumstances, or regularly but only in certain situations. Constant concepts are primarily concerned with the actions of impersonal bearers of certain statuses and roles rather than the actions of specific persons. It is only during interactions with specific people that persons in an organisation apply them secondarily as a basis for anticipating the actions of particular individuals.

I use the term "recognition of concepts" for the cognitive, value-based and emotional readiness and practically implementable intention of the members of a group to adapt their decisions and actions to the constant concepts of others. The parties involved in the co-operation, who are determined to do so, can recognise the constant concepts of others in two ways – by "sharing" or by "respecting". They "share" those concepts that are close to them personally, which they subjectively support and, together with others, which they perceive as correct and worth being pursued. The parties involved "respect" the expectations of "others", based on concepts that are "foreign" to them personally. Recognising them therefore has an instrumental significance for them – although not sharing them, the parties involved adapt their decisions and actions to these expectations in a belief that this will enable them to achieve their own objectives.

Here, the word "adapt" has a broader meaning than in everyday language, which sees it as something rather passive or subordinate – someone "adapts" to circumstances, e.g. the concepts of another person. Yet the term "to adapt one's decisions and actions to constant concepts" can also have an active meaning. The worker of an organisation who is aware of the concepts of others may passively concede ground and adapt his actions to the expectations of other people. The same worker may, in relation to the known

ideas and tendencies of other people, act so as to ensure that the other people, loyal to their usual ideas, do what is in accordance with his own concepts of desirable actions. The first option can, metaphorically speaking, be characterised as: "Well what can I do when the Boss wants it that way." The other option is illustrated by the rather familiar: "The Boss must think that what I've planted into his head was his own idea."

**What types of cultural bonds provide for anticipation of the actions of people in an organisation?**

From the viewpoint of the perpetual approach to culture the constancy of concepts and mutual anticipation of actions by people in an organisation are ensured using several types of bonds. The literature calls them *"consensus"*, *"subcultures"*, *"shared concerns* […], *multiple meanings"* (Martin, 1992), *"ideological hegemony"* (Howe, 1986) and *"false expectations"* (de Swaan, 1988). The latter two can be understood as two versions of "quasi-consensus" reached through the ideological influence of the elite on the rank-and-file members of the organisation. Further in the text I will describe these types of cultural bonds and the way in which they make it possible to anticipate the actions of others.

***Consensus***

The word "consensus" refers to the idea that people who co-operate have generally gained, in the process of socialisation, identical concepts of the desirable actions in an organisation. The idea of "consensus" therefore includes the assumption that they are equipped with "pre-understanding" before entering the organisation and they should therefore spontaneously apply similar concepts of desirable actions. If the organisation is arranged along these values and rules, new members of the organisation tend to accept this arrangement thanks to pre-understanding. People who lack pre-understanding for the values and rules of the given organisation will sooner or later leave, or they stay in the organisation in the role of tolerated deviants. The majority equipped with pre-understanding can assume rather reliably that others will act in accordance with broadly shared ideas, thanks to which almost everyone will respond identically to both usual and unusual situations.

***Quasi-consensus***

In contrast to "consensus", "quasi-consensus" is agreement which is not based on pre-understanding but results from the ideological influence of the elite. Authors who deal with this type of cultural bond do not use the very term "quasi-consensus" but they describe the processes that lead to its establishment. They do not assume that people in an organisation have the same concepts of desirable actions. What they do assume is that if the rank-and-file members of an organisation are exposed to the effective influence of the elite's ideas in the long term, they begin to perceive the ideas promoted by the elite as rather obvious guidelines for desired actions.

The above-mentioned "ideological hegemony" is an example of establishment of identical concepts of desirable actions under the influence of the elite. In this concept, the powerful elite in an organisation promotes rules that enforce upon the personnel the language and, hence, the concepts that represent the hegemonic individual's interests. In England, for example, according to Howe (1986: 112, 125–126), professional managers became the "ideological hegemonic individuals" in social service organisations in the 1980s. These managers *"design"*, in the organisations, an *"ideological climate"*, *"perceptions, cognitions and preferences"* of social workers favourable to themselves and channel them when they divert from the given ideological framework and the managers' interests seem at risk.

We can therefore assume that communication in the language of the managers will teach frontline social workers to think and act routinely from the perspective of the superiors' concepts. Simultaneously, the frontline workers will believe that all other people routinely think and act along the same concepts. This belief need not be substantiated. It is likely that there will be people in the organisation who routinely follow a model of desirable actions which differs from their authentic concepts. Nonetheless, the habit of routinely communicating on working issues in the language of managers results in a situation where talking about the job in an alternative way, other than in the managers' language, appears irrelevant to people. Therefore, alternative concepts of desirable actions also become irrelevant in the eyes of the personnel. When, for example, social workers become accustomed to assess a "case" in

terms of the "number of contracted services" and "number of consultations required for making a contract", a rather interesting talk by a colleague on "difficulties in establishing trust with the client" just holds things up for the others and the subject of relationships with the client is seen as being "beside the point"[9].

The use of the same language and a routine response to the communications delivered using this language create the impression of consensus but are not based on pre-understanding. They are a learned response of people with diverse cultural backgrounds who, under the ideological influence of binding rules of conduct promoted using the positions of power, became accustomed to "functioning" according to certain rules and communicating in a certain language.

Another model of the process leading to constant concepts of desirable actions under the ideological influence of the elite is described by de Swaan (1988: 26–27, *et alibi*.) He asserts that even people who do not necessarily personally identify themselves with a concept of desirable actions become engaged in the joint action if *"false expectations"* enable them to expect that others will follow the same concept. This belief need not be entirely justified; it is sufficient if the elite makes sure that the idea that *"most will be ready"* is sufficiently widespread. The false belief then becomes a self-fulfilling prophecy. People begin to act following the concept promoted by the elite even though some do not personally believe it or have their doubts.

De Swaan (1988: 21–28) gives the example of peasants co-operating in providing funds to care for the poor in the Middle Ages. He points out that motivation for organised care for the poor followed from the need to protect the peasants' land, crops and wealth against dangers from vagrants - fit for work, and hence physically fit poor people. These were welcomed as occasional workers, but they could also steal and damage crops, destroy property or be otherwise aggressive. However, according to de Swaan, concerns about personal safety, crops and wealth were not sufficient motivation for the peasants to donate to the funds administered by local clergymen. These local elite representatives therefore emphasised that a donation coming from a sincere heart could open the way to salvation for the donor's soul. Even this was not enough to convince the religious peasants to give to the poor. They needed to make sure that others give as well. The local clergy therefore initiated collections, but also reproached, praised and, most importantly, provided opportunities for acts of love towards their fellowmen before the eyes of other worshippers. This way they ensured that *"most people believed that others believed"*. It was not necessary to make every person believe that donations were a path to salvation. It was required that this belief be demonstrated by a certain number of people, which made everyone believe that others would donate too. Lack of confidence in the willingness of others to participate was overcome and the belief that their neighbours would join in led to self-fulfilment. The peasants became virtuous because their *"virtue rests upon expectations about the virtuousness of others"*.

We shall only add that the not fully justified faith in the virtuousness of others enabled them to predict how the others would act when the clergy asks them to donate.

The example from the Middle Ages may create the impression that the false belief principle is no longer valid. This assumption is contested by the analogy between the homogenising action of self-fulfilling false belief and the above-mentioned routine use of the hegemonic individual's language. In addition, de Swaan (1988) shows how the principle of false belief ensured the predictability of other actors in co-operation during the development of collective action up until the 20th century. We can therefore suggest that, even in contemporary social work service organisations, the process leading to constancy of concepts of desired actions and predictions of other people's actions is conditional on the belief that others will follow similar rules.

***Subcultures***

The existence of "subcultures" is another type of bond ensuring constancy of concepts and predictability of actions of diversely thinking people. This term can be used for the cultures of individual groups whose members are bound by mutual solidarity. This solidarity may stem from a similar position and shared interests in an organisation (for example, the subcultures of managers, rank-and-file helping or administrative workers), a similar position or shared interests in broader society (e.g. subcultures of minorities

– Roma people, gays and lesbians or people with disabilities) or it may be based on shared emphasis on certain issues and certain responses to them (for example, subcultures of workers in various helper professions, religious or gender groups, etc.).

Martin (1992: 83, 96–98) claims that there is consensus within subcultures, but there are – sometimes considerable – differences between the concepts of different subcultures, which may lead to a conflict in the organisation.

This means, for a specific worker of the organisation, that the part of the personnel which adheres to his subculture will have the same concepts of desirable actions as he has. As a rule, he can rely on these people responding similarly to events in the life of the organisation and will sympathise with him in case of difficulties. On the other hand, an individual cannot assume that the members of some other subculture will respond to events at work in the same way as he does. However, based on experience with the members of other subcultures, he can understand their constant concepts and recognise their recurring responses to certain situations. Thus, the members of various subcultures can predict the actions of the members of other subcultures and formulate constant concepts of how to proceed in contact with them to ensure that the interaction takes the path which they find desirable.

***Common questions, different answers***

Consensus on established topics or questions that emerge in various situations and are viewed and responded to differently by different people in different situations constitutes another type of bond which enables concepts to become constant and the actions of other people to be predicted in an organisation. In dealing with a question, a person is inclined to take the view of a group and to apply concepts that correspond to that group's approach. He refers to these concepts repeatedly and, as a result, he usually responds to a generally recognised issue in a manner which others "already know" and expect. However, if that issue is momentarily less important and the topic changes, the same person will join another group of people in dealing with a new issue and he will look at the new topic from a different angle. It may be confusing for others that his response to the new issue is inconsistent with his view of the earlier topics, but he will apply it repeatedly in dealing with the new issue, and his standpoint is therefore predictable. It is common that, where an issue is concerned, an individual adheres to the views of a group, but when another issue is addressed, he will abandon the standpoint of the original group and join the viewpoint of those he previously contested. Even these group shifts can be predicted as they occur repeatedly.

According to Martin (1992: 113–134, 150–154), *"ambiguity"* is a typical feature of cultural bonds characterised by different responses and responses that change with the situation to common issues. I do not consider this term to be appropriate from the viewpoint of the perpetual approach to organisational culture. From the perpetual perspective, the personnel of an organisation repeatedly encounter different responses and situation-based reactions of different people to different but generally recognised issues, thanks to which they are able to identify, predict and adapt to them. Even dissimilar concepts tend to be constant and may become a general background for mutual predicting and co-ordination for personnel who have experience with them.

In the context of a fragmentary type of culture, co-operation depends on the ability of the parties involved to predict and act on a case-to-case basis and to use a wide range of strategies of action with diversely oriented fellow workers in a relatively broad range of recurring situations. The question is whether and how it is possible, in the long term, to endure the psychological stress accompanying the necessity of permanent "switching" from one established code of action to another. It seems certain that, in the world of the above-mentioned individualised entities, the need to respond to different responses and varying reactions of various people to common issues depending on the situation has become a matter of daily routine.

According to Martin (1992), different types of the aforementioned cultural bonds appear in parallel in a single organisation. A member of the organisation's personnel shares some concepts of desirable actions with others on the basis of a general consensus. He routinely goes along with other concepts because he believes that all the other members do the same. He shares some concepts of desired actions with "those of his own kind", i.e. the members of some of his subcultures,

knowing that "they", meaning people from other subcultures, "see it differently". He also knows that some, like himself, consider a topic to be important but regard the matter in a completely different way. If necessary, he can work with any of them, because he can tell by experience which of their concepts other people repeatedly follow in their actions and in what situations. He therefore has the prospect that there will be simple understanding with some while, with others, he will have to think about what to do for at least partial success. He can estimate when to "hold back" to avoid conflict in place of co-operation and when to enter into conflict with a person who could block a sensible solution.

**Conclusion – avoiding feelings of deviance by means of the perpetual perspective**

Dissimilarities within individualised and sub-cultural concepts of desirable social workers' behaviour towards their clients seem to be unavoidable and omnipresent from the viewpoint of the aforementioned "individualising identity" thesis. Under this condition, thinking of these dissimilarities in terms of the perpetual perspective can be seen as helping social workers in avoiding the stress deriving from the dilemma they can perceive between their conformity and authenticity.

I believe that the habit of social workers to experience dissimilarities in concepts of desirable actions from the consensual perspective gives rise to many of the negative feelings they experience in their everyday practice in organisations. From the consensual perspective, it seems that uniformity is desirable and differences therefore seem undesirable. As a result, social workers who follow their own authentic and individualised ideals experience dilemmas between conformity and authenticity. Individualisation of identities inevitably results in dissimilarity of their authentic concepts of desirable conduct concerning clients inside an organisation; however, from the viewpoint of the expected "uniformity", every display of authenticity, i.e. faithfulness to one's own ideals, is accompanied by the feeling of "deviation" from what is desired. This feeling creates stress in many social workers and leads them to conspiratorial behaviour. They conceal the differences in their actions (see, for example, Musil, Janská, 2010; Musil, Janská, 2011) because they are unable to be identical. This creates additional stress driven by fear that the conspiracy will be discovered.

A view from the perpetual perspective could help relax this stress. A social worker who experiences his individual strategies as "deviations" that should be concealed in the name of the "inherent uniformity" would realise from the perpetual perspective that dissimilarities are "normal" and it is not necessary to expect his or her own conformity. He could therefore cease to regard himself as a "deviant" and would not have to conceal his ideals. He could shift his attention to the question of how to treat his experience with the recurring actions of those whose concepts of desirable handling of clients are different from his own. Instead of unnerving himself by concealing his "deviations", he could think and debate with others about how to respond, in the interest of attaining his own ideals, to those whose ideals are different. For example, he could ask when the application of his view, or in contrast, the view of "the others" is harmful for the client, and consider under what circumstances the different views could complement each other in work with clients.

From the consensual perspective, different views of desirable handling of clients appear as competing approaches, only one of which may become – after suppressing the others – a basis for uniformity. From the perpetual approach to culture, different concepts, without the negative emotions that usually accompany competitive relationships, can be seen as different paths whose appropriate use should be considered. Incongruent expectations towards social workers by superiors, fellow workers or clients follow the dissimilarities in concepts of desirable action in working with those who need help. And thinking of the ensuing disagreements in terms of the perpetual perspective is not a usual and easy task in social work organisations where the consensual view and expectation of uniformity predominates.

This is why social workers may expect support or training in looking at dissimilarities and disagreements in their everyday practice in terms of the perpetual perspective which promotes tolerance towards differences and helps to see them as a chance to compare different views of client's problems, situations and prospects.

Hence, one can recommend social workers that they ask their peer-consultants to reflect on the meaning of the different views and expectations of their superiors, fellow workers and clients concerning help. Teachers and students of social work can make the meaning of dissimilar ideas and expectations regarding help to clients the issue of their collective reflecting on practical experience.

The result of such reflections can be two-fold. Firstly, they can promote the motivation and capacity of social workers to think about their practice in organisations inhabited by people with individualised or sub-cultural identities in a manner which is more receptive to dissimilarity. As the second output of the discussion regarding the meaning of the aforementioned differences, an answer can be given to the following question: "Will the idea find its substantiation that thinking about dissimilarities in terms of the perpetual perspective can help social workers avoid the trap of presupposed uniformity?"

translated by Jan Adámek

**BIBLIOGRAPHY**


BECK, U.: **Risk Society, Towards a New Modernity.** London etc.: Sage, 1992.

CLARK, J., NEWMAN, J.: **The Managerial State.** London: Sage, 1997.

DUSTIN, D.: **The McDonaldization of Social Work.** Aldershot – Burlington: Ashgate, 2007.

GIDDENS, A.: **Modernity and Self-Identity, Self and Society in the Late Modern Age.** Oxford: Polity Press, 1991.

HARRIS, J.: **The Social Work Business.** London – New York: Routledge, 2000.

HASENFELD, Y.: **Human Service Organizations.** Englewood Cliffs: Prentice-Hall, 1983.

HOWE, D.: **Social Workers and Their Practice in Welfare Bureaucracies.** Aldershot – Vermont: Gower, 1986.

KELLER, J.: **Úvod do sociologie.** [*Introduction to Sociology.*] Prague: SLON, 1992.

KOŁAKOWSKI, L.: **The Presence of Myth.** Chicago and London: The University of Chicago Press, 2001.

van der LAAN, G.: **Otázky legitimace sociální práce.** [*Aspects of Legitimacy of Social Work.*] Boskovice – Ostrava: Albert – Medical-Social Faculty of the University of Ostrava, 1998

LIPSKY, M.: **Street-level Bureaucracy, Dilemmas of the Individual in Public Services.** New York: Russell Sage Foundation, 1980.

LYOTARD, J. – F.: **O postmodernismu. Postmoderno vysvětlované dětem a Postmoderní situace.** [*On Postmodernism. Postmodern Explained to Children and Postmodern Situations.*] Prague: Institute of Philosophy of the Academy of Sciences of the Czech Republic, 1993.

MARTIN, J.: **Cultures in Organizations, Three Perspectives.** New York – Oxford: Oxford University Press, 1992.

MUSIL, L.: **Coping with Dilemmas, Working Conditions and Interactions of Social Workers with their Clients.** Stassfurt: ISIS, 2006.

MUSIL, L., JANSKÁ, V.: **Neochota ke změně – rigidita nebo rezistence?** [*Reluctance to Change – Rigidity or Resistance?*] In: Winkler, J., Klimplová, L. (eds.), Nová sociální rizika na trhu práce a potřeby reformy české veřejné politiky, [*New Social Risks in the Labour Market and Need for Reform of Czech Public Policy*], Brno: Masaryk University, 2010, pp. 161–185.

MUSIL, L., JANSKÁ, V.: **Dilema "loajálního úředníka a empatického pomocníka" a akceptace změn.** [*The dilemma between the Loyal Clerk and Empathic Helper and the Acceptance of Changes.*] In Winkler, J., Žižlavský, M. (eds.) Institucionální změna a veřejná politika. Analýza politiky zaměstnanosti. [*Institutional Change and Public Policy. Analysis of Employment Policy.*] Brno: Masaryk University, muniPRESS, 2011, pp. 121–147.

MUSIL, L., NEČASOVÁ, M.: **Zvládání nesourodých očekávání a morální orientace sociálních pracovníků.** [*Coping with Dissimilar Expectations and Moral Orientation of Social Workers.*] In: Šrajer, J., Musil, L. (eds.), Etické kontexty sociální práce s rodinou, [*Ethical Codes of Social Work with the Family*], České Budějovice – Brno: Albert, 2008, pp. 83–106.

SWAAN, de A.: In **Care of the State, Health Care, Education and Welfare in Europe and the USA in the Modern Era.** Cambridge: Polity Press, 1988.

WHITE, V.: **Quiet challenges? Professional practice in modernised social work.** In: Harris, J., White, V. (eds.), Modernizing social work, Critical considerations, Bristol: The Policy Press, 2009, pp. 129–144.

**Endnotes**

1 Dissimilar concepts of desirable actions of social workers are commonly held by clients, colleagues from other helping professions, superiors, councilors, sponsors or inspectors, etc. in the course of co-operation with social workers within organisations.

2 Here I am quoting the participant of a survey carried out in 2008 at an unnamed labor office.

3 In Latin, the word *perpetuitas* means "constancy, continuity and permanence".

4 It seems relevant to instigate a debate on the relationship between the idea of "using the perpetual perspective in coping with the dilemma between conformity and authenticity" and the question of the "professional design and status of social work". However, I assume that the elementary postulation of the "perpetual perspective" and its interrelatedness with the dilemma between conformity and authenticity is a matter of the theory of organisation and should be defined in its context. In terms of this elementary postulation, the idea concerns social workers irrespective of their professional or non-professional status or aspiration. I believe that the elementary formulation of usefulness of the perpetual perspective for coping with the dilemma should precede any discussion in terms of its meaning for the professional design and status of social work and hence such a debate should follow only after conclusions are made from this article.

5 Kołakowski (2001: 2–5) uses philosophical arguments in support of his assertion that the human mind has "*a need*, […] *to grasp the world of experience as intelligible by relating it to* […] *purposeful order* […], *to see the world as continuous* […], *to avoid acceptance of a contingent world*" (Kołakowski, 2001: 2–5).

6 The tensions between formalisation and autonomous thinking of frontline social workers is discussed by Clark and Newman (1997), van der Laan (1998), Harris (2000), Dustin (2007), White (2009), and others.

7 Lipsky (1980: 3–4) uses the term *"street-level bureaucrats"* to describe those public service workers who interact regularly and directly with citizens in the course of their jobs. Their working situation is characterised by a relatively high degree of independent judgment and resources (mainly time and available services) that are usually not proportionate to their tasks. Lipsky (1980: 27, 77, 150, 243 *et alibi*) places social workers among street-level bureaucrats.

8 The term "social bonds" is used here for those constant patterns of relationships and interactions whose recurrence allows the parties involved to anticipate the responses of other parties and, as a result, to establish routine relationships with them. "Cultural bonds" are an individual type of social bonds understood in this way.

9 I formulated the case myself; the theme of collision with the idea that establishing a relation with the client is, or is not, necessary for providing assistance, is taken from Dustin (2007: 4).

# The Professional Readiness of Hospice and Palliative Care Workers for Accompanying Dying People

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**Abstract**

**In the present** article, the authors focused on identifying the training needs of hospice staff and other health care workers in palliative care. The authors conducted an extensive research project interviewing workers involved in the direct care of clients in the terminal stage of their life. The staff were interviewed on readiness for their existing professions in which they accompany the dying and encounter death on everyday basis. The research objective was to determine whether the respondents' education is adequate, in their own view, for accompanying the dying and whether it enables them to come to terms with the finiteness of life.

## Introduction

*"Just as* **a human being begins** *his or her* **life in weakness and dependency**, *he or she* **needs protection and support** *when* **dying."** (Charter of Rights of the Dying).

In life, we accompany others on various journeys and at the same time they accompany us. The hardest of all is accompanying of the dying because there is no hope to which we have clung in all previous periods of life. At this point entirely different values appear: the right to die in dignity, the right to die without unnecessary distractions, the right to die with the participation of those who understand the matter and who do not rely overly on the achievements of modern medicine (which enables people to survive a deteriorated health status and to keep the terminally ill alive but for people in the terminal stage this condition may no longer be considered living in the true sense). This seems to be the right time to introduce consoling palliative medicine and other approaches of hospice care where one of the most

important issues is social work aimed not only at social needs of the dying but also at those of their relatives. For social work with persons in the terminal stages of their lives it is typical that material needs are put aside and their place is taken by needs based on human co-existence. One of the main tasks of social work with persons in the terminal stage of their lives is seen by the authors as mediating an interaction with the external social environment and in supporting social relationships of clients with their existing relationship network. In agreement with Musil (2008: 65), the authors understand social work in hospices as work of a specialist "…who aims at a complex consideration of heterogeneous and individually specific circumstances that impede the client (an individual or a group) in successfully coping with interactions with the social environment." A space is being opened for work with people so as they should not remain alone at the end of their lives, the importance of which was aptly specified by Musil (2010), who sees helping in coping with interaction as one of the possible roles of the social worker. "If someone experiences hardly manageable troubles in interactions and does not have someone close who may help him spontaneously with these troubles he remains alone" (Musil 2010: 15). This is also linked with the view of Student (2006) speaking about the social workers in hospices having a role as a link, i.e. experts on cooperation who are trained with regard to team and communication abilities and conflict-solution capabilities.

The aim of the research in hospices and other institutions of palliative care was to identify areas in which there are deficits in social work with persons in the terminal stage of the their lives and to identify, on the basis of the obtained data, areas on which professional training of social workers should be focused on, workers who decide to connect their professional career with helping the dying persons and their close ones.

**Hospice care and palliative care personnel or human relationship as a part of the profession**

The very title of Kopřiva's publication (1997) points to the fact that the basic component in all helping professions is a human relationship. This premise applies even more to workers in palliative care. Staffing for palliative care is usually standardised. As stated by Haškovcová (2007), the head of hospice is a physician and the medical staff composition is similar to that of hospitals (secondary physicians, consulting doctors, a head nurse or charge nurses, physiotherapists, nurses, orderlies, etc.). Compared to the conventional hospital facility, in hospices the emphasis is placed on the presence of social workers, psychologists, priests, pastoral assistants, etc. In this country, it is still less common for volunteers from the general public to be involved.

Parkers et al. (2007) claim that work in a hospice facility makes extraordinary demands on the staff. Unlike clients who usually feel much safer in hospice than in hospital, the same does not apply for the members of the hospice team. Nurses, GPs and other staff members often rely solely on themselves in their work. They must make immediate decisions without being able to consult their colleagues and unlike hospital staff they do not even have the option of constant surveillance of the patient. It is very important for hospice care team members to get together regularly and to provide each other with mutual support. This type of work requires someone who is strong enough, someone who is confident, able to make decisions, tolerant and manages to reduce tension in clients' families. The individual must be independent and self-sufficient but able to help if necessary and above all he must be able to recognise such a need.

Based on cooperation established between a working group of the Ministry of Health (MH) and the Association of Hospice Palliative Care Providers (AHPCP), Standards of Hospice Palliative Care AHPCP were officially issued in April 2007 defining the requirements to be met by specialised palliative care providers in the Czech Republic to ensure its necessary and adequate quality. Education in the field of palliative care must be based on internationally recognised fundamental values and principles and must take into account the following:

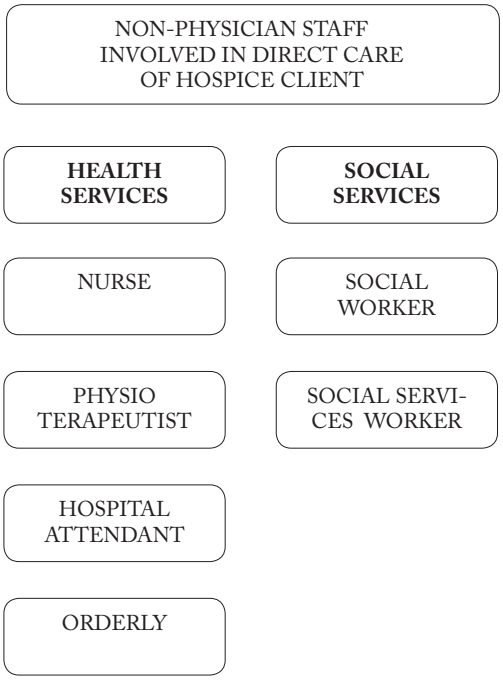
- an interdisciplinary character of care,
- ethical aspects of palliative care,
- training in communication (communicating the diagnosis, communication about death and dying, emotional support and accompanying the patient and his/her loved ones, help in coping with death),
- consideration of value priorities, cultural and

spiritual orientation,

- respect for individual wishes and needs of patients and their loved ones.

Each palliative care team member follows a personal development plan according to which they educate themselves further. The education system in the organisation also reflects the emotional impact of the profession. Team members (including volunteers) can access emotional and psychological support in the form of regular meetings and supervision. A supervision management system has been established in many hospices which helps improve mutual communication between the working teams and thus leads to a more efficient management of the entire organisation.

***Figure 1 Non-physician staff involved in direct care of a hospice client***




Source: authors' own

Non-physician staff involved in direct client care and their job descriptions are governed by two Acts. Under the Non-Physician Health Care Professions Act (i.e. general nurses, physiotherapists, hospital attendants and orderlies), a health care profession is understood as a set of activities carried out in providing health care pursuant to the Act. The job description of the professional social worker and the social service worker is generally established by the Act on Social Services. However, the above mentioned Act does not recognise the concept of hospice yet. Both these Acts provide essential legislative anchoring prerequisites for professions within a hospice team.

The question then is whether the education obtained indeed enables graduates to accompany the dying in the area of "humanity" and teaches them to apply not only their expertise but also their social and emotional skills because these skills prove much more important in extreme situations than the expertise itself. As rightly pointed out by Svatošová (2008), not everyone can work in a hospice. It is certainly not enough to be a doctor, a nurse or an orderly there. Although expertise is absolutely necessary and lifelong learning is a self-evident duty of all, the prime role here is played by human relationship. Only one who truly and unconditionally loves people can work in a hospice. A person who has not come to terms with his/her own finality cannot work in a hospice for a long time.

## Evaluating Professional Readiness of Hospice and Palliative Care Personnel - Research Investigation

The aim of the research (Polepilová, Vávrová, 2011) was to determine how staff in direct care of clients in hospices and other facilities evaluate their professional readiness to accompany clients in the terminal stages of life and whether their professional training contributed to the art of coping with demands faced by them in practice.

With regard to the stated aim and the research problem, a quantitative research strategy, a statistical method and a technique of survey data collection were chosen. The aim was to obtain more data from a larger number of respondents and thus ensure research reliability. The authors created a non-standardised pilot questionnaire to be verified in a particular hospice facility. The subsequent questionnaire evaluation showed that respondents understood the questions; hence there was no need to modify

the questionnaire further. Due to the above fact, the pilot questionnaires were also used in the overall research. The questionnaire was then used in the research itself. The research subjects were non-physician staff in direct client care in hospices and similar facilities.

Another objective was to find how/whether the given variables are interdependent. For this purpose the research hypotheses were set which were to be confirmed or disproved in the evaluation of the research data (see below).

The data collection took place in in-patient and home hospice facilities in the Czech Republic from the database of the civic association The Homecoming[3]. It addressed all of the 14 in-patient hospices in the Czech Republic (at the time of data collection, the Hospice Malovická in Prague and the Hospice in Frýdek Místek were not in operation) and 14 home hospice facilities (at the time of data collection, the Hospice Jordán in Tábor was not in operation). Answers from the House of St. Anthony in Moravské Budějovice, from Naděje Zlín Dům pokojného stáří (House of Peaceful Old Age), Atlas Hospital Department of Aftercare and the Oncology Department in Bata Hospital in Zlín were included in the sample. It was assumed that these respondents encounter clients in terminal stages of life during the course of their work. Communication took place mostly through a social worker and occasionally through the director/head of the facility. In several institutions, respondents refused to cooperate strictly on the grounds that they were overwhelmed by "questionnaires".

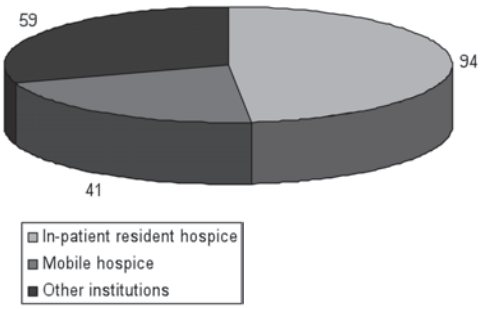



***Figure 2 Respondents sample description***

Source: authors' own

All professionals working in direct care of people in terminal stages of life whose functions require at least the Bachelor's degree were included in the research. Doctors and psychologists, whose positions require a master's degree/follow-up master's education, were not included on the assumption that their extensive education covers the issue which is the subject of research of this paper at lower levels of education. Priests and volunteers were not included in the sample, either, as they constitute a very specific group within the nursing team and their initial education does not necessarily involve caretaking of clients in terminal stages of life. Due to the total number of 194 respondents, with only 6 men, i.e. 3%, it was not possible to consider the problem in relation to gender.

### Data Processing and Evaluating and Research Results Interpretation

In order to test the hypotheses, the goodness-of-fit chi-square test ($\chi 2$) was used for the contingency table with the significance level of 0.05. This category of tests of significance measure whether the frequencies obtained by measuring social reality differ from the theoretical frequencies, which correspond to the null hypothesis (Chráska, 2007). Significance tests of this kind can be used, for example, when deciding whether there is an association (dependence) between two phenomena that were captured by the nominal (or ordinal) measurement. This situation is common e.g. in processing questionnaire survey results.

The data obtained for all hypotheses were processed to contingency tables (matrices which follow two characteristics in the statistical units). Each hypothesis is accompanied by a contingency table (Anděl, 2007). For each hypothesis described below, the value of the test criteria R and the critical value of the test criteria $R_{crit}$ were calculated. Comparing the calculated value of the test criteria with the critical value, if the calculated value is higher we can reject the null hypothesis (Chráska, 2007). Furthermore, in the rejected null hypotheses, each quantity which functions as a variable in the table with the data obtained, it is indicated whether it appears in rows or columns in the given contingency table.

Some respondents did not answer all the questions, and some questions generated multiple answers. That is why the total number

of responses for each question varies. The $R_{crit}$ value is always calculated for a particular question based on the number of responses, and therefore a different number of responses does not affect the results of hypothesis testing.

**H1 The younger the worker is, the higher they evaluate their professional readiness for accompanying the dying.**

The dependency was obtained based on the data of these two variables:

**Tab. 1 Age (rows) – Respondent distribution according to age**

| | Age | Absolute frequency | Relative frequency |
|---|---|---|---|
| a | 18-25 | 22 | 11% |
| b | 26-35 | 67 | 35% |
| c | 36-45 | 63 | 33% |
| d | 46-55 | 30 | 16% |
| e | 56-65 | 9 | 5% |
| | Total | 191 | 100% |

Groups **d** and **e** were merged due to the small number of respondents.

**Tab. 2 Professional readiness (columns) - Respondent distribution according to professional readiness***

| | Answer | Absolute frequency | Relative frequency |
|---|---|---|---|
| a | absolutely agree | 16 | 8% |
| b | quite agree | 69 | 37% |
| c | I don´t know | 25 | 14% |
| d | rather disagree | 57 | 31% |
| e | absolutely disagree | 18 | 10% |
| | Total | 185 | 100% |

Groups **a, b** and groups **c, d** and **e** were merged due to the small number of respondents.

*_Question: Do you think that your study field (or your specialised training) has prepared you sufficiently to manage the task of accompanying the dying from the professional perspective (i.e. in terms of knowledge of care for the dying, their needs, ways of communicating with the dying, etc.)?

$R = 0.055$; $R_{crit} = 7.815$ – null hypothesis has not been disproved.

**H2 The lower the attained education of the worker is the higher they evaluate their professional readiness for accompanying the dying.**

**H2 (0)** There are no significant differences in the evaluation of their professional readiness for accompanying the dying, depending on their educational attainment.

**H2 (A)** There are significant differences in the evaluation of their professional readiness for accompanying the dying, depending on educational attainment.

The dependency was obtained based on the data of these two variables:

**Tab. 3 Educational attainment (rows) – Respondent distribution according to educational attainment**

| | Educational attainment | Absolute frequency | Relative frequency |
|---|---|---|---|
| a | Elementary | 6 | 3% |
| b | Secondary | 32 | 17% |
| c | Secondary with maturita exam | 109 | 56% |
| d | Higher | 16 | 8% |
| e | Tertiary - bachelor´s degree | 22 | 11% |
| f | Tertiary - master´s degree | 9 | 5% |
| | Total | 194 | 100% |

Groups **a, b** and **d, e, f** were merged due to the small number of respondents.

**Tab. 4 Professional readiness (columns) – Respondent distribution according to professional readiness ***

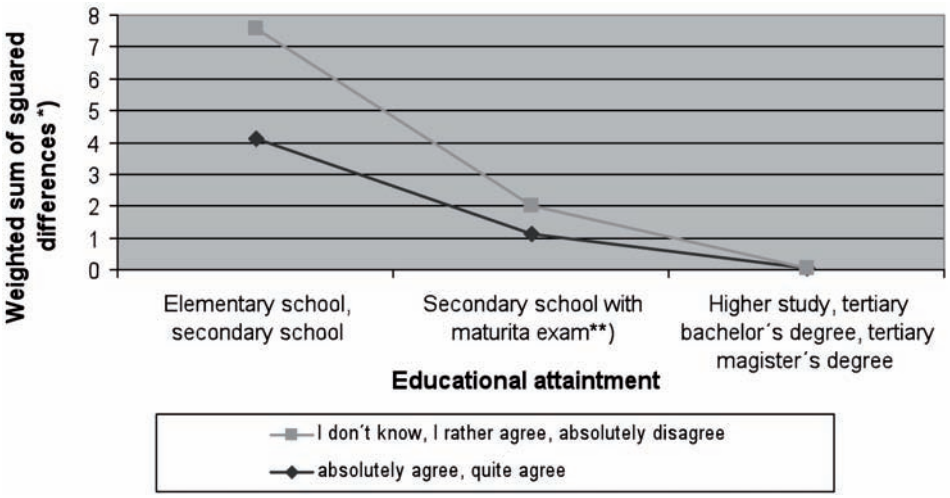
| | Response | Absolute frequency | Relative frequency |
|---|---|---|---|
| a | absolutely agree | 16 | 9% |
| b | quite agree | 69 | 37% |
| c | I don´t know | 25 | 14% |
| d | rather disagree | 57 | 30% |
| e | absolutely disagree | 18 | 10% |
| | Total | 185 | 100% |

Groups **a, b** and **c**, **d, e** were merged due to the small number of respondents.

* Question: Do you think that your study field (or your specialised training) has prepared you sufficiently to manage the task of accompanying the dying from the professional perspective (i.e. in terms of knowledge of care for the dying, their needs, ways of communicating with the dying, etc.)?

**The null hypothesis has been disproved**, because the test criterion R = 9.669 is higher than the critical value $R_{crit}$ = 5.991, so **the factor dependency** is statistically significant. We accept the alternative hypothesis **H2 (A). We claim with certainty that there are significant differences in the evaluation of their professional readiness for accompanying the dying, depending on educational attainment. The biggest difference** of the test criteria of 4.137 between the measured and the random (hypothetical) frequencies were in the category of respondents with elementary and secondary education. The respondents believe that they are absolutely prepared for their professions. The number of responses in this category differed from a random number of 16 respondents by 8 (the total of 24). More respondents with primary or secondary education than would be expected by the random frequency do not doubt their professional readiness to accompany the dying. Paradoxically, respondents with lower education feel that they are professionally more prepared compared to how respondents with higher education feel. This may be caused by the fact that with growing education a person becomes more aware of his/her limits.

*Figure 3 Professional readiness of respondents to accompany the dying in dependence on attained education *)*




* weighted sum of squared differences of measured and hypothetical frequencies

** secondary school-leaving exam/maturita exam

R = 9.669; $R_{crit}$ = 5.991 – factor dependency is statistically significant.

**H3 Health care professional graduates evaluate their professional readiness for accompanying the dying higher than graduates of other disciplines.**

**The dependency** was obtained based on the data of these two variables:

**Tab. 5 Field of study (rows) – Respondent distribution according to the field of study**

| | Field of study | Absolute frequency | Relative frequency |
|---|---|---|---|
| a | general nurse | 95 | 49% |
| b | physiotherapy | 6 | 3% |
| c | social policy and management | 1 | 1% |
| d | nursing | 37 | 19% |
| e | health care management | 9 | 4% |
| f | social work | 15 | 8% |
| g | social pedagogy | 8 | 4% |
| h | other | 23 | 12% |
| | Total | 194 | 100% |

Groups **b, c, e, f, g, h** were merged due to the small number of respondents.

| Tab. 6 Professional readiness (columns) – Respondent distribution according to professional readiness* | | | |
|---|---|---|---|
| | Response | **Absolute frequency** | **Relative frequency** |
| a | absolutely agree | 16 | 9% |
| b | quite agree | 69 | 37% |
| c | I don´t know | 25 | 14% |
| d | rather disagree | 57 | 30% |
| e | absolutely disagree | 18 | 10% |
| | Total | 185 | 100% |

Groups **a, b** and **c**, **d, e** were merged due to the small number of respondents.

* Question: Do you think that your study field (or your specialised training) has prepared you sufficiently to manage the task of accompanying the dying from the professional perspective (i.e. in terms of knowledge of care for the dying, their needs, ways of communicating with the dying, etc.)?

R= 5.052; $R_{crit}$= 5.991 – null hypothesis has not been disproved.

**H4 Staff working currently in the position of general nurses evaluate their professional readiness for accompanying the dying higher than other employees.**

Given that H4 partially corresponds with H3 and it has not been confirmed by the research, we do not present the processed data in tabular form.

H5 The shorter time an employee works in his/her position, the higher they evaluate their professional readiness for accompanying the dying.

The dependency was obtained based on the data of these two variables:

| Tab. 7 Length of working in the area of accompanying the dying (rows) – respondent distribution according to years of working in the area of accompanying the dying | | | |
|---|---|---|---|
| | Length | Absolute frequency | Relative frequency |
| a | less than a year | 25 | 13% |
| b | 1 – 3 years | 65 | 34% |
| c | 4 – 9 years | 61 | 32% |
| d | 10 and more years | 40 | 21% |
| | Total | 191 | 100% |

Groups **a** and **b** were merged due to the small number of respondents.

| Tab. 8 Professional readiness (columns) – respondent distribution according to professional readiness * | | | |
|---|---|---|---|
| | Response: | Absolute frequency | Relative frequency |
| a | absolutely agree | 16 | 9% |
| b | quite agree | 69 | 37% |
| c | I don´t know | 25 | 14% |
| d | rather disagree | 57 | 30% |
| e | absolutely disagree | 18 | 10% |
| | Total | 185 | 100% |

Groups **a, b** and **c, d, e** were merged due to the small number of respondents.

* Question: Do you think that your study field (or your specialised training) has prepared you sufficiently to manage the task of accompanying the dying from the professional perspective (i.e. in terms of knowledge of care for the dying, their needs, ways of communicating with the dying, etc.)?

R = 0.795; $R_{crit}$ = 5.991 – null hypothesis has not been disproved.

**H6 Hospice care workers feel less professionally prepared than workers in other facilities.**

**The dependency** was obtained based on the data of these two variables:

| Tab. 9 Type of institution (rows) – respondent distribution according to the type of institution | | | |
|---|---|---|---|
| | Type of institution | Absolute frequency | Relative frequency |
| m | mobile hospice | 41 | 21% |
| d | home for seniors | 26 | 13% |
| c | in-patient care hospice | 94 | 49% |
| a | hospital | 33 | 17% |
| | Total | 194 | 100% |

Groups **a, d** and **c, m** were merged due to the small number of respondents.

| Tab. 10 Professional readiness (columns) – respondent distribution according to professional readiness* | | | |
|---|---|---|---|
| | Response | Absolute frequency | Relative frequency |
| a | absolutely agree | 16 | 9% |
| b | quite agree | 69 | 37% |
| c | I don´t know | 25 | 14% |
| d | rather disagree | 57 | 30% |
| e | absolutely disagree | 18 | 10% |
| | Total | 185 | 100% |

Groups **a, b** and **d, e** were merged due to the small number of respondents.

* Question: Do you think that your study field (or your specialised training) has prepared you sufficiently to manage the task of accompanying the dying from the professional perspective (i.e. in terms of knowledge of care for the dying, their needs, ways of communicating with the dying, etc.)?

$R = 2.471$; $R_{crit} = 5.991$ – null hypothesis has not been disproved.

### H7 Hospital staff need more time to cope with the death of people in their care than staff of other facilities.

**H7 (0)** There are no significant differences between the type of facility in which the staff work and the length of time needed to cope with the death of people in their care.

**H7 (A)** There are significant differences between the type of facility in which the staff work and the length of time needed to cope with the death of people in their care.

The dependency was obtained based on the data of these two variables:

| Tab. 11 Type of institution (columns) – respondent distribution according to type of institution | | | |
|---|---|---|---|
| | Type of institution | Absolute frequency | Relative frequency |
| m | mobile hospice | 41 | 21% |
| d | home for seniors | 26 | 13% |
| c | in-patient care hospice | 94 | 49% |
| a | hospital | 33 | 17% |
| | Total | 194 | 100% |

Groups **a, d** and **c, m** were merged due to the small number of respondents.

| Tab. 12 The length of time needed to cope emotionally with death of people in care (rows) – respondent distribution according the length of time needed to cope emotionally with death of people in care * | | | |
|---|---|---|---|
| | **Length of coping** | Absolute frequency | Relative frequency |
| a | I had no problem with it | 87 | 48% |
| b | months | 27 | 15% |
| c | years | 12 | 7% |
| d | I still have not come to terms with it | 26 | 14% |
| e | I have not thought about it | 29 | 16% |
| | Total | 181 | 100% |

Groups **a, e** and **c, d** were merged due to the small number of respondents.

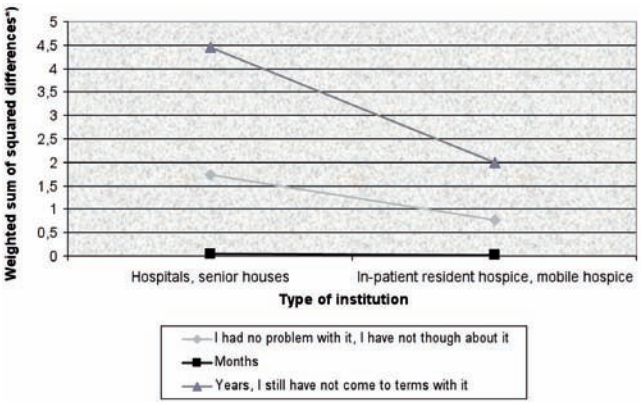
*Question: How long does/did it take you to come to terms emotionally with your demanding profession and death of clients in your care?

We accept the alternative hypothesis **H7 (A) There are significant differences between the type of facility in which the staff work and the length of time needed to cope emotionally with the death of people in their care. The biggest difference** of test criterion 4.462 between the measured and the random (hypothetical) frequency showed that the category of respondents working in hospitals and homes for seniors reported that they took years to cope emotionally with the death of people in their care, or that they have not come to terms with it yet. As for hospital staff, the frequency of responses in this category differed from a random number of 12 respondents by 7 (the total of 19), i.e. 7 more than what was the expected frequency. It can thus be assumed that more hospital workers doubt their emotional equilibrium more than would be expected by the random frequency. For respondents working in hospices, the response frequency for the same questions was (19) lower by 7 compared to the random frequency (26). Fewer hospice workers answered this way than expected by random frequencies. Both phenomena may be explained by the very different missions of each facility. Hospitals try to save the life of an individual at any cost. In hospices, efforts are made to make the most of each day left in the client's life.

Respondents could provide specific information

as to how long it took them to cope with the death of people in their care. 35 respondents took this opportunity (i.e. 18% of all respondents). The shortest time period mentioned was 1 month, by 4 respondents, 20 respondents reported 2-8 months, answers of 10 respondents ranged from 1 to 3 years. The longest time period reported in the questionnaire by a single respondent, was 5 years.

***Graph 3 The length of time the respondents needed to cope emotionally with the death of persons in their care *)***




* weighted sum of squared differences of measured and hypothetical frequencies

R= 9.045; $R_{crit}$= 5.991 – factor dependency is statistically significant.

**H8 The older the worker is, the more their family environment/support helps them cope with stressful situations.**

The dependency was obtained based on the data of these two variables:

**Tab. 13 Age (rows) – respondent distribution according to age**

| | Age | Absolute frequency | Relative frequency |
|---|---|---|---|
| a | 18-25 | 22 | 11% |
| b | 26-35 | 67 | 35% |
| c | 36-45 | 63 | 33% |
| d | 46-55 | 30 | 16% |
| e | 56-65 | 9 | 5% |
| | Total | 191 | 100% |

Groups **d** and **e** were merged due to the small number of respondents.

**Tab. 14 Coping with stressful situations (columns) – respondent distribution according to the way of coping with stressful situation***

| | Coping with stressful situation | Absolute frequency | Relative frequency |
|---|---|---|---|
| a | good family support | 149 | 29% |
| b | good friends | 121 | 23% |
| c | faith | 75 | 15% |
| d | hobbies, leisure time activities | 75 | 15% |
| e | relaxation | 93 | 18% |
| | Total | 513 | 100% |

Groups **c** and **d** were merged due to the small number of respondents.

* Question: What else helps you cope with stressful situations in the workplace (select or indicate the three most important factors)?

R = 3.187; $R_{crit}$ = 16.919 – null hypothesis has not been disproved.

**H9 Workers in a facility without established supervision need a longer time to cope with the death of people in their care than in facilities with supervision.**

**H9 (0)** There are no significant differences between the facilities with established supervision of workers and without, in relation to the length of time needed to cope emotionally **with the death** of people in their care.

**H9 (A)** There are significant differences between the facilities with established supervision of workers and without, in connection with the length of coping with the death of people in their care.

The dependency was obtained based on the data of these two variables:

**Tab. 15 The length of time needed to cope emotionally with death of people in care (rows) – respondent distribution according to length of emotional coping with death of people in care ***

| | Length of coping | Absolute frequency | Relative frequency |
|---|---|---|---|
| a | I had no problem with it | 87 | 48% |
| b | months | 27 | 15% |
| c | years | 12 | 7% |
| d | I still have not come to terms with it | 26 | 14% |
| e | I have not thought about it | 29 | 16% |
| | Total | 181 | 100% |

Groups **b, c** were merged due to the small number of respondents..

* Question: How long does/did it take you to come to terms emotionally with your demanding profession and death of clients in your care?

**Tab. 16 Established supervision (columns) - respondent distribution according to non-/ established supervision in the workplace***

| | Supervision | Absolute frequency | Relative frequency |
|---|---|---|---|
| a | Yes | 98 | 53% |
| b | No | 87 | 47% |
| | Total | 185 | 100% |

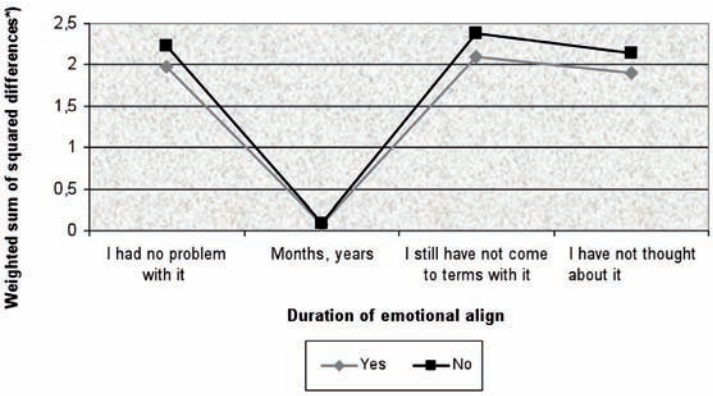
*Question: Is there an established system of supervision in your facility (i.e. employee support by an outside professional)?

**The null hypothesis has been disproved,** because the test criterion R = 12.897 is higher than the critical value $R_{crit}$ = 7.815, thus the **factor dependency** is statistically significant.

We accept the alternative hypothesis **H9 (A) There are significant differences between the facilities with established supervision of workers and without it, in connection with the length of coping with the death of people in their care.**

The biggest difference in test criterion 2.375 between the measured and random (hypothetical) frequencies showed the category of respondents working in facilities without established supervision reported that they have not yet coped emotionally with the death of people in their care to this day. The number of responses in this category differed from a random number of 12 respondents by 5 (the total of 17). We can thus assume that their emotional equilibrium is doubted by more workers from facilities without supervision than would be expected by random frequency. This dependence confirms the statistical significance of the role of supervision for the profession in direct client care. However it should be noted that, in the surveyed hospitals, supervision is not supported, so the results may be influenced by hospital staff due to the absence of supervision, as well as due to a distinctive mission of these facilities compared to hospices. Therefore, the same dependence was also verified among respondents working in hospices, where the null hypothesis failed to be disproved. When analysing the answers of respondents by type of facilities, it was found that in home hospices, an established supervision system was reported by 85% of respondents (40 responses, 34 of which were positive), in in-patient hospices, reported by 57% of respondents (92 replies, 52 of which were positive), homes for seniors 48% (25 replies, 12 of which were positive) and no hospital respondent responded positively when it came to the system of supervision in their facility. When considering only hospice facilities, 65% of workers reported an established supervision system in their facility.

***Graph 4 Duration of emotional coping of***



***respondents with death of persons in their care according to non-/established supervision in workplace *)***

* weighted sum of squared differences of measured and hypotetical frequencies

R= 12.897; $R_{crit}$= 7.815 – factor dependency is statistically significant.

**H10 to H14** focused on finding specific areas of education, in which care workers are well prepared, with emphasis on the subject of thanatology (see Tab. 21).

**H15 The higher their education the more frequently the worker has reported as the reason for choosing the profession their feeling of being useful and fulfilling their need to help others.**

**The dependency** was obtained based on the data of these two variables:

**Tab. 17 Educational attainment (rows) – Respondent distribution according to educational attainment**

| | Educational attainment | Absolute Frequency | Relative frequency |
|---|---|---|---|
| a | elementary | 6 | 3% |
| b | secondary | 32 | 17% |
| c | secondary with maturita exam | 109 | 56% |
| d | higher | 16 | 8% |
| e | tertiary - bachelor´s degree | 22 | 11% |
| f | tertiary - master´s degree | 9 | 5% |
| | Total | 194 | 100% |

Groups **a, b,** and **d, e, f** were merged due to the small number of respondents..

**Tab. 18 Influences on career choices (columns) - respondent distribution according to influences on career choices**

| | Influences on career choices | Absolute frequency | Relative frequency |
|---|---|---|---|
| a | encountering death of a close one | 43 | 14% |
| b | recommendation of a particular person (teacher, relative, friend, acquaintance, etc.) | 37 | 12% |
| c | I felt I will be useful there and I will fulfil my ambition to help others | 132 | 43% |
| d | time convenience (hospice is nearby my place of living) | 37 | 12% |
| e | job vacancy | 43 | 14% |
| f | other, complete | 17 | 5% |
| | Total | 309 | 100% |

Groups **d, f** were merged due to the small number of respondents..

R = 9.739; $R_{crit}$ = 15.507 – null hypothesis has not been disproved.

**H16 Hospice workers reported higher job satisfaction compared to workers of other facilities.**

**The dependency** was obtained based on the data of these two variables:

**Tab. 19 Type of institution (rows) – respondent distribution according to type of institution**

| | Type of institution | Absolute Frequency | Relative frequency |
|---|---|---|---|
| m | mobile hospice | 41 | 21% |
| d | home for seniors | 26 | 13% |
| c | in-patient care hospice | 94 | 49% |
| a | hospitals Bata´s + Atlas | 33 | 17% |
| | Total | 194 | 100% |

Groups **a, d** and **c, m** were merged due to the small number of respondents.

**Tab. 20 Job satisfaction (columns) – respondent distribution according to the feeling of job satisfaction**

| | I am satisfied with my job | Absolute Frequency | Relative frequency |
|---|---|---|---|
| 5 | absolutely agree | 58 | 32% |
| 4 | quite agree | 84 | 47% |
| 3 | I don´t know | 26 | 15% |
| 2 | rather disagree | 10 | 5% |
| 1 | absolutely disagree | 2 | 1% |
| | Total | 180 | 100% |

Groups **1, 2** and **4, 5** were merged due to the small number of respondents.

R = 4.270; $R_{crit}$ = 5.991 – null hypothesis has not been disproved.

**Conclusions and Suggestions for the Professional Field**

The evaluated data on hospice and other palliative care workers' sense of professional readiness (H2) suggest that staff with lower levels of education should be properly motivated to further their professional education and self-development. It is ironic that the lower education the worker reached, the better prepared he/she feels to accompany people in the terminal stage of life. Workers with higher education (H13) are ready and motivated to educate and broaden their expertise as well as socio-emotional competence in the field related to the care of dying. Respondents also identified study areas considered relevant for practical accompaniment of dying (H11). These are: 1) communication with the dying and their relatives, 2) ethical approach to the dying, 3) self-knowledge, work with their own emotions when caring for the dying, 4) death and dying as part of the life cycle (thanatology) and 5) psycho-hygiene (with focus on prevention of burnout).

From the results presented, we may draw conclusions not only for social work in hospices but mainly for the area of professional training of social workers who should be its guarantors and coordinators in hospice establishments. Identifying the areas of *communication with the dying and their relatives* as one of the most important competencies for work with people in the terminal stage of their life is surely not a surprising finding. Basically, it is confirmation of its importance in the professional training of future social workers as discussed by Musil (2008, 2010). If the social workers are sufficiently trained in the area of mediating interactions in depressing social situations where clients are not able to cope with them by themselves or with the help of their close relatives, their work of "mediators" of interpersonal relationships and interactions will surely become effective and purposeful. Social workers should aim their work in hospices not only at clients and their family members who often remain lonely in their grief but also at their less qualified colleagues in direct care of clients as they also need support or professional advice and help.

It is also interesting to find out that subjects where most respondents gained knowledge of accompanying the dying (H10) were in 36% psychological ones and in 33% health care ones while thanatology subjects represented only 18%. This fact can be explained by the fact that in many study programmes thanatology subjects were not even offered. We can thus recommend thanatology as a part of studies for those graduates who are likely to meet death and who are likely to accompany dying clients/patients in their professions.

The research clearly confirmed the importance of supervision. The proven benefits of supervision (H9) should persuade responsible managers of hospices and similar facilities to introduce supervision where it is still absent. It is certainly worth considering the possibility of introducing supervision in hospitals (H7) as it was demonstrated that this is where the respondents took the longest to cope emotionally with the death of people in their care. In conclusion, the results of the hypotheses testing are provided in the following overview table:

***Tab. 21 Hypotheses overview based on the research data interpretation***

| | | |
|---|---|---|
| ☒ | H1 | The younger the worker is, the higher they evaluate their professional readiness to accompany the dying. |
| ☑ | H2 | The lower the attained education of the worker, the higher they evaluate their professional readiness to accompany the dying. |
| ☒ | H3 | Health care professional graduates evaluate their professional readiness to accompany the dying higher than graduates of other disciplines |
| ☒ | H4 | Staff working currently in the position of general nurses evaluate their professional readiness to accompany the dying higher than other employees. |
| ☒ | H5 | The shorter time an employee is in his/her position, the higher they evaluate their professional readiness to accompany the dying. |
| ☒ | H6 | Hospice care workers feel less professionally prepared than workers in other facilities . |
| ☑ | H7 | Hospital staff need more time to cope with the death of people in their care than staff of other facilities. |
| ☒ | H8 | The older the worker is, the more family environment/support helps cope with stressful situations |
| ☑ | H9 | Workers in a facility without established supervision need longer to cope with the death of people in their care than in the facility with supervision. |

| | | |
|---|---|---|
| ☒ | H10 | The lower educational attainment, the less often the worker chooses thanatology as a subject providing the most knowledge in the field of accompanying the dying. |
| ☒ | H11 | The lower the educational attainment of a worker is, the less important are subjects in the field of self-knowledge. |
| ☒ | H12 | Graduates of medical professions often attended subjects / courses in thanatology. |
| ☑ | H13 | The higher the education attained, the more the respondents would welcome a subject/ course in thanatology (accompanying of the dying). |
| ☒ | H14 | The older the respondent is, the more important they considered it to further their own abilities and skills in thanatology. |
| ☒ | H15 | The higher their education, the more frequently the worker reported as the reason for choosing the profession, their feeling of being useful and fulfilling their need to help others. |
| ☒ | H16 | Hospice workers reported higher job satisfaction compared to workers of other facilities. |

**Bibliography**


ANDĚL, J. **Základy matematické statistiky**. Praha: Matfyzpress, 2007.

CHRÁSKA, M. **Metody pedagogického výzkumu: Základy kvantitativního výzkumu.** Praha: Grada, 2007.

HAŠKOVCOVÁ, H. **Thanatologie**. Praha: Galén, 2007.

KOPŘIVA, K. **Lidský vztah jako součást profese.** Praha: Portál, 1997.

MUSIL, L. **Různorodost pojetí, nejasná nabídka a kontrola výkonu „sociální práce"**. *Sociální práce / Sociálna práca*, 2008, roč. 7, č. 2, s. 60-79.

MUSIL, L. **Tři pohledy na budoucnost sociální práce**. In **Sborník z konference VII. Hradecké dny sociální práce**. Hradec Králové: Gaudeamus, 2010, s. 11- 24.

PARKERS, C. M., RELFOVÁ, M., COULDRICKOVÁ, A. **Poradenství pro smrtelně nemocné a pozůstalé.** Brno: Společnost pro odbornou literaturu, 2007.

POLEPILOVÁ, R. (VÁVROVÁ, S.) **Profesní připravenost pracovníků hospiců k doprovázení umírajících** (diplomová práce). Zlín: Univerzita Tomáše Bati ve Zlíně, Fakulta humanitních studií, 2011.

SVATOŠOVÁ, M. **Hospice a umění doprovázet.** Kostelní Vydří: Karmelitánské nakladatelství, 2008.

STUDENT, J. Ch., MÜHLUM, A., STUDENT, U. **Sociální práce v hospici a paliativní péče**. Jinočany: H & H, 2006.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**Internet sources:**


http://www.asociacehospicu.cz [on-line] [3. 8. 2011]

http://www.cestadomu.cz/cz/adresar.html [on-line] [2. 7. 2011]


**Endnotes**

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# Ethical Challenges in Humanitarian Assistance

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**Abstract**

Humanitarian assistance is generally understood as a positive action with good impacts, but sometimes especially in war situations and combined crises (disaster and war) it is connected with many ethical dilemmas which have to be solved by humanitarian workers. In this article some principles and theories are introduced that could help to find solutions. However application of the theories and the principles alone is useless. Real knowledge of the theories and ability to combine them, wisdom, humility, prudence and a lot of experience are important in order to be able to solve the dilemmas and help in favour of the people in need.

**Keywords**

ethical dilemmas, humanitarian assistance, humanitarian worker, ethical theories, ethical principles, Code of Conduct, Sphere Project, human rights

## 1. Introduction

Humanitarian assistance is the help offered to people suffering humanitarian crisis. Because of the very complicated and various contexts in which different humanitarian emergencies happen these activities are never the same. Humanitarian workers constantly encounter new and unexpected situations and their decisions are full of dilemmas that are frequently ethical in their nature. In war and conflict situations, the ongoing crisis makes these decisions more difficult and the ethical questions of the whole process become more prominent.

The most serious dilemmas are posed at the level of the aid recipient, because it is only in a relationship where one is seeing the face of another person that the decision-making process acquires its ethical nature, this is the moment when one is exposed to the greatest responsibility. (Lévinas, 1997) As regards assistance provided through an intermediary, it is only the field worker nearly at the recipient's level who sees the face of the other person. Thus, the sequence of duties is reversed: the person who makes decision at the top of the chain bears hardly any responsibility according to Lévinas, the greatest genuine responsibility rests with those who are supposed to fulfil and obey the will of someone else, which is in fact one of the deepest paradoxes of remotely administered aid.

The goal of this article is to explore the possible approaches to decision making in situations of war or armed conflict (from the perspective that there is always a negative aspect of any solution available) and to examine what ethical principles

and theories are available to humanitarian workers to deal with such losing propositions.

## 2. Situations encountered by humanitarian workers in armed conflicts

Humanitarian workers face dilemmas particularly in an environment which does not respect the principles of humanitarian law. This particularly applies to internal conflicts or complex crises. Humanitarian law determines the rules and governs the protection of non-combatants (for any reason whatsoever) in international conflicts; it is also ratified as an international law. In times of international conflicts, humanitarian law provides protection to civilians, non-governmental organisations, e.g. the Red Cross and other international aid organisations. In such an environment, the observance of principles of neutrality and impartiality is defined; the endeavour of the humanitarian workers to obtain consent of the warring parties to their activity is usually accepted. In internal complex crises, the interests of the warring parties are usually so complicated that there is no "either/or" solution available, i.e. agreement or disagreement of the warring parties, but there is often no one to ask, or there is no full (uniform) command, therefore the consent given by one officer does not necessarily mean the consent of the other even if both the officers are theoretically from the same warring party. There are far more possibilities and concurrently no possibility at all, no principles work, only the space for dilemmas expands to make the choice even more difficult. (Weiss, Collins, 2000)

Probably the most appalling case for all humanitarian workers is that of refugee camps in Rwanda, when nearly two million Hutus fled to Zaire and neighbouring countries in the second half of the year 1994. Most of these people had blood on their hands as they murdered Tutsis, "cockroaches" as they called them and moderate Hutus on their escape. From the refugee camps lying near the Rwandan borders, some of them even carried out raids back in Rwanda to kill the locals, loot and take their swag back to the camps. They were well-organised, stratified in the camps to the rich and the poor, with their own leaders and militia. The militia seized up to 60% of food in the camp, one part of it was utilised, while the other re-sold to the people in the camp. The citizens were forced to pay a tithe for the humanitarian assistance to the leaders and even to the "exile" government living at the hotel in Goma, these resources were used to maintain the army. It was dangerous to move inside the camp because of the ubiquitous violence. (Polman 2010). Fiona Terry described the situation in much the same way as Linda Polman; in both cases they witnessed a total ethical catastrophe: "Shall we take care and nurse anyone irrespective of who he/she is or are we expected to assume broader responsibility?" (Terry, 2002, p.31) Linda Polman said everyone had acted as if they had completely forgotten about the context, political correlations. This "forgetting" afflicted not only the humanitarian workers, who initially were up to their elbows in work as cholera raged through the camps and they suffered from a complete lack of water and hygiene; journalists and politicians also seemed unaware of the situation. Two years later the camps were razed to the ground by the Tutsis themselves. Just imagine, the operating costs of these camps amounted to 1 million U.S. dollars per day! (Polman, 2010)

Out of a total of 250 humanitarian organisations working in Rwanda, only two left when the crisis stage was over and cholera was eradicated, these were – the French sections of the Médecins Sans Frontières and IRC (International Rescue Committee). They justified their departure by pointing out to their unconditional commitment to follow the established principles and they simply cannot work neutrally and impartially in conditions like those. In most cases, the humanitarian workers are forced to drain the cup of sorrow to the dregs. They strive to adhere to the principles to preserve dignity and to alleviate suffering, to provide assistance to people who evidently need it (even if they know that they have already received it but were deprived of it after a while) knowing that at the very same time they also help do evil along with those who profit from the assistance. Apart from this fundamental dilemma, they are also exposed to the pressure from the managers who want new contacts from the donors (countries), who support the assistance and are glad to hush the voice of their conscience through the assistance. For instance, Butrus Butrus-Ghálí, the then Secretary-General of the United Nations, wanted to garrison the places of conflict in Rwanda with troops with a more robust mandate but none of the countries wanted

to send its soldiers to intervene in the combat between the Tutsis and the Hutus (Security Council, 1994). Thus, the thorny problem fell again on the heads of the aid organisations. The snag is that the humanitarian system is always left to itself with such a prodigious credulity that no one, not even the journalists, needs to control it. The public does not care that much (except for the moments of crisis which they can watch live on the TV), it is only of marginal interest to them. Ten billion U.S. dollars annually donated from the federal taxes to humanitarian assistance are not a big deal if compared to 14 billion dollars spent annually for cosmetic surgery (Polman, 2010, p.162). It should be mentioned that the concept of dilemma in these cases does not fully correspond to the complexity of the decision-making process to be carried out by the humanitarian workers.

These are hard choices and compromises which the humanitarian worker should face in such cases. Paths to solution are long and winding, if not impossible. "Fundamentally, a decision to act or to refrain from acting must take into account inevitably averse consequences; but action, and a decision to engage or disengage is obligatory and not discretionary. In Dante's *Inferno*, the hottest room was reserved for those who vacillated. In war zones, "punting", or avoiding a decision, is not an option. This is one reason why the past decade's tragedies have shaken humanitarians to the core." (Weiss, Collins, 2002, p.124, 125).

### 3. Possible dilemmas arising

I agree with Linda Pollman as well as Fiona Terry arguing, that the decisions they had to take are beyond the situation of current dilemma, nevertheless I would like to explore what theories could be used in order to find the way out of these difficult situations and the proof of their adequacy for these purposes.

First it is necessary to define dilemmas arising from the situation described above.

1. Do we have the duty to help people although we cannot make difference between those really in need and the killers; and, in addition, to feed the killers and support them in killing those who in fact need our help?
2. Although we feed killers, who would again kill the needy people, we at the same time feed a lot of the innocent people, who really need our help - is this better?
3. What do we do in the situation where the human rights of people are not respected and even trampled on?
4. What are the duties of the humanitarian workers and rights of victims in these situations?

The research question for this article will be following:

Do we have principles or values and theories that we can rely on in such hard situations when all solutions seem bad?

#### 3.1. The theoretical framework.

A large number of rules have been established in the effort to overcome the obstacles which are imposed on humanitarian workers. The context of proper provision of humanitarian assistance poses certain basic dilemmas, namely those between the charitable-philanthropic and human-rights approaches as well as between the duty-based and utilitarian approaches. International assistance is provided more or less in this framework with a higher or lower degree of risk.

The duty-based approach is sometimes seen by some humanitarian workers as a token of fundamentalism, while the utilitarian approach is felt to be pragmatic (Hilhorst, 2004). The charitable-philanthropic approach, focused merely on the provision of assistance on the basis of the needs of the recipients irrespective of the particular situation that people are living in, and without any desire to change anything, many a time it has helped maintain the sinister status quo in a country and in some ways has petrified the current situation. Some organisations tend to apply the human-rights approach in their work and strive for its assertion, though in communication with the domestic donors, they still use philanthropic arguments to describe the affected, starving and ill people as the needy victims who require their compassion instead of explaining to the donors that it is more helpful to urge the governments to further the observance of human rights world-wide, which would also include a request for responsible and just governance, the result of which would be a reduction in the number of these victims (Slim, 2002).

In the following paragraphs I will try to find out

the solution to the above-mentioned dilemmas within this theoretical framework.

### 3.2. Are we obliged to help the people in need? Duty based on humanitarian imperative.

Duty based or deontological ethics in humanitarian assistance commits humanitarian organisations and humanitarian workers to the duty of helping people in need, who are suffering and loosing human dignity. Duty ethics is based on the humanitarian imperative and charitable (philanthropic) approach expressed in the Code of Conduct for The International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programs: "As members of the international community, we recognise our obligation to provide humanitarian assistance wherever it is needed." (Sphere, 2011, p. 370). The humanitarian imperative has become a fundamental feature also of the Humanitarian Charter: "Based on the principle of humanity we affirm the primacy of the humanitarian imperative: that action should be taken to prevent or alleviate human suffering arising out of disaster or conflict, and that nothing should override this principle." (Sphere, 2011, p.20).

The Code is based on needs, i.e. the humanitarian imperative is related to the needs of the people in distress.

On the 10th anniversary of the Code of Conduct, Dorothea Hilhorst carried out a survey the results of which were appended to the relevant provisions of the Code thereafter. The survey which the author based on polling humanitarian workers with long field experience was aimed at identifying to what extent the Code is applicable in the present-day, constantly changing, situation of international conflicts, while many respondents of the pooling were those who participated in those "hell" camps of Zaire. She came to the conclusion that the Code is not a lifeless document, though at the beginning it was suspected of having nothing more to say or advise. Its importance began to grow when it was used for the first time as a reference framework for evaluation of the assistance provided after the earthquake in Gujarat, India, 2001. The problems brought forth primarily by the interventions in Afghanistan and Iraq have also awakened the interest in "dilemmas which we have to face". Last but not least, the Code also forms a basic structure and a base to generate ethical codes for individual organisations, which accentuate one or another aspect of ethical behaviour in various contexts. The results of the survey cast doubt on whether the humanitarian imperative can be applied under any circumstances. Are we obliged to help if observance of the humanitarian imperative does not ensure positive result, e.g. at the camps in Zaire in the mid-1990's, which became a place of recreation for the armed men? Is it not a blind fundamentalism to abide by the imperative in such cases? Would it not be better, in such cases, simply to leave the place and let thousands of people die of hunger including the needy that we cannot distinguish from those armed? (Hilhorst, 2004). According to Kant, it is important and valuable that we at least attempt and are willing to accomplish the good that should be done (Kant, 1990). The question is how to recognise the good in such a case?

### 3.3. Are we obliged to help the people in need? Duty based on human rights.

The fundamental and most recent document (revised in 2011) which governs the provision of humanitarian assistance is "The Sphere Project" (Sphere, 2011), whose basic ideas section is formed by the Humanitarian Charter. The Charter is grounded on human rights, international humanitarian law, and refugee law.

The Humanitarian Charter expresses shared conviction of humanitarian agencies that all people affected by disaster or conflict have a right to receive protection and assistance to ensure the basic conditions for life with dignity. It professes its commitment to the fundamental moral principle of humanity and the humanitarian imperative that is based on this principle. It recognises three basic rights: the right to life with dignity, the right to receive humanitarian assistance, and the right to protection and security. It reflects the obligation to protect and secure these rights, primarily by the state or other relevant authorities which bear the primary responsibility. The international community shall only respond whenever the state authorities fail or are not willing to do so (Sphere, 2011).

Preservation of human dignity also forms a framework for all the standards, be it those applicable to water supply, provision of shelter, food or medical care. The Sphere Project is a living

entity which reflects the first-hand experience of humanitarian workers. It also attracts interest because it fills the space between the law, ethics and practice. It reflects the psycho-social needs of people in all areas of assistance and emphasises the support of the capacities of local actors and their own efforts. The standards and quantitative indicators are very hard to achieve during some humanitarian crises, especially at their outset or whenever the situation is complicated (e.g. after the 2010 Haiti earthquake), but they can be efficiently used for measuring the assistance and establishing the goals on their basis. The Minimum Standards are also essential for coordination of the assistance; the quality of assistance is measured against these standards to be subsequently presented to the donors and the recipients. It is important to mention that the process of development of the Sphere Project started in 1994, as the consequence of the experience from Rwandan camps in Zaire.

### 3.4. Is it possible to feed killers among the innocent victims? Utilitarian answer.

The application of utilitarianism is the logical outcome of dilemmas about whether the provision of assistance, primarily in areas of conflict, should adhere strictly to the established principles or whether these principles should be judged according to their potential consequences, especially when it is impossible to adhere to them. Nevertheless, there is danger that, combined with insufficient knowledge of the conflict history and political circumstances, this may lead to very disputable and morally hardly defensible outcomes.

According to Bentham's principle of utility (the greatest happiness of the greatest number is the measure of right and wrong), utilitarianism is based on hedonism, consequentialism and universalism. (Habibi, 2007) It features four principles: the principle of consequences, i.e. moral judgement is based on the consequences; the principle of utility, which endeavours to implement something that is good by itself; the principle of hedonism (what I like), and finally the social principle, which supplies the consequences with quantitative and qualitative dimensions – happiness, benefit, good or utility and amount thereof. This happiness is not defined by any means and cannot be distributed equitably – if we think of an average happiness, we can never estimate whether the happiness will be distributed equitably. The utilitarian calculation therefore admits that a suffering of one person may be balanced by higher amount of happiness experienced by another person. Utilitarianism is concerned with the consequences of our actions but these actions may also be governed by rules which would subsequently influence the distribution of social utility within the meaning of justice. (Anzenbacher, 2001)

A representative of utilitarianism in the sphere of international assistance is a practical philosopher Peter Singer. "An ethical judgment that is no good in practice must suffer from a theoretical defect as well, for the whole point of ethical judgments is to guide practice." (Singer, 1993, p. 2) His theory concerning the ethics of international assistance is grounded in universalism and the consequential impeachment of borders that may be created by the distance among people, the wealth of ones and the poverty of the others or the frontiers between the countries. He affirms that if we admit that there is an element of impartiality and universality in every person (and not only the selfish interest), people are able to make moral judgements and therefore utilitarian considerations as well. (Singer, 1972) If we accept that our own interests cannot be more important than those of someone else just because these are his/her interests, then deciding on better alternatives cannot be influenced by our own interest more than by the interest of anyone else. Consequently, we must – after due consideration – choose the action that produces the best results for all those affected by the decision.

Singer's fundamental premises are as follows: "… Suffering and death from lack of food, shelter, and medical care are bad" "…If it is in your power to prevent something bad from happening, without sacrificing anything nearly as important, it is wrong not to do so." "…By donating to aid agencies, you can prevent suffering and death from lack of food, shelter, and medical care, without sacrificing anything nearly as important. (Singer, 2009, p. 15, 16)." He also pronounces the request that the rich and people of position and influence (the affluent countries) should give as much money as they nearly reach the level of that poor Bengali. (Singer, 1972) Singer creates a close link between the obligation to give and the outcome, which he considers indisputable and clear. In fact, these outcomes are not that clear. Singer's

theories concerning the assistance provided to the poor are based on money and on the prerequisite that this money should be properly managed. Dozens of years have been spent discussing the method of doing so, and Singer's failure to supply any solution to this question is one of the greatest weaknesses of Singer's utilitarian ideas. Singer's appeal for individual abnegation, modesty, lower consumption in rich countries, is still enormously important. If all the burden of responsibility was so individual and if it was borne by the substantial majority in the rich countries, then it would probably be unnecessary to protect the markets of the rich countries (which deforms business relations with the poor world, and actually casts it into poverty), and to protect its safety to such an extent. This call to responsibility would definitely have concrete global impact. It is clear, that according to utilitarianism it is important to choose the action that produces the best results for all those affected by the decision and not to think about other negative impacts.

**3.5. The importance of respect for human rights.**

Recognition of the natural dignity and equal rights of all members of the human community is the crucial idea of the Universal Declaration of Human Rights adopted by the United Nations General Assembly on 10 December 1948 in Paris, Palace Chaillot (UN Declaration, 1948). Human rights are anchored in the recognition of equality between people; although this equality is fundamental for many religions, its importance and feasibility started to be possible with the emergence of human rights as subject-matter of international treaties, the commitment and responsibility of governments and other organisations which have the power to exercise them. (Slim, 2002) The promotion of human rights of disaster-affected people or those suffering from long-term hunger or conflicts is one of the side effects of international assistance, though not all organisations identify themselves with these efforts and such promotion is not always practicable.

"It is no exaggeration to say that the idea of universal human and civil rights is the only common ground for political thought in the modern world, if not the only possible common ground." Human rights constitute an important framework for tackling the issues of justice, rights and duties at the international level. The UN in its documents, such as the Millennium Development Goals, sees the extreme poverty as a violation of human rights. (UN Millenium Declaration, 2000). All human rights and fundamental freedoms should be considered as indivisible and interdependent, that means the issue of poverty cannot be separated from the issue of human rights. This prerequisite is sometimes impracticable, which makes it a major topic in the discourse of international assistance. (Riddell, 2007) This is mainly due to non-existence of adequate coercive measures to ensure that states that have certain obligations imposed upon them (and which often acknowledge such an obligation by signing them), actually recognise and observe these rights. In such circumstances, humanitarian workers often find themselves aspiring to relieve human suffering, e.g. hunger, without taking account of observance of human rights by the state authorities. This activity is aimed at a higher principle than the request for human rights, i.e. rescuing lives and human dignity.

The human rights issues, and an emphasis on the observance of them, be it at the level of individual states or international organisations engaged in international assistance, are both crucial topics. The stress laid on observance of human rights is usually a kind of barter at the international level, it is used for example in provision of loans for certain countries. It is often too easy to lay stress on human rights in the countries which are well-known for their dependence on international assistance. It is far more difficult to mention human rights in the countries which function as international creditors and no such topic is really raised many times. Even the organisations engaged in international assistance may find themselves in a situation when open declaration of their human-rights positions would prevent them from further operation in the country. Such situations tend to become a source of ethical dilemmas.

At the level of the suffering, the conscious perception of people (recipients of assistance) with respect to their human rights is of the greatest importance for the ethics of assistance. Shifting the approach from philanthropic to human-rights-oriented one certainly has an enormous impact on the recipients as they are taken as human beings with their own rights, dignified persons with equal rights, who get justice. These rights constitute a framework of

universal values, they are related with justice, they much rather contribute to the victims' dignity than victimise them. An emphasis on human rights prevents a paternalistic attitude among assistance providers. Human rights establish clear standards and objective criteria for human behaviour in situations full of passion and prejudice and may also become the criteria according to which people would be called to account. A problem in asserting the human rights in different cultures may be seen in their close connection to the Western culture, which can arouse resistance in certain governments. As experienced many times in Europe, any ideology in specific situations may become a blessing or a curse, depending on who controls it (Slim, 2002). Assistance provided on the basis of human rights is definitely more time-consuming and can be applied primarily in the follow-up and development assistance. From the recipients' point of view, both these aspects of assistance and human rights are not to be missed, but from a long-term perspective it is much more important whether the recipients finally gain their rights (this is particularly true of the ethnic minorities' rights being deliberately disrespected). Unfortunately, humanitarian organisations are in a situation where making the observance of human rights a condition of humanitarian assistance may hinder many countries and the needy from being provided with any assistance at all, due to the fact that the human-rights approach cannot be applied as there is no one to fulfil the commitment and the humanitarian organisations are often allowed to provide the assistance on condition that they pass over the human rights violation in silence.

International humanitarian organisations often argue that by criticising the human rights violation they may expose their aid workers to danger coming from the violating party; thus some of the organisations just close their eyes to the violation of human rights. Another argument is that by pointing to the violation (acts of gross violation, such as restriction of personal freedom, rape, etc.), they would run a risk of being expelled by the government responsible for the violation, without even reaching the needy. Other organisations and those strictly oriented towards protection of human rights argue that complex crises, which form the background for such situations, would be history long ago if the country adheres to and observes human rights. The act of ignoring the violation of human rights does not only involve the international humanitarian organisations but also governments whenever they find it politically advantageous; nevertheless it is one of the most flagrant signs of politicisation of the assistance. The dilemmas for the humanitarian organisations persist anyway. Thanks to various crises, such as those experienced in Bosnia and Rwanda, assistance that does not take into account the observance of human rights is nowadays considered short-sighted. Of course, individual cases differ from each other and they always create appalling dilemmas which should be weighed up carefully and which are likely to offer no optimal solution (Weiss, Collins, 2000).

### 3.6. Rights of the victims and duties of humanitarian workers.

The Humanitarian Charter declares that all the affected civilians have rights to live in dignity, to protection and to assistance (Sphere 2011, p.21). This right is derived from international human-rights documents, humanitarian and refugee law. If such a law exists, there must also be an obligation to obey it. This obligation arises for the humanitarian organisation if states are not able or willing to fulfil it. The declaration of obligation to assist, support and protect is a subject for debates at the international level. The leading opponent of the obligation is the organisation "Médecins sans Frontières" which refuses the *duty* to assist while insisting on its *right* to assist. They are too particular about their tradition „sans frontières" and "droit d´ingerence" (Ruffin, 1994). This might be the reason why they did not accede to the Sphere Process. Humanitarian organisations charged themselves with various obligations and duties in the Humanitarian Charter, yet in the very same text they mention that there are many crisis-affecting factors which lie outside their control (Slim, 2002).

The protection of civilians is guaranteed by the Geneva Conventions – mainly by the Fourth Geneva Convention and the amendment protocols. In addition, the protection of civilian persons has been confirmed by two tribunals: the International Criminal Tribunal for the former Yugoslavia and the International Criminal Tribunal for Rwanda. Protection of civilians is the core idea on the basis of which the International Criminal Court was established. It is often hard to tell who are civilians in the

environment of internal conflicts. „Talking about the general category of "civilians" does not work with people at war because it is not a general group that concerns a warring party. Instead, it is a very specific group they hate and want to kill. It is those Sunni or those Shia, those Hutus or those Tutsis, those Israelis or those Palestinians, those Tamils or those Sinhalese. You need to talk to people about their specific enemy and not about some general idea of civilians." (Slim, 2007, p.270). The Geneva Conventions are but rules which are of no interest to civilians. It is necessary to take a look at the moral reasons why these rules were established, that there really are moral reasons why civilians should be protected. These may include: the value of human life, mercy, endeavour to fight fairly, consciousness of innocence, etc. Slim is convinced that in conflicts, people tend to think in a duality pattern – friend/foe (often at very short time intervals), if there is something vital it is the change in thinking – instead of this dual thinking pattern they need to resume their pro-civil thinking, because it is normal not to have an enemy. Slim believes that there is some archetypal thinking, which leads to the restriction of the conflict, i.e. in terms of life preservation. There is a consciousness of common humanity… These values along with the archetypal thinking should become the foundation stones for creation of the pro-civil thinking (Slim, 2007).

#### 4. Do theories and principle give a sufficient answer? Prudence and practical wisdom, do no harm.

There are many theories representing different ways of dealing with dilemmas, but there is still no clear solution provided. In order to complete the answers to the research question there have to be other principles arising mostly from experience and practical wisdom. It is quite obvious that none of these approaches may be applied to an absolute extent, on the contrary, as suggested above, the combination of both is often the only possibility left (if any). The obligation of duty and potentially negative impacts of "blind" help within the framework of the charitable and philanthropic approach are balanced by the necessity to minimise the influences, i.e. the utilitarian principle.

The principle "Do no harm" could be understood as one which will minimize the negative impacts of the assistance in difficult contexts. It is well-known in the sphere of medicine and social work (primum non nocere) and is also known in the field of humanitarian assistance primarily connected with Mary B. Anderson, who collaborated with a team of colleagues to summarise her experience, carried out the case studies and on the basis of voluminous cases she designed an analysis of conflict as well as the opportunities when the conflict might be influenced. These are opportunities to help in the conflicts, how assistance and conflict interact, what to do when situation seems desperate. Assistance may deepen the conflict or prolong it, but it may also lead to conciliation and lessening of the tension. Methodology that is based on long experience of work in conflicts encompasses methods of avoiding the escalation of the conflict, allowing people to free themselves from the conflict, and creating alternative system where the organisation may still operate even in the conflict environment. Not to stop assistance, because it failed in many conflicts, but to find the way to make the assistance possible, so that it can help people survive, gives them hope and contributes to peace. A very important part of the "Do no harm" method is the support of the conflict-affected people that would direct them to the use of their own resources and capacities for peace. This applies primarily to the analysis of internal conflicts and assistance provided during civil wars. The method also describes various negative messages which are often unintentionally passed on by humanitarian workers towards the locals; these messages can be rectified. Although the method is called "Do no harm" it is not only about how to arrive somewhere and do no harm; the minimalistic request "Do no harm" is rather a sign of humble approach to a complex issue (Anderson, 1998). Many personalities in the sphere of humanitarian assistance consider the method outdated, it is not necessarily that obsolete. The humble approach that strives to understand may become a foundation for the "invisible" support of communities in their mutual conciliation and development.

Humility, prudence, providence or practical wisdom are often mentioned as the secondary principles wherever the single principle cannot be adhered to. This is the reason why Paul Ricoeur recommends that the teleological and deontological views should be neatly interlinked rather than mutually excluded. This would lead to a creation of "inventive behaviour which may satisfy the victims' demands while not entirely compromise the principles." (Ricoeur, 1990, p.312). It is, in fact, a kind of "exception" to the

rules. Wisdom lies in the sensitivity to recognise the appropriateness of such an exception. Of course, there is no magic formula that would guide you through the individual situations. Humanitarian situations are full of unpredictable moments and every one of them needs to be considered responsibly. This may be another reason why there are so many international non-governmental organisations with different moral values between which one should always find correspondence. "At the end of deliberation, prudential judgement mobilises the experience gathered from the past, the knowledge of the principles, the faithfulness to the originating ethical intention, the refined appreciation of the situation, the power of invention of the ´creative imagination´, consideration for the consequences of the action. Thus, it will be understood that ethical richness is concentrated in the act of prudence." (Etxeberría, 2001, p.93).

### 5. Conclusion

I hope I have met the goal of the article introducing some ethical theories and principles the humanitarian worker could rely on. Nevertheless we have to be aware of the fact, that the core ethical dilemma in the situation is that no solution is really good, and therefore humanitarian worker always carries the responsibility for these solutions on his shoulders.

Blind application of the principles does not bring any result – almost any behaviours can be justified: the humanitarian worker has either to stay because he has to help according to his duty or he has to leave because the situation does not correspond to his principles. He has to stay because he wants to protect and support human dignity but he has to leave because the human dignity is being trampled and the assistance has no meaning from the longer point of view. He has to stay because he hopes that the help to the needy outweighs the amount of misappropriation of his efforts. He has to leave because he cannot be neutral in such a situation. He has to leave because he is not able to protect and he stays because he is compelled to help and protect...

It is not a blind application of principles that is needed. It is the knowledge of all those principles, the skills to combine them, the unique wisdom of the individual, prudence, humility, experience, openness to new situations and contexts that is needed for the new challenges.

### Bibliography


ANDERSON, M.B. **Do no harm**. Lynne Rienner Publishers, 1999.

ANZENBACHER, A. **Úvod do etiky.** Praha: Academia, 2001.

ETXEBERRÍA, X. **The Ethical Framework of Humanitarian Action**. *In Reflections on Humanitarian Action.* Pluto Press 2001.

HABIBI, D.A. **Human Rights and Politicized Human Rights: A Utilitarian Critique**. *Journal of Human Rights,* 6, 2007, pp.3-35.

HILHORST, D. **A Living Document?** The Hague: Disaster Studies Wageningen University, 2004.

KANT, I. **Základy metafyziky mravů**. Praha: Nakladatelství Svobody, 1990.

LÉVINAS, E. **Být pro druhého**. Praha: Zvon, 1997.

POLMAN, L. **We did nothing.** Penguin Books, 2004.

RICOEUR, P. **Soi-même comme un autre**. Éditions du Seuil. Paris: Points, 1990.

RIDDELL, R.C. **Does Foreign Aid Really Work?** Oxford University Press, 2007.

RUFIN, J.CH. **L'aventure humanitaire**. Gallimard, 1994.

**Security Council Resolutions**: http://www.un.org/Docs/scres/1994/scres94.htm (accessed December 10, 2011)

SINGER, P. **Famine, Affluence, and Morality**. *Philosophy and Public Affairs. 1*, 1972, 1, pp. 229-243

SINGER, P. **Practical Ethics**. Cambridge University Press, 1993.

SINGER, P. **The Life You Can Save**. New York: Random House, 2009.

SLIM, H. **Not Philanthropy But Rights: The proper Politicisation of Humanitarian Philosophy.** *The International Journal of Human Rights*, 6,2002, 2, pp.1-22.

SLIM, H. **Killing Civilians. Metod, Madness and Morality in War.** United Kingdom, HURST Publisher, 2007.

TERRY, F. **Condemned to repeat?** Cornell University Press, 2002.

**The Sphere Project**: http://www.sphereproject.org/content/view/720/200/lang,english/ (accessed December 10, 2011)

**UN Declaration of Human Rights:** http://www.ohchr.org/en/udhr/pages/introduction.aspx (accessed December 10, 2011)

**UN Millenium Declaration**: http://www.un.org/millenniumgoals/bkgd.shtml (accessed December 10, 2011)

WEISS, T.G., COLLINS, C., ed. **Humanitarian Challenges and Intervention.** Westview Press, 2000.

# Social Care in Czechoslovakia in the 70s and 80s of the 20th Century

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**Abstract**

The objective of this article is to react to negative evaluations of the 70s and 80s of the 20th century in Czechoslovakia published by contemporary authors. Findings obtained on the history of social care and social work in the studied period rest upon scientific procedures using relevant research strategies. Methodologically, the results are based on historical research, which is a specific type of scientific research dealing with history. Primary and secondary sources of written character deposited in the Research Institute for Labour and Social Affairs in Prague and the Ostrava City Archive are the subject of this research. To ensure validity of the findings from the content analysis, the research technique of questionnaire and semi-structured interview is applied within the methodology triangulation. Social care after 1970 concentrates on five areas of interest: care for elderly citizens, care for citizens with changed work abilities, care for children, young people and family, care for socially maladjusted citizens, and care for citizens of Roma origin. In terms of its content, the article deals with common features of social care indentified in the particular target groups.

**Key words**

history of social work, historical research, social care, target groups

## 1. Introduction

This article reacts to the predominantly negative evaluations of the development of social care and social work in Czechoslovakia in the 70s and 80s of the 20th century. Contemporary specialized literature in the Czech Republic has not given appropriate attention to this issue yet. For instance, Jiřina Šiklová (2001: 148) reminds us that numerous research investigations into understanding the life in socialist Czechoslovakia were conducted, the results of which have not been fully valued and have been waiting for elaboration. So far there has been no publication of a historical nature, dealing with historical development of social work in Czechoslovakia in the studied period in a comprehensive and systematic way. If there is a mention in a specialized article about social care or social work in the 70s and 80s of the 20th century, it is very likely to be an unflattering statement not supported by any relevant research strategy. I regard the cause of the unsubstantiated comments as a common association of everything happening in Czechoslovakia in the studied

period with the influence of the governing political party in the country. Also Miloš Večeřa (2001) points out that the issue of social policy and social securities as *"priorities of real socialism"* before the November 1989 carried ideological and populist connotations. The aim of historical research is to enrich the data published so far through findings obtained solely by a relevant research strategy, supported by triangulation methodology.

## 2. Methodology

To obtain findings of historical nature in the field of social work, the method of historical research is applied, which is basically a qualitative research strategy approach. As Hamilton claims (in Berg, 1998: 43) historical research enables contemporary scientists *"to burst the bonds of their own period"* and to descend into the past. The work rests upon the background of hermeneutic thinking. One of the functions of hermeneutics is interpretation of old texts. Historical research consists in identification, analysis and interpretation of old texts as well (Špiláčková, 2011a). Content analysis combining theoretical and descriptive approach after J. Plichtová (1996) was selected to be the research technique used. Text documents of primary and secondary character deposited in the library of the Research Institute for Labour and Social Affairs in Prague and the Ostrava City Archive are the subject of this research.

I give the following official documents as an example:

- documents from the Ministry of Labour and Social Affairs of the Czechoslovak Republic such as Methodology Aids for Employees at National Committees, Methodology Manuals, Methodologies, Methodology Guidelines,
- research papers and Final Reports of the Czechoslovak Research Institute for Labour and Social Affairs,
- public official records of Committees of Social Affairs and Health in Ostrava, election programmes of the National Front etc.

To ensure the validity of the findings within triangulation methodology, the research technique of questionnaire and semi-structured interview was applied, in which the respondents are direct participants of social care of the 70s and 80s of the 20th century in Czechoslovakia. On one hand, the respondents' answers support the information obtained from the then materials; on the other hand they contribute to enriching the work through facts which are not recorded in the written materials. **The brief description of the historical development of social care** in the particular target groups in the 70s and 80s **is an interpretation of the findings obtained through historical research**. A comprehensive description of the methodology used including an entire overview of the obtained findings is available in both of my university graduate papers titled *History of Social Planning in Ostrava* (Bednárková, 2006) and *Social Planning in the 70s and 80s of the 20th Century in Czechoslovakia* (Špiláčková, 2011a).

## 3. Terminological Definitions of Terms

Terms used, such as social policy, poor relief, social care etc., were and have been mostly ambivalent (i.e. not entirely specific) and they have been developing throughout history. Different definitions by individual authors were and have been no exception (Tomeš, 2010).

The word "**social**" is of Latin origin. As Tomeš (2010) states, after the World War II the adjective social was used according to the Dictionary of Czech Language from 1948 with the following meaning:

- related to society
- concerning improvement of social conditions
- concerning provision of material resources.

According to Kutty et al. (1980) the word "social" in a broader sense means that what is studied within social sciences as opposed to natural or engineering sciences. More specifically, the word social is sometimes equated with the term *"sociological"*. Lamser (in Novotná, Schimmerlingová, 1992) mentions at least two meanings of the attribute "social". The first meaning corresponded to the connotation "concerning human society", the other was more specific and denoted phenomena, processes, cases, problems or situations in need of a solution.

**Social care** is a part of social policy of any state (Schimmerlingová, Novotná, 1992a). In the system of community care[2] for people, social policy represented a superordinate category out of which basic principles of social work were constituted (Novotná, Schimmerlingová, 1992).

The term social care has been used in the territory of the present Czech state since as early as the end of the 19th century. Social care replaced the older term poor relief and it was used as an expression to comprise all public social administration (Tomeš, 2010). Normatively, the content of social care was regulated the Social Security Act from 1975 (No. 121/1975 Coll.). Pursuant to this act (Section 80, Art. 1), social care was perceived as government aid to citizens who happened to be in adverse life circumstances which they were unable to overcome without community assistance. Within social care, allowances and social services were granted. Also Novotná, Schimmerlingová (1992) rank social services along with allowances among forms of social care. After 1989 the term social care was replaced by the term **social assistance** (Schimmerlingová, Novotná, 1992b).

It follows from these points that social care was included with the social policy system. Social work practice was most often implemented within the scope of social services which represented one of the two forms of social care. However, the performance of social work was not explicitly regulated by the Social Security Act.

## 4. Social Planning – on the National and Regional Level

The principle of economic management in Czechoslovakia after 1946 was central planning, the instrument of which was **a state plan** of a directive nature. The state plan defined the priorities and objectives of economic development, which meant that keeping to it was binding within the whole national economy. At party congresses, **social programmes** following the state plan were declared, as a rule every five years, which presented variations within the planning system. The social programme, also known as the social policy plan, was created in line with the state plan. It proposed concrete tasks for all areas of social policy in Czechoslovakia. A particular example of a social programme in Czechoslovakia is *the Concept of Social Services of Czechoslovakia from 1969*.

### 4. 1. Social Care Focusing on Enterprise Employees

**Long-term programmes of care for employees in enterprises** are considered to be one of the first social plan variations. Social care for enterprise employees is to be found in archival materials under different names. These are for instance: *"Planning of Work Groups Development"*, *"Plans for Enterprise Social Growth"*, or *"Care provided by Enterprises for Employees"* (Špiláčková, 2011a). First enterprises elaborated this programme as early as in 1971-1973 (Bednárková, 2006). Within the programme, care for the needs of employees or their families, care for individuals and for groups of employees requiring special and more intense organizational aid, and care for former employees of the organization and their families was specified. *Care provided by Enterprises* for employees focused on social activities for employees and assistance with employess´social problems. These activities were provided by a social worker in enterprise. The primary task of a social worker in enterprise was screening, which means searching for employees who needed assistance. The social worker was a member of a team which dealt with people, employees of work groups in the enterprise, professionally and systematically. The position of social workers within the enterprise was mainly influenced by the tradition and characteristics of each enterprise. The basic methods of social work were:

- collective or general work
- work with groups
- individual or case work

These methods of social work complemented one another, were interconnected and were part of social activities for employees and an assistance with employess´social problems. As a rule, social work was provided by a social department or department of care for employees, incorporated in staff (Růžička, Šálková in Špiláčková, 2011a).

### 4.2. Regional planning models

Following enterprise social planning, planning of social development of territorial units was developed in the late 60s. This was induced by the fact that social development of work groups did not embrace the life conditions of employees in a complex way. Plans for the social development of territorial units, in the first stage of towns and town districts, responded to deficiencies in plans of care for employees in enterprises (Kutta et al. in Špiláčková, 2011a).

The creation of plans in the social field also rested upon scientific findings about predicted

trends of the social system development which were based on social surveys monitoring social aspects of development trends in various fields. The whole practical social field was marked by its interdisciplinary character, and both quantitative and qualitative changes. This applied to social work as well (Charvátová, Brablcová in Špiláčková, 2011a).

**Regional planning models** were based on their respective statistical data and the specific nature of social problems. They represented certain transformation of the nationwide social intentions into a concrete, individual or group situation demanding a solution. A particular example of a territorial unit plan is *The Social Policy Model of the National Committee of the Town of Ostrava from 1973*.

The social policy plan and the territorial unit plan also included **a social work plan**. It provided space for creation and development of particular forms of social work. Cooperation between scientific and professional workplaces proved itself good at creation of these plans and conceptions. Research, exploratory social investigation and pilot projects were carried out, as well as analyses of statistical and demographic data.

## 5. Target Groups

In Czechoslovakia in the 70s and 80s of the 20th century, the notion of ***a target group*** appeared neither in practice, professional literature nor in archival materials, although care for certain groups of people was based on old traditions. In the Model of Social Services from 1969 **groups of problems** were included into a set of social services, such as care for children of working mothers and for healthy children in general, care for children difficult to educate, exposed to moral dangers or morally disturbed, care for elderly citizens, care for handicapped citizens and care for citizens requiring particular attention from society. The Social Policy Model of the National Committee of the Town of Ostrava from 1973 sought to aim social care more specifically. It described five areas of interest: care for elderly citizens, care for citizens with changed work abilities, care for children, young people and family, care for socially maladjusted citizens, care for citizens of Roma origin. It is clear from these examples that even though areas of care for target groups of citizens in the two Models were named differently, their contents and subject matter were interconnected and as a result, they formed a comparable unit (Špiláčková, 2011b).

### 5.1. Care for Older people

**Care for older people** concentrated on general aspects of care, i.e. on **maintaining their social integration**, maintaining older people's feeling of security and contentment, ensuring sufficient material resources necessary to satisfy all their life needs and interests and ensuring the social service as well as preventive therapeutic needs. Forms of care used in social services covered leisure and work activity of older people (pre-retirement training, finding suitable free time activities), their connection with the community (Pensioners' Clubs), facilitated their lives, household management and care for themselves (home care service, boarding for older people, visiting service), ensured suitable individual housing (targeted construction of flats), or ensured complex institutional care for older people in cases when living in an individual flat was impossible (old people's homes, treatment institutions, geriatric wards within departments of internal medicine in hospitals) (Špiláčková, 2011a). *The Model of Social Services* (in Špiláčková, 2011a) accentuated the **requirement of complex sociological research on older people' life** as it was no longer possible to rely on empirical knowledge only. A necessary precondition of social care was a qualified social worker, specially trained for social work with elderly people.

### 5.2. Care for Citizens with Changed Work Abilities

The main task of **care for citizens with changed work abilities (hereafter CWA)** in the 70s was to **ensure their return into the employment process** and into working groups. The basic forms of social care were social care allowances (financial or material), field services, institutional care and consultancy. Within social care institutions, ergotherapy and work activities became an inseparable component of the care complex. Ergotherapy along with therapeutic physical education and physical treatment formed a system known as **therapeutic rehabilitation**, the role of which was to gain and maintain health and thus also social integration. Roughly one in ten citizens with CWA employed belonged to a cooperative of disabled people. Manufacturing Cooperatives of Disabled People (hereafter MCDP) created,

within their respective possibilities, suitable work opportunities for handicapped citizens (Špiláčková, 2011a).

Care for children and young people with a handicap was in the 70s conceived in a complex way. It included modern medical care and special educational, psychological and social care. The main emphasis was placed on **improvement of consultancy care for families with a handicapped child**. Social help for citizens with a handicap was granted to the citizens in need through so-called **social advocates in MCDPs** or also through social workers at national committees, in hospitals, in enterprises (Špiláčková, 2011a).

### 5.3. Care for Children, Young People and Family

In the Model of Social Services (1969) the **care for children, young people and the family** was aimed at children and young people with learning difficulties, exposed to dangers to their moral development and with a mental handicap. **Committees for Care of Children** became responsible for this target group. In these Committees, as a rule, citizens who were professionally close to solving the issues of family and children tended to concentrate. The Committees for Care of Children paid special attention to **Care Assemblies for Families and Children** as a new form of participation of a wide circle of citizens in social care for families and children. The Assemblies functioned as auxiliary bodies on care for families and children to enhance the citizens' involvement in activities of national committees on social care for families and children. Volunteer counsellors' qualifications were increased by regularly held consultations, instruction meetings and methodology leadership (Špiláčková, 2011a).

In 1976 departments of care for families and children were reorganized. The work at the division for care of the family and at the division of care for children (social-legal protection of children and young people) was unified.

In the field of social care for abandoned or orphaned children, substitute family care was preferred, implemented by means of adoption or individual or group foster care. The system of substitute family care in the 70s was divided into the three following types: adoption or individual foster family (substitute family care in ordinary families), special facilities for foster care development (substitute family care with professional foster carers) and family group homes or Children's Villages (Špiláčková, 2011a).

To deal with the issue of social care for juvenile delinquents, specialized social workers known as **Youth Curators** were established (Špiláčková, 2011a).

### 5.4. Care for Citizens Requiring Special Community Attention

Issues such as alcoholism, prostitution, reoffending were included in the Concept of Social Services (1969) as **care for people requiring special community attention**. Community care for Roma citizens belonged to this group of problems as well (Špiláčková, 2011a).

With regard to the fact that there was no system of prison after-care, the Model of Social Services (1969) proposed a solution to the situation by means of social workers specializing in work with this group of people, establishing an institution to ensure transition from serving a prison sentence into community life, creating a system of continual social care in Educational Correctional Facilities and for people having been released from them, and **providing professional social work through a system of post-penitentiary care**. In Ostrava, the requirements of the Model were met in an ideal way. Parole officers as specialized social workers started to appear in the Czech Republic from 1969 and in the Slovak Republic from 1972. The modern approach to care for citizens requiring special community attention in CSR was not solely the matter of national committees but of a complex of institutions and organizations. Economic organizations were perceived to be one of the most important components within this complex. The main emphasis of work of parole officers and organizations in individual care for citizens requiring special community attention was **long-term care**. Reality therapy with its focus on the present situation and its solving, on client's nearest perspective in terms of both their work and private life, was well-suited for parole officers and also social workers from other fields (Špiláčková, 2011a).

### 5.5. Care for Roma Citizens

One of the main tasks in care for Roma citizens was building a network of specialized social workers, ensuring scientific research related to

Roma citizens and eliminating illiteracy in all age categories. An important feature of the Roma citizens' structure was the fact that 50.7% of the total number of Roma citizens were children younger than 15 years of age. **Boards on Issues for Roma Citizens** were established in places with high numbers of Roma citizens which were assisted in their work by **Assemblies of Voluntary Co-workers** (Špiláčková, 2011a).

The main emphasis of social work consisted of work with a group, particularly in work with young men and women. Examples include health-educational courses for adolescent girls and boys, summer recreational educational camps for Roma children, **social work with a group of Roma families within one house** or **within a municipality** (Špiláčková, 2011a).

The care for Roma citizens in Ostrava, covering all age categories but primarily relating to children and young people, attained the same success as prison after-care. Work with the youngest age-group started in the specialized class of a kindergarten in Ostrava-Poruba, continuing with 14-day **boarding courses for both Roma girls and boys** and finishing with compulsory school attendance, including the organization of **summer recreational educational camps** (Bednárková, 2006; Špiláčková, 2011a).

## 6. Common Features In Target Groups

In the studied period, the attention of social workers concentrated on the particular target groups mentioned above. Having described the development of social care, I identify common features which appeared in the particular target groups. These are creation of card indexes of citizens in social distress, establishing Boards of Social Care for the given target group, involvement of the public and community organizations in assistance, extending the work classification of social workers to cover newly emerged target groups, application of methods of social care and the development of research activities. Below, the particular common features are dealt with successively.

### 6.1. Social Screening – Card Indexes

Alongside the emergence of newly-formed target groups, the need originated to create card files of people who were provided with or offered help by social workers. Detailed record keeping was a necessary precondition for long-term work with citizens in need. The first way of creating any records of citizens in social distress was in the past mainly through social screening. Social workers went out into the field and actively searched for people in social distress. Also citizens' committees, medical doctors, nurses from the home care service and voluntary co-workers from community organizations such as the Czechoslovak Red Cross etc. cooperated at obtaining the information. There were two types of records of people in social distress: **a) living records** including files of citizens whose social situation was subject to current examination by a social worker and **b) quiescent records** including files of deceased citizens. The quiescent records were discarded in compliance with valid regulations. In Ostrava, due to the lack of social workers, questionnaires were used to particularize the records until mid-1973.

### 6.2. The Boards

National committees, as the main pillars and organizers of community care established Boards for each target group. In these Boards, as a rule, citizens who were professionally close to solving the care issues of the given target group concentrated for cooperation. These were employees of courts, public prosecution departments, of the then Public Security Forces (today's Police), health facilities etc. Examples of them are ***The Committee for Care of Children, the District and Administrative Board for the Protection of Public Order*** or ***The Board on Issues for Roma Citizens***. In districts of the North-Moravian Region and at the district committees of the City of Prague ***Boards for Educational Correctional Activity*** were established, too. The Boards became a panel for collective resolution of both individual cases and general issues (Brabenec, 1972). Their tasks included participation in the elaboration of plans to solve the needs of the given target group in a complex way and adopting perspectives on all crucial questions. The Boards were assisted in their work by ***Assemblies of Voluntary Co-workers***.

### 6.3. Assistance of the Public and Community Organizations

An important intermediary between the state, as the provider of social care, and target groups, as its recipients, was the public. During the studied

period, involvement of the wider public into help to the people in need in Czechoslovakia can be demonstrated. It was implemented by means of a system consisting of two elements - the signalling service and the function of volunteer counsellors'.

The signalling service was based on active searching for people of all age categories, primarily elderly people and children, from risk-creating milieux in need of community help, and on notifying the national committees of these cases. The signalling service could also be provided by people who came in contact with elderly citizens in their households due to their job duties, e.g. postmen or the Socialist Union of Youth members. The function of volunteer counsellors, as another opportunity for citizens' involvement in assistance for those in need, presented a significant form of voluntary citizens' participation. It was used, for instance, at the division of care for children and the division of care for elderly people. The most notable share in a voluntarily developed social activity can be credited to the following community organizations: the Czechoslovak Red Cross, the Socialist Union of Youth, the Women's Union, the Union of Disabled People. The legal framework for carrying out voluntary social action was subject to a government resolution. The tasks of volunteer counsellors involved drawing attention to needs of children and young people whose upbringing showed serious deficiencies or to needs of elderly people who lacked care. Selected citizens were appointed to their functions by district national committees. The work content of a volunteer counsellor was grounded in providing a constant liaison among districts, municipalities and the district national committee. Social workers built an organized network based on individual counsellors – a board of social counsellors, so-called **Assemblies**. National committees ensured leadership in practice method development for the Assemblies' members and they also actively participated in the leadership. The Assemblies functioned as auxiliary bodies and served to enhance citizens' participation in the activity of national committees in the field of social care. The membership in an Assembly was honorary.

Volunteers in Ostrava formed an inseparable and very important part of social care for citizens requiring special community attention. Volunteers were also engaged in the area of care for Roma citizens, and they created Assemblies of Voluntary Co-workers, most frequently from within the Roma citizens themselves. Through their way of living, they set good examples to other Roma people.

The role that volunteer counsellors or the signalling service performed in the past is in many ways comparable with present-day voluntary work.

The motivation or reasons which led to citizens' willingness to become a counsellor or to work with and to develop the signalling service is a contentious professional issue. I am aware of the complexity of potential explanations, which were not the subject of this historical research project. Research is needed to establish and further elaborate citizens' motivation in performing the function of volunteer counsellors.

### 6.4. Education of Social Workers

At the turn of the 70s of the 20th century, new target groups requiring community care came into existence. Practice reacted to this fact by preparing qualified social workers whose specialization was focused on the given target group. The preparation mainly consisted in an additional training course tied to a course of higher education. The following table presents an overview of the work classifications of social workers.

***Tab. No. 1. Typology of Work Classification of Social Workers***

| Target group | Specialized social worker |
|---|---|
| Employees in enterprises | Enterprise social worker |
| Older people | Field social worker |
| Older people in an institutional facility | Nurse for social service |
| Citizens with changed work abilities | Social advocate (in Cooperatives of Disabled People) |
| Children and young people with educational problems | Youth curator |
| Socially maladjusted citizens | Parole officer |
| Roma citizens | Social worker for solving problems of Roma families |

(Špiláčková, 2011b)

*"Nurse for social services"* emerged as a new line of work and it was performed by nurses (general health nurses, children's nurses, gynaecology nurses) mainly in institutional care facilities. Social service in health facilities was directly linked to the activity of social workers. Nurses obtained their qualifications by education linked to higher education course and specialization. The work content of a social worker and a nurse for social services was markedly similar (Anthology of Lectures in Špiláčková, 2011a).

University level education in the field of social work was for a long time discontinued after two universities closed in the 50s. Both experts and individual social workers, who would have applied their knowledge, skills and abilities as teachers or academic research workers, if university education had existed, "involuntarily" had to move into practice. Also graduates of these last universities specialized in social work asserted their knowledge mainly in practice. I hypothesise that a paradoxical benefit of the non-existent academic level of education in social work was that of creating an influx of qualified professionals into practice. Their knowledge and skills in the field of theory, methods of social work and research in the social area, not asserted within university education, but applied in social work practice, resulted in remarkable development of social work.

### 6.5. Methods of Social Work

In the studied period, especially the **diagnostic model of social work** was used, which fully corresponded to the then level of understanding. The main causes of problems were considered to be clients' personality traits. Social workers, in line with the applied model, determined the client's diagnosis which was followed by a therapy. Methods of social work described within the profession and applied in practice used in Czechoslovakia in the 70s and 80s of the 20th century were case work and social group work. Community social work as the youngest method of social work is mentioned in archival materials only to a lesser extent. It appears under the terms of social work in a municipality, social work in a region or social work in a territorial community. Schimmerlingová (1972), too, highlights the fact that in the Czech literature up to that point nobody dealt theoretically with interpretation and definition of the term of social work in a community from the perspective of social work methods.

Apart from traditionally applied methods and techniques of social work, completely new methods developed in the studied period. They found their use mainly in the field of care for citizens requiring special community attention and care for Roma citizens in Ostrava.

In the Centre of Labour Education for Young Citizens Requiring Special Community Attention in Ostrava, social work was performed after an individual social therapeutic plan which was formed in cooperation of parole officers with external experts. The **Socio-therapeutic Plan** was a plan to solve the given individual problem, to indicate the particular social actions (interventions and measures) and their time sequence. It was aimed at rendering social help with health, finance, accommodation and placement into the employment process, and it was oriented towards initial stabilization of the client (Parole Officers Team, 1974). With its content focused on fulfilling planned tasks within a set time period, it bears features of the Reid and Epstein's task-centred approach.

Social work focusing on citizens requiring special community attention applied **Glasser's reality therapy** at which two important trends can be noted:

1. reality therapy focused on the client's present and future,
2. in long-term practice with clients, used up to then, diagnostic approaches, were typically used and started to shift towards more effective short-time therapy (Špiláčková, 2011a).

The Prison After-care Centre sought new forms of work with clients, including group work in a small group with the active assistance of already rehabilitated clients. The beginnings of social work with people under suspended sentence, today referred to as probation, can be found in the 70s (Bednárková, 2006).

Another target group in which new methods of social work were introduced was care for Roma citizens. The practice of social workers in care for Roma citizens brought new types of group social work. Apart from social-health courses for adolescents and summer recreational educational camps, mentioned above, social work with a group of Roma families within one house or

social work with a group of Roma families within a municipality was done.

### 6.6. Research Activities

Research activities formed an inseparable part of the social work planning. Relevant research strategies ensured analyses of the population age structure and other demographic and statistical data within a territory. At creation of models, cooperation with scientific and professional workplaces proved successful, as they also conducted minor research, exploratory social investigation and pilot studies, as well as analyses of centrally collected statistical data (Charvátová, Brablcová in Špiláčková, 2011a).

Research was carried out covering all the studied target groups. The following pieces of work are examples of the most interesting ones:

- Research with the title *"Research on the Life and Needs of Elderly Citizens"*, the investigator of which was PhDr. Věra Schimmerlingová, was elaborated in two stages – *Life Conditions of Elderly Citizens in Towns* and *Life Conditions of Elderly Citizens in the Country* in the years 1978 and 1979.
- Research with the title *Social Care for Severely Health Impaired Citizens* from the period of 1986-1990, the investigators of which were T. Čakrtová, a graduated lawyer, Doc. J. Škaloud, CSc. and Dr. J. Veselá.
- In the years 1977 – 1978 *Research on Parole Officers* was carried out as one the four planned stages of research in the area of prison after-care. Its investigator was Doc. Ing. L. Junková, CSc., the author of the final report was M. Čermáková.
- In December 1970 the Institute for Public Opinion Research conducted public opinion research with the title *Opinion on Roma People.*
- Research *Roma Children in Substitute Family Care* from 1977*,* which was aimed at obtaining a comprehensive view of the state of substitute family care for Roma children in the 80s (Špiláčková, 2011b).

An important role in the area of scientific and research activity in Czechoslovakia was played by the Research Institute for Labour and Social Affairs. In Slovakia in 1964 ***The Research Institute for Labour*** (later renamed as *The Czechoslovak Research Institute for Labour and Social Affairs*) and ***The Research Institute for Living Standards*** were established. At the beginning of 1984 these two institutes merged and ***The Research Institute for Social Development and Labour*** (RISDL) was formed as one of the five centres of economic research in former Czechoslovak Socialist Republic. Its headquarters was in Bratislava and it had a branch office in Prague. The significance of the RISDL as a scientific and research institution was considerable. It was one of the few federal workplaces based in Slovakia which enabled contacts with foreign countries and development of know-how, including personal growth of Slovak professionals in the field of social research (Bednárik, 1999).

## 7. Conclusion

In the contemporary specialized literature the field of social care and interconnected social work in Czechoslovakia in the 70s and 80s of the 20th century is neglected. In my opinion, the lack of experts' interest in carrying out research activities with the aim of analyzing and describing this period is caused by insufficient knowledge. The period concerned is commonly connected with ideological influences on developments in the country, which I consider as one of the reasons of absent interest in findings of historical nature on the side of professional public. This rather negative evaluation of social care also means the marginalization of the real existence of social work between the years 1968 – 1989. The objective of this article is to enrich the information published so far using historical research as a relevant research strategy, and thus helping to uproot the usual myths about social care and social work in Czechoslovakia in the given period.

In the studied period, the system of central planning was applied, the instrument of which was a state plan subsequently reflected in prepared social programmes and models of social policy and social care on both the national and regional level. Social work plans were an inseparable part of these. This way of planning had its undisputed advantages as it enabled unification of selected work procedures. Hence it was possible to rely on them for instance within the government budget or important documents. Methodology materials issued by the Ministry of Labour and

Social Affairs were aimed at making social work with particular target groups of citizens more effective. They offered the latest methods of work, examples from practice and models of solutions to problematic situations (Špiláčková, 2011a).

*"Although social policy in the 70s and 80s was responsive to the then regime, it cannot be stated that it did not exist"*, Ing. Petr Víšek said in an interview. Social services were being developed in a very successful way. The system of prison after-care was established, as well as the system of social protection of handicapped children and young people, and foster care was being intensively developed. Social services in Czechoslovakia were so renowned internationally, that excursions from all over the world to our social facilities were organized (Víšek in Špiláčková, 2011a).

Social care focused its interest on five target groups: care for elderly citizens, care for citizens with changed work abilities, care for children, young people and family, care for socially maladjusted citizens, and care for citizens of Roma origin. Based on active searching for citizens in need out in the field, social workers created index files which were a basis for long-term work with clients. The general public was an important intermediary between social workers and clients. Its assistance was implemented by means of signalling service and voluntary service within community organizations. Cooperating organizations were the Czechoslovak Red Cross, the Union of Disabled People, the Czech Women's Union and the Socialist Union of Youth. At the beginning of the 70s, their assistance focused on the field of care for older people and care for children, young people and family.

The development of social care was accompanied by corresponding development of social work. In particular areas of the social care interest, the traditional diagnostic model of social work was applied which was based on the triad of terms: anamnesis, diagnosis and therapy. As to the intervention technique, social case work and group social work prevailed. Professional public and social workers also started to turn their attention to its newest technique – community social work. Apart from traditionally applied methods and techniques of social work, completely new methods developed in the studied period. They found their use in the field of care for citizens requiring special community attention and care for Roma citizens. The existence of new target groups further necessitated specialization of social workers. New work classifications of social workers with regard to the clients' needs emerged. Taking into account that education in social work was only possible on the level of a follow-up training course, specialization was implemented by means of additional trainings. Preparation of models and social programmes could not go without findings from research projects. Research activities were carried out in all areas of the social care interest.

State intervention in the form of government plans and concepts of social policy contributed to the development of social care and social work even in the period after 1968, which was connected with a high-quality level of the work undertaken then. Social work developed continually as a specialized branch and methodology for practice as well. Its growth may be credited mainly to enthusiastic individuals who were unable to apply their abilities, learning and developed knowledge at the missing stage of university education in the field of social work. They brought the latest knowledge from the theoretical area and methods of social work into practice and thus contributed to introducing new professional social services for existing target groups, for example in care for children, people with changed work abilities, socially maladjusted citizens, for elderly people or for Roma citizens. Social work did not discontinue its renewal process after 1968, on the contrary it became extended, and in a significant and noticeable way (Špiláčková, 2011a).

**BIBLIOGRAPHY**

BEDNÁRIK, R. **Sociálny výskum na Slovensku.** In STRIEŽENEC, Š. **Úvod do sociálnej práce. (**Introduction to Social Work). Trnava: AD, 1999. p.143.

BEDNÁRKOVÁ, M. **Historie sociálního plánování v Ostravě.** Diploma thesis. Ostrava: Medical-Social Faculty of the University of Ostrava, 2006.

BERG, B. L. **Qualitative Research Methods for the Social Science**. Long Beach: Allyn and Bacon, 1998.

BRABENEC, F. **Sociálně právní ochrana dětí a mládeže.** In **Péče o děti**. Příručka pro pracovníky národních výborů. Compiled by Olga Teplá. Prague: MLSA, 1972. RILSA, sign. G 3378. pp.61-85.

Kolektiv sociálních kurátorů Správy sociálních služeb NV hl.m. Prahy. **Průběh resocializační péče.** In **Péče o občany společensky nepřizpůsobené**. Metodická pomůcka pro pracovníky národních výborů – praktická část. Prague: MLSA CSR, 1974. pp.38-114.

**Koncepce sociální politiky Národního výboru města Ostravy do roku 1980.** Ostrava: Department of Social Affairs of NCTO, 1973. OCA, sign. A 11295.

**Koncepce sociálních služeb.** Prague: MLSA CSR, 1969. RILSA, sign. F 8918.

KUTTA, F. et al. **Sociální plánování a programování**. Prague: University of Politics, 1980. RILSA, sign. G 5242.

NOVOTNÁ, V. SCHIMMERLINGOVÁ, V. **Sociální práce. Její vývoj a metodické postupy.** Prague: Charles University, 1992.

PLICHTOVÁ, J. **Obsahová analýza a jej možnosti využitia v psychológii.** Czechoslovak Psychology 4(40), 1996. pp.304-314.

SCHIMMERLINGOVÁ, V. **Metody sociální práce se starými lidmi.** Praha: MLSA CSR, 1972. RILSA, sign. G 3294.

SCHIMMERLINGOVÁ, V. NOVOTNÁ, V. **Poslání, místo a pojmové vymezení**. In Social Policy. Vol. 18, No. 1, 1992a, pp. 14-15.

SCHIMMERLINGOVÁ, V. NOVOTNÁ, V. **Změny kvality a obsahu. Teorie a praxe sociální práce.** In Social Policy. Vol. 18, No. 3, 1992b, pp. 16-17.

ŠIKLOVÁ, J. **Sociální práce v našem státě od druhé světové války do současnosti.** In MATOUŠEK, O. et al. **Základy sociální práce.** Prague: Portál, 2001. pp.139-153.

ŠOLCOVÁ, M. et al. **Sociální politika KSČ.** Prague: Svoboda, 1984.

ŠPILÁČKOVÁ, M. **Sociální plánování sedmdesátých a osmdesátých let 20. století v Československu**. Dissertation. Ostrava: Faculty of Social Studies of the University of Ostrava, 2011a.

ŠPILÁČKOVÁ, M. **Vývoj sociální práce v sedmdesátých a osmdesátých let 20. století v Československu.** In TOKÁROVÁ, Anna. (eds.) **Fenomén premeny vo vzdelávaní, kvalifikácii a sociálnej pomoci. Sociálne kontexty vývoja v minulosti, prítomnosti a**

TOMEŠ, I. **Úvod do teorie a metodologie sociální politiky.** Prague: Portál, 2010.

TOMEŠ, I. **Koncepce systému sociální pomoci.** Bratislava: RILSA, 1991. RILSA, sign. 892 a,b.

VEČEŘA, M. **Sociální stát. Východiska a přístupy.** Prague: SLON, 2001.

**Zákon č. 121/1975 Sb. o sociálním zabezpečení.**

### List of Abbreviations

| | |
|---|---|
| CS RILSA | Czechoslovak Research Institute for Labour and Social Affairs |
| CSRC | Czechoslovak Red Cross |
| CSSR | Czechoslovak Socialist Republic |
| CWA | Changed Work Abilities |
| Fold. No. | Folder Number |
| MCDP | Manufacturing Cooperatives of Disabled People |
| MLSA CSR | Ministry of Labour and Social Affairs of the Czechoslovak Republic |
| NCTO | National Committee of the Town of Ostrava |
| OCA | Ostrava City Archive |
| RILSA | Research Institute for Labour and Social Affairs |
| RISDL | Research Institute for Social Development and Labour |
| RNC | Regional National Committee |
| sign. | Signature |
| SSR | Slovak Socialist Republic |
| SUY | Socialist Union of Youth |

### Endnotes

1 E-mail of author: **marie.spilackova@osu.cz**

2 Authors of the study materials used both the term social care and community care simultaneously. By their meaning, they both represented "the care of the state, community", thus I consider them synonymously in the text.

# The Czech Childcare Policy Model The Principles, Goals and Functions of Early Childcare Services (0 to 6 Years) in the Czech Republic within the Context of European Childcare Policy Goals[1]

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Blanka Plasová is part-time researcher in the Institute for Research on Social Reproduction and Integration at the Faculty of Social Studies of Masaryk University in Brno, the Czech Republic. Her main research interests are focused on the issue of reconciling work and family life. Further, she analyzes childcare policy (evolution, evaluation of quality and availability of childcare facilities) in the Czech Republic as well as in other central-European countries. Until now she published mainly in Czech journals and also numerous articles in Czech anthologies about women's participation in the labour market, work-family imbalance as a new social risk and family-friendly policies on the level of employers. In recent years, she has also worked as a lecturer at Masaryk University focusing on the family policy, equal opportunities for men and women in the labour market and social programs within organizations.

**Abstract**

The main goal of this article is to clarify and characterize the principles, goals and functions of the childcare service system for children aged 0-6 in the Czech Republic in the context of the requirements and expectations of contemporary European childcare policy. Currently, the system of childcare is one of the fastest growing areas in the EU; however, this development is not occuring at the same pace or in the same way in all European countries (Sector Futures-Childcare Services Sector 2006). We can find two basic ideal principles on which European countries usually build child-care systems (Scheiwe, Willekens 2008). The first idea concerns the need of children below the age of obligatory schooling to be already publicly educated. The second idea promotes the reconciliation of care work and paid work, therefore it concentrates more on the needs of parents. We can say that in the Czech system of childcare there are both basic principles: the educational model and the reconciliation model. However, at the first glance there is an obvious difference between the concept of care for children from 0 to 3 years and that of children over 3 years of age; there is a strictly maintained division between the two in the Czech Republic. The provision of public care for children under 3 years (nursery schools) has practically disappeared. There is much pressure exerted on parents to take care of their children under 3 years within the family. This somewhat undermines the respect for differentiation among various family patterns, choices and strategies. On the other hand, the system of kindergartens for children of 3 to 6 years is a part of a social policy in the Czech Republic that is fully supported, and not just financially. Besides the mentioned main goal, this article provides also information about tools and measures which are available for social workers and about the conditions and also limits of the childcare system which represents (state) enviromental support for coping conflicting pressures between paid work and childcare.

**Keywords**

childcare policy, family policy, nursery, kindergarten, work-family reconciliation, early education, Czech Republic, European context

## Introduction and Legitimacy of the Topic

The topic of providing and ensuring a network of care for the youngest children in today's society is growing in importance for several reasons that interconnect, but may have different consequences on the structure and organization of the entire system. The need to build and/or provide accessible services of a particular type is primarily motivated by (1) current developments in the labour market and at the same time changes in the lives of families. There is an increase in the general uncertainty of the labour market in terms of specific jobs, but also of employment as such and the insecurity of ensuring adequate income (cf. Sirovátka et al. 2009). Furthermore, there is increasing pressure on the flexibility and adaptability of the workforce, which is forced to adapt relatively quickly to changing market needs, or the needs of employers (e.g. Taylor-Gooby 2004, Bonoli 2006, Esping-Andersen 1999, etc.). These trends go hand in hand with changes in the organization of the traditional division of labour between men and women, where the male was the breadwinner of the family and the woman was responsible for childcare and running the household (ibid.). With the massive entry of women into the labour market and pressure to promote the principles of equal opportunity for men and women, the model of the so-called male breadwinner begins to recede (even disappear). In order to mitigate the conflict between work and family life (especially of women), there is a growing need to outsource the care of dependent persons (e.g. Bartáková 2008). This externalization of domestic work and childcare can be provided either through government or market mechanisms (Bonoli 2006).

To a certain extent, these processes partially force the welfare state to assume some of the responsibility and to co-operate in providing childcare. It should be emphasized that these arrangements of the welfare state could be implemented in two basic ways, which are possible to combine. This can be done either through the promotion of parental early childcare, or through the support of non-parental (i.e. usually institutional) childcare services. Although the pressure to at least partly defamilize childcare services was started in some European countries earlier than in others, the trend is currently evident in all countries, even if it is disproportionately distributed.

(2) The second motive leading to the implementation of care for the youngest children is related to the development of post-industrial society as a whole, and again with the development of the labor market in particular. Many experts state that early childcare and particularly education are necessary for the subsequent acquisition of life-long skills, which are basic presumptions for effective participation in society, a knowledge-based economy/society and the development of a person's full potential (cf. Starting Strong I 2001, Starting Strong II 2006, Haddad 2002, Mahon 2002; Scheiwe, Willekens 2008, etc.).

(3) Another incentive to develop and provide childcare services is the prevention of child poverty, or at least the reduction or elimination of child poverty. This kind of incentive is connected to both the motive of reconciliation of work and family life (the financial security of the family, the necessity of a dual-earner family) and the motive of early childhood education (equal opportunity for disadvantaged children, increasing demands on the high qualification of workers in the labour market, etc.) (see, for example, Sector Futures - Childcare Services Sector 2006, Babies and Bosses 2007).

The main goal of this article is to clarify and characterize the principles, goals and functions of the childcare service system for children aged 0-6 in the Czech Republic in the context of the requirements and expectations of contemporary European childcare and family policy.

Firstly, different variations of non-parental care of children in the Czech Republic are characterized. In the second section, the requirements and targets of European childcare services are described. The third section analyses the ideal motives and principles on which the childcare services can be built. These European expectations and ideal motives are used as the main framework for the discussion of the principles, goals and functions of the Czech childcare services. In the conclusion the main "pressure points" of the childcare service system are summarized, including the implications of those pressure points for social work with families.

## Characteristics of the early child care system in the Czech Republic

In the Czech Republic at present, early childcare outside of the family is provided through nurseries,

kindergartens and various types of private childcare facilities. According to regulation No. 242/1991 Coll., on the constitution of health care facilities provided by district offices and municipalities, the term ***nursery*** is in a category of *special health service facilities.* Nurseries are meant to provide daycare for children up to about 3 years of age, usually. According to the Czech legal code they should provide *therapeutic-preventative care* and fall under the jurisdiction of the Ministry of Health (MH) of the Czech Republic. However, the MH has not established any regulations on the compulsory technical or practical facility set-up of nurseries, or any legal directives outlining even compulsory staff requirements. What does still have validity are the Methodological Measures of the MH published in MH Report No. 10, section 17-18 from 1968, where the MH issued some methodological instructions for ensuring the individual conditions of providing nursery care. These methodological measures pertain to the staffing and work descriptions of personnel as well as the basic features of operating a nursery. Although these Methodological Measures determine the exact extent of the workload of a doctor in a nursery, there is no mention of the ratio of nurses to children. In any case, most of the measures set out in this report are not feasible by today's standards (Svobodová, 2007). The personnel of most nurseries are usually paediatric nurses who sometimes have additional educational or psychological training.

In the past, nurseries would be regularly visited by a paediatrician, whose workload would differ based on the capacity of the nursery; however, today doctors have no workload at nurseries. Other professionals include carers who have by today's standards undergone a year-long preparatory course and assist nurses with all their duties; nevertheless, they are not allowed to work without the supervision of a paediatric nurse or a head nurse.

Health care provided in nurseries is not covered by public health insurance, but rather by the insurance of the provider of the nursery. Since 1991, the provider in 95% of nurseries has been the municipality and in the remaining 5% it has been a legal or physical individual. Most nurseries are a part of a public allowance organization. The overall financing comes from a "two-source system": specifically, the operation costs are partly covered from the budget of the provider and partly from a contribution from parents.[2] The specific objectives, general quality of the services and service fees are all, to a certain extent, determined by the providers themselves (under the assumption that they are, of course, upholding the law[3]). As is evident from binding program documents at the government level, the official strategic objective of nursery services is "…to provide care in the multi-faceted development of children up to the age of three, usually. Nursery care builds upon the familial care of children." (Regulation No. 242/1991 paragraph 21, article 1).

***Kindergartens*** are a part of pre-school education and according to school regulations[4] are the first level of public education, falling into the jurisdiction of the Ministry of Education, Youth and Physical Education (ME); according to ministry regulations, kindergartens are a public service. As such, kindergartens are legally bound to the educational constitution as a type of schooling and are regulated by laws that are similar to those of other types of schooling. This type of pre-school childcare facility is meant for children from three to six year of age, or, exceptionally, seven.[5] Every child has the legal right to make use of this service at least one year prior to regular school attendance.

After 1989 there was a differentiation among kindergarten providers and the offered services, even though the percentage of private providers is only 1.4% of the total. Kindergartens were transferred to municipal, private or church administration. Furthermore, kindergartens with above standard services came into being, offering advantages such as rehabilitative exercise programs and year-round operation, although for a higher price. In comparison with the fees for nursery school services, kindergartens are much cheaper partially because their financing is at least "three-source" – that means the provider (usually the municipality), the ME (through the agency of school administration), which covers the costs of wages and educational aids) and fees paid by parents (which can comprise a maximum of 50% of the total costs; in fact, in the case of socially disadvantaged families, this fee is excused).

A binding and authoritative document for all kindergartens is the *General Educational Program for Pre-school Education (2004)*, which determines the common framework and must be upheld[6]. However, maintaining these common rules is

in the jurisdiction of the provider, therefore employees of individual kindergartens can create and implement their own educational program. The employees of kindergartens are teachers who must by law have professional qualifications. The explicit objective of institutionalized pre-school education is to complement family upbringing and to act in close co-operation with the family to help ensure specialized care for children in an environment suitable for stimulating their development and education (Rámcový 2004). Additionally, the White Book (2001: 45) states, "in cases of need here [in kindergartens], there is compensation of inadequacies to satisfy the needs of children and their developmental stimulation. In the case of disadvantaged children, this involves assistance intended to even out differences and improve their life and educational opportunities."

Recently, Ministry of Education, Youth and Physical Education (ME) express the interest to support employers as the providers of private kindergartens (as we can see in recent press releases of ME - e.g. Tisková zpráva MŠMT 9.8.2011, Tisková zpráva MŠMT 17.5.2011).

Ministry of Education now offers state subsidy to firms' kindergartens, if they register in the register of schools. In the first year of provision, the state offers subsidy up to 60% of school norm per child (Tisková zpráva MŠMT 17.5.2011). If the firm's kindergarten meets all requirements of the Education Act (No. 561/2004 Coll.), in further years of provision, the firm's kindergarten could draw up to 100% of school norm per child (ibid.). The norm per child is about 3000 CZK per month (ibid.).

In accord with the Law for Trade and Business (No. 455/1991 Coll., as amended), there arose a possibility to provide childcare as a business opportunity. The responsible body is the Ministry of Industry and Trade (MIT), without any ties to other ministries. One of the possibilities is to provide controlled trade licences for ***"Day care of a child up to three years of age by non-family individuals"*** in private facilities. This activity is of a similar nature to the running of nurseries, except that it is not considered a health facility. Nevertheless, it must fulfil similarly stringent food and hygiene standards[7]. The requirements of this professional trade licence are stated in Government Regulation No. 491/2004 Coll., as amended, in paragraph 1 as "individual educational care of entrusted children up to the age of three in day care or week-long care intended to develop reasoning and speaking skills, motor, working, musical and creative skills, and cultural hygiene habits appropriate to the age of each child. Furthermore, the health and safety of the children is guaranteed, as well as the provision of fresh-air activities, resting time in clean premises, personal hygiene and any necessary first aid." The fee for the service is determined by the provider. The required education for child daycare to three years, according to this trade regulation (and related directives)[8], is a university degree in nursing, or a college diploma in paediatric nursing or general nursing with a specialization in paediatrics. Since 2008 the professions have been extended to include those having competence in general nursing, nursing assistance, professional care-provider, childbirth assistance and rescue work (according to Act No. 96/2004 Coll., on non-medical health professions), or those having competence in social work (according to Act No. 108/2006 Coll., on social services). In order to be allowed to provide this trade, however, there is no stipulation on the length of work experience, nor any legal responsibility to pursue life-long learning or continued studies, as is the case for healthcare workers.

Another option for providing a professional trade in the given sector is through obtaining an unqualified trade in the ***"Provision of Services for Families and Households"*** (Act No. 455/1991 Coll., on professional trades). This primarily pertains to services involving the running of a household, such as cooking, cleaning, laundry, ironing, gardening, shopping services, as well as the individual care of children over three years of age in families and occasionally the short-term care of children (including those under three years of age), and providing care to individuals requiring extended care. Care of children over three can be provided by someone with an unqualified trade license according to Government Directive No. 140/2000 Coll.; this involves the trade ***Extra-curricular Care and Education,*** which includes the care of children over three years of age in pre-school facilities, in private schools and facilities serving for specialized education that are outside of the school system, school and pre-school facilities for extra-curricular care and education, tutoring, and educational and care activities at children's camps.

Since 2008, there have been negotiations about the draft of a law in the form of Pro-family Package[9] (MPSV 2008, updated version MPSV 2010). According to this Pro-family Package, the standards of qualification of professional trade providers could be relaxed somewhat in the future. To obtain a license for this controlled professional trade, it would be enough to have a "certificate of re-qualification, or another document certifying the professional qualification or specialized competence for the stated activity, issued by the accredited facility according to particular legal regulations of the ME or which ever ministry the activity pertains to". (MPSV 2008: 68, cf. MPSV 2010).

Further, this draft law elaborates additional options for the care of pre-school children. The first option is through (1) ***Parental Mutual Assistance (PMA).*** This provider is a position that is limited to parents who are taking care of their own child under 7 years of age; they must have a clean criminal record, the consent of their spouse and a safe and appropriate location. They can take care of a maximum of three children (including the person's own child). Other conditions of care are a matter of negotiation between health care providers and parents. There are no maximum earnings for care providers within the PMA and it is subject to taxation on personal income (MPSV, 2010). In 2011, a newly proposed form of childcare is (2) ***Commencement of au-pair/baby-sitting provision*** establishing the individual care of child at his/her home (Tisková zpráva MPSV 23.8.2011). This kind of childcare supposed to be provided in accord with the Act for Trade and Business. There are supposed to be some special qualification requirements of the provider, however, this is not clear yet. Ministry of labour and social affairs plans to open special courses for providers which would be probably similar or same as the course for controlled professional trade mentioned above.

Another option being proposed by the government is the concept of so-called (3) ***children's groups.*** This childcare arrangement could be set up by employers, civic associations, charitable organizations, clerical (church) legal persons, regions or municipalities for a maximum of 4 children aged from 6 months to 7 years of age on a non-commercial as well as on a commercial basis. Qualification requirements for care-providers should be the same as in private business (and non-medical professions or a certificate of competency) and the costs of setting up and operating such children groups would be tax deductible. However, the question of taxation is also not clear yet. Further, there would be an obligation to develop a specific pedagogical concept for this children group. The main difference between commercial and non-commercial children groups we can see in the number of children in such a group and consequently in the requirements for hygienic standards. If the number of children is smaller (probably up to 4 or 8 children at maximum), the requirements for hygienic and other standards would be applied less strictly than in case of bigger groups which are supposed to be provided as a business opportunity.

## Requirements and Expectations of European (EU) Policy Regarding Childcare

Currently, the system of childcare is one of the fastest growing areas in the EU; however, this development is not occuring at the same pace or in the same way in all European countries (Sector Futures - Childcare Services Sector 2006). The key factors, especially in EU countries, are the quality of childcare and flexibility for parents; however, there is no model that can be identified as a standard within the EU, especially given the very different historical developments in the area of childcare (ibid.). Nevertheless, it can be said that while "the more developed countries tend to share responsibilities of child care between the family and the state" (Starting Strong I 2001: 40), other resources based on information from various international organizations in less developed countries advocate the following: programs should be as inexpensive as possible and should be implemented mainly by mothers and communities; parents and close caregivers (such as older siblings) should be an equal target population; the establishment of the programs should be based more on community or home-based care; private sector involvement should be encouraged, etc. (Arango 1998, Young 1996 cited by Haddad 2002).

On the other hand, the OECD particularly stresses the somewhat problematic relationship between the quantity and quality of care and the provision of market-based childcare services (Starting Strong I 2001). Similarly, Leitner

(2003) warns that if childcare outside the family is provided primarily by the private sector, it may be available only to those parents who are able to pay for the service. It is not therefore possible to rely fully on the market to provide childcare services in sufficient quality and quantity; however, a combination of sources should be considered. The state should always provide at least part of the funds and control conditions for service provision (quality standards, removing information barriers, etc.), thereby helping the efficient functioning of the market (Starting Strong I 2001, Mahon 2002). However, if the state ignored the issue of costs, it could lead to especially low-income families looking for care-givers on the black market without guarantees of their qualifications and expertise, which could have negative consequences for quality of care (Mahon 2002).

Thus, the OECD is proposing a number of recommendations for program developers responsible for early childhood education and care services based on ensuring the widest accessibility and improving the quality of care, mainly through increasing public investment and supporting the training of staff in these services. The nature of care should depend on the child's age and should be individually designed; therefore, it should be tailored to the needs of each child, as well as the needs of parents in reconciling work and family responsibilities. The specific quality of care conditions aimed at reducing the anxiety or fear of the child's separation from parents can be provided through professional care providers, an environment that is familiar to the children and having a group of their peers (Goossens, 1986). The following OECD recommendations will then form a framework for discussion of the Czech model/system of childcare in respect to its principles, objectives and functions (Starting Strong I 2001, Starting Strong II 2006):

- A systemic and integrated approach to early childhood education and care policy (ECEC)
- To create the governance structures necessary for system accountability and quality assurance
- A strong and equal partnership with the education system
- A universal approach to access, with particular attention to children in need of special support (within the social context of early childhood development)
- To place well-being, early development and learning at the core of ECEC work, while respecting the child's agency and natural learning strategies
- Substantial public investment in services and the infrastructure 1) to achieve quality pedagogical goals; 2) to reduce child poverty and exclusion through upstream fiscal, social and labour policies, and 3) to increase resources within universal programs for children with diverse learning rights
- Encourage family and community involvement in early childhood services
- A participatory approach to quality improvement and assurance (develop broad guidelines and curricular standards with the stakeholders for all ECEC services)
- Appropriate professional education, training and working conditions for all staff in all forms of provision
- Provide freedom, funding and support to early childhood services
- Systematic attention to data collection and monitoring
- A stable framework and long-term agenda for research and evaluation

## Ideological Bases of Building a System of Childcare

In this section we will firstly introduce the basic principles and themes that may be in the background of the development of a childcare system and then we will discuss and analyze this in connection with the Czech model of childcare.

As is already clear from the introductory part of the text, the basic ideal principles on which European countries usually build child-care systems are as follows (Scheiwe, Willekens 2008):

1. *The idea that even children below the age of obligatory schooling are in need of public education* (an idea which presupposes children to be already of an age at which they can be publicly educated)
2. *The idea promoting the reconciliation of care work and paid work* (this idea may justify public childcare for children of any age)

(1) The principle based on the assumption that the systematic education of children should be started as early as preschool age is at the root of most of the first childhood education systems, which involve either variant (a) child centered or (b) state or society centered (Scheiwe, Willekens 2008). The first option is based on the idea that the desirable development of a child necessitates that the child begin at a certain age to associate with other children and adults outside the family.There is also the idea that even pre-school children can benefit from systematic education similar to that of schools, but is not yet mature enough to attend regular school (Scheiwe, Willekens 2008, cf. Starting Strong II 2006, Haddad 2002). The offer of such oriented services may have its roots in the principle of equal opportunities for children of different social, cultural and linguistic backgrounds. The inevitable inequalities that arise from these differences in the family background of the child should be offset by the general availability of the public education system (Scheive, Willekens 2008). Evidently, even from this system, built primarily on the interests of the child, there are many positive consequences for society as a whole. However, systems whose starting point is more concentrated on the interests of society and the state place more emphasis on the need to instill the values of the given political system to all its citizens right from the cradle.

Some examples are the French model, the states of the former socialist block and the United States at the turn of the 19th century, where there was significant migration of people from many different cultures, which supported the argument of educational and developmental values of U.S. citizens from the earliest age (ibid.). Pre-schools of either variant did not replace parental/maternal care, but were perceived more as a supplement (e.g. teachers were expected to emulate maternal behaviour). The educational ambitions that formed the foundation of the majority of nursery schools or similar facilities across the Euro-American zone ended up emphasizing, among other things, the principle of universality in that each child should be entitled to some form of pre-school education.

(2) The second motive for developing a system of childcare is to facilitate the reconciliation of work and family life. The main objective, in contrast to the previous reason, is to provide childcare for parents who are both participating in the labor market. In the past, this concerned mainly those parents working in agriculture and industry, especially as they had to ensure an adequate family income and therefore could not take care of their children at the same time. Such policies were targeted only at those who could prove that they were in need, leaving them marginalized. There were other interdependent objectives: women's liberation (from their dependence on men) was allowed through their entry to the labour market, thus eradicating child poverty through the employment of their mothers; the possibility of a female labour market supported economic efficiency. The principle of building a network of childcare services has currently become a central theme of European employment strategy discourse and equal opportunities for men and women, as well as serving as an indicator of different models of the social state, or family policies, particularly on the axis of familialism – defamilialism (cf. Esping-Andersen 1999, Leitner 2003). "A familialistic system is one which public policy assumes, indeed insists, that households must carry the principal responsibility for their members' welfare. A de-familializing regime is one which seeks to unburden the household and diminish individuals' welfare dependence on kinship" (Esping-Andersen 1999: 51). This concept is further refined by Leitner (2003), who primarily focuses on the caring function of family and discerns several variants of familialism and de-familialism, depending on how the different instruments of family policy are combined. This mainly concerns strong or weak support schemes of maternity and parental leave, including related financial transfers and (b) strong or weak support of formal services for children under three years (explicit[10], implicit[11] or optional[12] forms of familialism and de-familialistic modes[13]).

State support for the care of pre-school children is proving to be essential for the participation of women/mothers in the work process of the formal labour market (cf. Esping-Andersen 2002; Bartáková 2008; Plasová 2008). Leitner (2003) therefore follows the percentage of children under the age of three who are placed in formal childcare facilities. According to some experts, the Czech Republic is classified to be among the countries with an explicit form of familialism, along with countries such as Austria, Germany, Italy and Luxembourg, which are characterized

by relatively long schemes of paid parental leave (the Czech Republic has one of the longest); at the same time there is very underdeveloped formal care for children under 3 years of age (e.g. Bartáková 2008).

### The Czech Model of Care for Children

The motives, described above, of course do not in themselves constitute social policies. They are ideal types from which particular sets of organisational and institutional principles and arrangements/tools can be derived and from which different kinds of questions and problems follow (Scheiwe, Willekens 2008). Often, some kind of mutual combination occurs, although it is interesting to see which of them is more dominant within particular tools/measures of childcare. We will look at a Czech example of this (see Table 1 below). "The ideal types tie in with dominant notions of gender and class relations and thus make it also easier to see how such notions are incorporated within different social policies" (Scheiwe, Willekens 2008: 4). They are ideal types from which particular sets of organizational and institutional arrangements and principles/tools can be derived and from which different kinds of questions and problems follow (Scheiwe, Willekens 2008).

If we examine the setup of the system of public childcare services in light of the above principles, we can say that the settings of kindergartens are based more on the educational model and nurseries have more in common with the work-care reconciliation model (Table 1).

The explicit aim of kindergarten is education, development and preparation of children for school attendance, and to be available to the general population of children from 3 to 6 years; this is widely made use of[14]. According to The Yearbook of Education Development in the CR (UIV database of information for the school year 2008/2009[15]), the proportion of three-year-olds who attended nursery school makes up 76.5% of the entire population. In 2008/09 nursery schools were attended by about 89.4% of all four-year-olds and 92.8% of all five-year-old children (ibid.). According to the settings of the system of kindergartens, we can deduce that a "particular age", which is appropriate for collective facilities is 3 years. This confirms a relatively new adaptation of entitlement to parental allowance, which since 2008 has simulateneously allowed parental contributions and partial childcare for children over the age of 3 at kindergartens for up to 4 hours per day (Act No. 117/1995 Coll., on state social support). This adjustment may be relevant to parents in terms of reconciliation of work and family, especially for those who for various reasons seek to at least partially return to the labour market.

On the other hand, it should be noted that kindergartens are attended by a quarter of the population of children between two and three year of age (in real numbers that means more than 26,300 children – information for the school year 2008/2009); this proportion has been stable for several years (see Annex 1) (UIV 2009; cf. Matějková, Paloncyová 2004). However, in the case of these children, the defined objective of the services shifts. The White Paper (2001: 45) states that "today there is a new need in justifiable cases to allow as an exception the inclusion of a child under three years, as 20% of children, according to research, are born into single-parent families". We can therefore infer that, unlike the case of older children, for whom the system wants to ensure universal access to kindergarten, for children under 3 years, childcare services are directed (at the level of more general goals) to them only in the case of emergencies where some kind of inadequate parental care is identified. However, in my opinion, there is a high proportion of the population of children under 3 years in kindergarten due to a combination of several factors and circumstances. The lack of nurseries or similar facilities for children under 3 years forces parents to create a demand for care for children under 3 years in kindergartens; kindergartens are less financially demanding than nurseries[16]; there is an emphasis by parents on education; there is a lack of confidence in nurseries – they persist in having a bad reputation from the days of the communist regime; and/or there may be a situation where parents prefer institutional care for their children in their second or third year, but do not want to expose their children to the burden of transition and adaptation from one facility to another and the changes this involves in the rules and teachers/caregivers within a relatively short period (cf. Plasová 2008; Bartáková, Plasová 2007; Klíč k jeslím 2007; Kuchařová, Svobodová and others 2006).

Furthermore, some research indicates (e.g. Plasová, Gelnarová 2005) that the directors of

**Table 1 Comparison of selected institutional settings of the educational model, the work-care reconciliation model and the Czech model of public care for children from 0 to 6 years of age**

| Institutional dimensions | Educational model | Work-care reconciliation model | Kindergartens in CR | Nurseries in CR |
|---|---|---|---|---|
| **Access** | **Universal** | **Targeted** | **Universal for children in the age of 3 and older** (especially for children who are 1 year before school attendance) | Formally **universal/** in reality **targeted** |
| **Entitled person** | **Children** | **Parents/child with special needs** | 1) all children from 3 to 6 years<br>2) children under 3 years with special needs | **Children** (especially of working parents) |
| **Pedagogical concept** | **Educational goals** (learning) | Mainly **care** | 1) **educational goals**<br>2) children under 3 – **equal opportunity** (disadvantaged children) | Mainly **care** (and education) |
| **Group size and organisations** | Relatively **big groups** (similar to school classes) | **Smaller groups** | Classes - average is 12.8 children per 1 teacher | **Smaller groups** (usually 3-6 children per qualified person, depending on the age of children) |
| **Professionalization of staff, payment*** | **Teachers** | **Lower level of professional education and payment than teachers** | Teachers | **Professional health personnel** (nurses, lower level health personnel) |
| **Fees** | **No fees for school** (possibly for meals, etc.) | Subsidised, but **parental fees** | **Fees** (up to 50% of non-investment costs at most; the last class before school attendance is for free) | **Fees** (decision of municipality): usually (a) depends on family income, or (b) flat rate |
| **Financing bodies** | **As for school** (national or regional financing) | **Mixed financing** with a share of community authorities (less centralized) | **Mixed financing – composed of three sources**<br>- parent fees<br>- municipality budget<br>- state budget<br>(national and regional financing) | **Mixed financing – composed of two sources**<br>- parent fees<br>- municipal budget<br>(local authorities, less centralized) |
| **Administrative competence** | **School authorities** | **Social welfare authorities** | **School authorities** (Ministry of Education) | **Local authorities** (Ministry of Health) |
| **Time patterns** | **Opening hours and holidays like schools** | **Varied** | **Opening hours** and holidays like schools | **Opening hours** (flexible, parents' needs are usually considered) |

Source: The author's own modification and completion of a table presented by Scheiwe and Willekens (2008: 9).

*Valid statistics concerning the wages of teachers of the Ministry of Education and the wages of nurses working in nurseries are not yet available in the CR.

kindergartens admit children under 3 years of age simply in order to fill the capacity and only if the child has almost reached the age of 3. This is often explained in such a way that, for example, when a child reaches the age of three in March, forcing the parents to finish their parental leave and return to work, the child would not be allowed to start attending kindergarten until September, thereby considerably complicating the parent's return to work. Therefore they opt to enrol the child in September of the previous year, but with real attendance beginning in March. In real terms this means that these statistics may include children who actually do not yet attend kindergarten. In addition, the objectives of The White Paper (2001) are not fully reflected in the actual functions of kindergartens. On the other hand, it is also necessary to take into consideration the major regional differentiations. In some locations, there is such a great demand for placement in kindergarten (also see Annex 2) that not even three-year-old children are enrolled (even for a partial stay of 4 hours per day). Preference is given to older children – those who are just about to start school. This is generally in line with the above-specified objectives and in some kindergartens, by contrast, they set up a special department for the youngest children. Despite the prevailing principle of education in kindergartens, we can find – at least implicitly – some features that are attributable to the idea of reconciling work and family care.

Apart from the aforementioned concurrence of parental contributions and the placement of the child in kindergarten for up to 4 hours a day, which allows parents to work part-time, we can find support for the reconciliation model, which is also in the process of setting criteria for admission to kindergarten. Due to inadequate capacity, many kindergartens are forced to establish criteria for the admission of children based on attendance (especially in larger cities), which do not have any basis in legislation, but simply are based upon their discretion (Kuchařová et al. 2008). The economic situation of both parents is one of the three most common criteria for the acceptance of a child into a facility (Annex 3).

The identification of principles, objectives and functions of nurseries in the CR is somewhat difficult, especially because current legislation governing the setting and operating conditions are not thoroughly resolved. The reasons and circumstances surrounding the relatively drastic "development" of the last 20 years (see Annex 4) are absent in this respect, along with valid data at the national level. Yet, as already mentioned above, the characteristics of nurseries rather correspond to the principle of services meant to facilitate the reconciliation of work and family (and at the same time, they are also an important indicator for the recognition of familialistic or de-familialistic regime of welfare state). However, there is an obvious effort not to guarantee "only" care, but to develop the child in many areas. At present, however, there remain in the CR only residual nursery services, and compared to the kindergartens, they are completely marginalized in the Czech model of the welfare state. Since the beginning of the 1990s, when the Czech Republic had more than a thousand nurseries with a capacity for nearly 40,000 children, their number declined significantly between 1990 and 1991, and gradually decreased to the current 46 facilities with a capacity for 1,413 children (UZIS CR 2009). Coverage of the target population, children from 0 to 3 years, ranges from 1 to 3% and has the worst status based on various international comparisons (e.g. Bartáková 2008). Based on national documents and some follow-up measures, there is quite an apparent attempt to ensure that nurseries remain only in a marginal way and that there is an effort to keep the care of children under 3 years of age within the family. This effort can be proven through several facts.

Although the EU and OECD recommend that all pre-school education and care should be united under one system or within one ministry (cf. Starting Strong I, 2001; Sector Futures - Childcare Services Sector EU 2006), in the Czech Republic nurseries are within the jurisdiction of the Ministry of Health, which reinforces the emphasis on the care-giving function and, understandably, is completely outside of the main agenda of the ministry. The position of the Czech welfare state to nurseries can also be demonstrated in the problematic meeting of priorities of the Lisbon Treaty (according to which by 2010 there should be 33% of children aged 0 - 3 years placed in childcare facilities). According to National Family Report (2004: 24), "This goal is in conflict with current policy, which is focused on family support and oriented by the child's welfare." From this declared position, we can determine that the system of care for children

from 0 to 3 years in the CR is built on the idea that the welfare of a child under 3 years is only possible in a family environment. For this reason, the system of public care for children in this age category can only be of a residual character, only addressing "emergency or abnormal situations" when child care cannot be provided within the family. Such a stance is then reflected in other measures, significantly affecting the availability of this type of care. The first measure is the setting of parental leave and parental contributions so that in comparison to the case of children older than 3 years, it does not allow the concurrence of parental allowance and the placement of the child in an institutional facility for 4 hours a day. This is essentially a provision that Czech mothers of children under 3 years of age would welcome most in their reconciliation of work and family care (cf. Plasová 2008; Křížková, Hašková 2003, etc.).

Even in relation to the innovations of taking parental leave and parental contributions[17], which financially favour the rapid withdrawal of parental allowances (rapid parental allowance can be withdrawn over the course of two years), we can pose the question of whether the system of public childcare in the CR is ready to provide for the needs of those parents who will return to the labor market in as little as two years. The planned amendment of the Ministry of Labour and Social Affairs (the Pro-family Package) is probably anticipating a solution to the problem through the provision of care for children under 3 years, particularly through an arrangement called Parental Mutual Assistance (see above). According to the objectives of this document, this step should legalize the current practice of parents who resolve the problem of inadequate childcare through parental mutual help[18]. This is in the field of the informal or "grey" economy, which prevents the practice from being used more widely. "This measure aims to extend the original offer of informal childcare services on an individual basis".... For the children being cared for, the provider creates an environment similar to that of a family, even simulating sibling groups" (MPSV 2008: 39). Again it is evident that there is pressure on childcare to be provided within a pure family environment. Despite the many positive effects that this childcare option offers (e.g. non-institutional, individual nature of childcare, affordable and socially viable), it is doubtful whether PMA will ensure high quality and affordable care. There are almost no set requirements or quality standards for hygiene, food, activities or child development, etc. The amendment rather relies on the fact that if the provider is a parent (particularly a mother taking care of her own similarly aged child), the fact of parenthood is sufficient to guarantee the quality of care for young children. Quality is also closely connected to the issue of the credibility of such a service for parents.

According to some surveys (Kuchařová et al. 2008), there is evidence that if the PMA legalized the already established relations on the basis of neighborly assistance (as is the intention of the package), then there would probably be only a legal change in the relation to nanny/friend, into whose care parents entrust the care of their child and who they trust. At this level, mothers would not expect any special training/courses from their nannies, except for a first aid course. On the other hand, if it was not possible to secure babysitting by a person the parent knows or at least someone recommended, and it was necessary to find a "stranger", then it would be likely that parents/mothers would demand that the care-provider be able to prove their reliability through the completion of a course or psychological test, etc. (ibid.). The relation between the PMA and other non-commercial facilities and commercial facilities in this area seems to be also problematic in certain level. In comparison to facilities provided on commercial basis, the PMA and non-commercial facilities (e.g. children group) would meet requirements for hygiene or equipping of the facilities only on lower level. The commercial facilities would need to reflect the higher costs (resulting from these higher requirements) in their services and this could represent an absolutely untenable form of competition (cf. Kuchařová et al. 2008). Further, there is the unclear question of quality requirements and control of quality in providing of all types of newly proposed childcare facilities.

**Table 2 Summary of principles, objectives and functions of public care for children from 0 to 6 years of age in the Czech Republic**

| | **Nurseries**<br><br>(care for children from 0 to 3 years) | **Kindergartens**<br><br>(care for children from 3 to 6 years) |
|---|---|---|
| **Principles** | Securing **sufficient childcare for working parents** / idea of reconciling work and family / two-income home model | **Universalism, preschool education as a value** / needs of the child / communities |
| **Objectives** | The aim is to provide comprehensive care for the all-round development of children **in terms of health and education as an indivisible whole.** Nursery care follows up on childcare in the family. | The goal/mission of kindergartens is to complement family care and closely connect it to the provision of **childcare in a professional environment with adequate incentives for the child's development and learning** |
| **Functions**<br><br>**Features** | **Primarily upbringing/care-giving;** secondarily educational/upbringing | **Primarily educational,** secondarily care-giving, compensation of socio-economic level |

### Summary of Pressure Points of the Czech Model of Childcare Systems

We conclude that in the Czech system of childcare there are both basic principles: the educational model and the reconciliation model. However, at first glance there is an obvious difference between the concept of care for children from 0 to 3 years and that for children over 3 years of age; there is a strictly maintained division between the two in the Czech Republic. The provision of public care for children under 3 years (nursery schools) has practically disappeared. There is much pressure exerted on parents to take care of their children under 3 years within the family. This somewhat undermines the respect for differentiation among various family patterns, choices and strategies. On the other hand, the system of kindergartens for children of 3 to 6 years is a part of a social policy in the Czech Republic that is fully supported, and not just financially.

We may, however, notice from certain signs of both the system itself and the diversified needs of parents that there is a need to change the models and their limits (e.g. the high proportion of children under 3 years in kindergarten, the demand of parents for non-parental childcare, a newly proposed arrangement of Parental Mutual Assistance (PMA) and other commercial as well as non-commercial facilities). Despite the expectations of European social policy (EU, European Commission), there are still existing Czech policies/measures that create pressure on parents to provide family care (preferably maternal care) for children under 3 years of age. If there is a "failure" within the family, then care should be provided on an individual basis (fully individualized care or care provided only in very small group) and in an environment that is as similar to the family model as possible (e.g. this can be demonstrated through long paid parental leave, the lack of institutional care for children under 3 years of age, the setting up of a Parental Mutual Assistance program, through au-pair/baby-sitting service or through the limited size of planned children groups). On first glance, it could also be said that such efforts are accompanied by the need for high quality childcare, but some features of the Czech system of services, specifically for children under 3 years, evoke certain doubts. Most probably it cannot always be said that family care of a child up to the age of 3 is the best possible solution under all circumstances. In this respect, the OECD points out in its key elements/directives on the establishment of a system of care for children: the objective is the elimination of child poverty and balancing the chances of children from different environments, etc. However, in this case it responds (at least at the level of declarations) by setting up a system of Czech kindergartens which, in exactly such cases, declare children under 3 years of age to be among its target groups. The guarantee of the quality of care could also be threatened if in the future the Czech Republic intends to provide care for children under 3 years of age outside of the family based on (1) Parental Mutual Assistance without any basic standards or requirements for the quality of care (other than that the provider has a clean criminal record, safe facility or some non-specified short-term courses), or (2) leaving the costs of providing childcare to parents and private providers (entrepreneurs, employers).

The care of children over 3 years, mainly provided by kindergartens, at least at the level of the declared objectives and principles, is marked by the attempt to provide universal access to education for children in a given age group (with preference given to children who are at the age just before compulsory school attendance). On the other hand, there can be some doubt about the fulfillment of the principle of universality for an entire age category of children, if some providers of kindergartens in the case of an excess of demand over supply create special criteria for the enrollment of children to school based on their actual needs.

Although this article is oriented mainly on the analysis of the Czech childcare policy, it has also some important implications for social workers. The Czech welfare state has been changing more and more to the so called workfare state (e.g. Keller 2005, 2011, Peck 2001). At the same time, families with dependent members (children, old people) are responsible for the welfare of all their members as a consequence of the familialistic regime (see above) with decreasing state support (e.g. lower family benefits, limited availability of childcare and other services). For families with small children it could mean that they are expected to take care of children on their own and at the same time to participate on the labour market which provides decreasing (financial) security (see also the concept of the working poor). For some families (e.g. lone mothers), these expectations are in a strong conflict. As some scholars point out, the difference between old and new social risks in this respect could be following: "while in the past a lone mother usually was not able to sustain her family if she did not have a paid job, currently the lone mother is not able to do it even if she participates in the labour market" (Keller 2011: 40). Social workers would be expected to help families (at risk of poverty) to cope with these conflicting pressures within a unique life situation. This article provides information about tools and measures which are at hand for social workers and about the conditions and also limits of the childcare system which represents social environment/ state support for the coping strategies of families with small children. Therefore, for example social workers at the Labour Offices or in NGO focusing on supported employment have to take into account these objective obstacles to participation in the labour market and/or to provide good quality childcare. As is obvious from this article, there could be a quite extensive geographical diffentiation of availability of childcare services (including different financial availability) and also differentiation of other conditions influencing the ability of clients to cope with their social/life situation. The situation appears sometimes as a vicious circle: how to meet the criteria, for instance to have a paid job, for admission to kindergarten, when at the same time a woman has a chance to get a paid job only in the case that the problem with childcare is already solved etc.

**Bibliography**

ARANGO, M. **Approaches to early childhood education**. In UNESCO. **Early childhood development: laying the foundations of learning**, 1998.

BARTÁKOVÁ, H.; PLASOVÁ, B. **Mechanismy rozhodování žen s vysokoškolským vzděláním o přechodu z rodičovské dovolené na trh práce**. In MAREŠ, P.; HOFÍREK, O. (eds); 2007. **Sociální reprodukce a integrace: ideály a meze.** *Sborník z konference*. Brno: Masarykova univerzita, Mezinárodní politologický ústav, 2007.

BARTÁKOVÁ, H. **Cesta zpátky. Návrat žen po rodičovské dovolené na trh práce v České republice.** *Disertační práce*. Brno: Masarykova Univerzita, 2008.

BONOLI, G. **Adapting employment policies to post-industrial labour market risks**.

*Working paper de l'IDHEAP 6/2006.* Chaire Politiques sociales, 2006.

ESPING-ANDERSEN, G. **Social Foundations of Post-Industrial Economies.** Oxford: Oxford University Press, 1999.

**Sector Futures - Childcare services sector**. European Foundation for the Improvement of Living and Working Conditions, 2006.

GOOSSENS, F.A. **The Quality of the Attachement Relationship of Two-years Old of Working and Non-working Mothers and Some Associated Factors.** Amersfoort : Acco, 1987.

HADDAD, L. **An Integrated Approach to Early Childhood Education and Care**. Early Childhood and Family Policy Series n°3. UNESCO-OECD co-operation for the

International Conference on Early Childhood Education and Care: International Policy Issues, Stockholm, Sweden, June, 2001.

HAŠKOVÁ, H. **Doma, v jeslích nebo ve školce? Rodinná a institucionální péče o předškolní děti v české společnosti v kontextu změn na trhu práce, sociálních politik a veřejných diskurzů mezi lety 1945-2006.** *Gender, rovné příležitosti, výzkum,* 2007, Vol. 8, No 2, pp. 15-26.

KELLER, J. **Soumrak sociálního státu.** Praha: Slon, 2005.

KELLER, J. **Nová sociální rizika a proč se jim nevyhneme.** Praha: Slon, 2011.

KOLÁŘOVÁ, J. (ed.). **Klíč k jeslím.** Praha: Gender Studies, 2007.

KŘÍŽKOVÁ, A.; HAŠKOVÁ, H. **Průzkum veřejného mínění o postavení žen na trhu práce.** Praha: Sociologický ústav AV ČR, 2003.

KUCHAŘOVÁ, V.; SVOBODOVÁ, K. **Síť zařízení denní péče o děti předškolního věku v ČR.** Praha: VÚPSV, 2006.

KUCHAŘOVÁ, V. (ed); BAREŠ, P.; HÖHNE, S.; NEŠPOROVÁ, O.; SVOBODOVÁ, K.; ŠŤASTNÁ, A.; PLASOVÁ, B.; ŽÁČKOVÁ, L. **Zmapování dostupnosti a podmínek pobytu dětí v jeslích, mateřských školách, školních družinách a obdobných zařízeních a jiných neinstitucionálních forem péče o děti v ČR včetně identifikace překážek jejich využívání s návrhy možných opatření k jejich rozvoji.** Praha: VUPSV, 2008.

LEITNER, S. **Varieties of Familialism. The Caring Function of the Family in Comparative Perspective.** *European Societies,* 2003, Vol. 5, No 4, pp. 353–375.

MAHON, R. **Child Care: Toward What Kind of „Social Europe?** *Social Politics*, 2002, Vol. 9, No 3, pp. 343-379.

MATĚJKOVÁ, B., PALONCYOVÁ, J. **Rodinná politika ve vybraných zemích II.** Praha: VÚPSV, 2004.

MPSV. 2008. **Soubor prorodinných opatření - Prorodinný balíček.** [online]. [http://www.mpsv.cz/files/clanky/5898/komplet_balik.pdf]

MPSV. **Návrh zákona o podpoře rodin s dětmi.** Příspěvek Kateřiny Jirkové na *Konferenci o rodinné politice 2010.* [online]. [http://www.mpsv.cz/files/clanky/10348/Katerina_Jirkova_CJ.ppt, 10.1. 2011]

MŠMT. **Bílá kniha. Národní program rozvoje vzdělávání.** Praha: ÚIV Tauris, 2001.

**National Family Report** (abridged version). Ministry of Labour and Social Affairs of the Czech Republic, 2004.

OECD. **Starting Strong I. Early Childhood Education and Care.** Paris : OECD, 2001.

OECD. **Starting Strong II. Early Childhood Education and Care.** Paris : OECD, 2006.

OECD. **Babies and Bosses. Reconciling Work and Family Life.** A Synthesis of Findings for OECD Countries. Paris: OECD, 2007.

PECK, J. **Workfare States.** New York: The Guilferd Press, 2001.

PLASOVÁ, B; GELNAROVÁ, K. **Podkladová studie pro strategický rozvoj služby jeslí v Brně.** Brno: Masarykova Univerzita, 2005.

PLASOVÁ, B. **Význam faktorů trhu práce pro návrat žen na trh práce po rodičovské dovolené.** *Sociální studia,* 2008, roč. 5, č.2, s. 89-105.

SCHEIWE,K.WILLEKENS,H.**Introduction: Path-dependencies and Change in Child-care and Preschool Institutions in Europe – Historical and Institutional Perspective.** In SCHEIWE, K. WILLEKENS, H. (eds.) **Child Care and Preschool Development in Europe. Institutional Perspectives.** UK: Palgrave Macmillan, 2008.

SIROVÁTKA, T. (ed.) **Nejistoty na trhu práce a jejich zvládání.** MU: Brno, 2009.

SVOBODOVÁ, R. **Péče o děti do 3 let mimo rodinu. Situace v městě Brně.** Atestační práce: Institut pro další vzdělávání pracovníků ve zdravotnictví, 2007.

TAYLOR-GOOBY, P. (ed.). **New risks, new welfare: the Transformation of the European Welfare State.** New York: Oxford Univerzity Press, 2004.

ÚZIS ČR. **Aktuální informace ÚZIS o činnosti kojeneckých ústavů a dětských domovů pro děti do tří let a dalších zařízení pro děti.** Praha: ÚZIS, 1990 – 2009.

ÚIV. **Vývojová ročenka školství.** Praha : ÚIV, 2009.

VÚP. **Rámcový vzdělávací program pro předškolní vzdělávání.** Praha: Výzkumný ústav pedagogický, 2004.

YOUNG, M. **Early child development:**

**investing in the future.** Washington D.C.:

World Bank, 1996.

Tisková zpráva MŠMT 17.5. 2011. **Firemní školky - základní informace.** [online]. [http://www.msmt.cz/pro-novinare/firemni-skolky-zakladni-informace, 18.5. 2011]

Tisková zpráva MŠMT 9.8. 2011. **Ministr Dobeš: Na firemní školky peníze najdeme.** [online]. [http://www.msmt.cz/pro-novinare/ministr-dobes-na-firemni-skolky-penize-najdeme, 23.9. 2011]

Tisková zpráva MPSV 23.8. 2011. **Dětská skupina ministerstva práce a sociálních věcí.** [online].[ http://www.mpsv.cz/files/clanky/11301/tzmpsv230811.pdf, 23.9. 2011 ]

**Legislative Sources**

Zákon č. 20/1966 Sb., o péči o zdraví lidu.

Zákon č. 455/1991 Sb., o živnostenském podnikání

Zákon č.48/1997 Sb., o veřejném zdravotním pojištění

Zákon č. 258/2000Sb. o ochraně veřejného zdraví

Zákon č. 96/2004 Sb. zákon o nelékařských zdravotnických povoláních

Zákon č. 561/2004 Sb., o předškolním, základním, středním, vyšším odborném a jiném vzdělávání (školský zákon), ve znění pozdějších předpisů (např. § 142 a násl. - Rejstřík škol a školských zařízení)

Zákon č. 117/1995 Sb. o státní sociální podpoře

Zákon č. 561/2004 Sb., o předškolním, základním, středním, vyšším odborném a jiném vzdělávání

Zákona č. 108/2006 Sb., o sociálních službách.

Vyhláška č.410/2005 Sb. o hygienických požadavcích na prostory a provoz zařízení a provozoven pro výchovu a vzdělávání dětí a mladistvých.

Vyhláška č. 242/1991 Sb., o soustavě zdravotnických zařízení zřizovaných okresními úřady a obcemi

Vyhláška č.135/2004 Sb. o hygienických požadavcích na koupaliště, sauny a hygienické limity venkovních hracích ploch.

Vyhláška č.137/2004 Sb., o hygienických požadavcích na stravovací služby a o zásadách osobní a provozní hygieny při činnostech epidemiologicky závažných

Vyhláška č.195/2005 Sb., kterou se upravují podmínky předcházení vzniku a šíření infekčních onemocnění a hygienické požadavky na provoz zdravotnických zařízení a ústavů sociální péče v platném znění.

*Vyhláška* MŠMT č. 43/2006 Sb., kterou se mění vyhláška č. 14/2005 Sb., o předškolním vzdělávání

Nařízení vlády č.491/2004 Sb.

Nařízení vlády č. 209/2001 Sb.
Nařízení vlády č. 469/2000 Sb.

Nařízení vlády č. 140/2000 Sb.

Metodické opatření MZ 1968: Věstník MZ č.10, částka 17-18.

Prováděcí předpisy k zákonu č. 258/2000 Sb., (vyhláška č.137/2004 Sb., o hygienických požadavcích na stravovací služby a o zásadách osobní a provozní hygieny při činnostech epidemiologicky závažných, vyhláška č.195/2005 Sb., kterou se upravují podmínky předcházení vzniku a šíření infekčních onemocnění a hygienické požadavky na provoz zdravotnických zařízení a ústavů sociální péče)

**Annex 1**

**Kindergartens – children from 2003/04 to 2008/09 according to age**

| Age of children | | 2003/04* | 2004/05* | 2005/06 | 2006/07 | 2007/08 | 2008/09 |
|---|---|---|---|---|---|---|---|
| **Total** | | **286,340** | **286,230** | **282,183** | **285,419** | **291,194** | **301,620** |
| including | Up to 3 years | 23,092 | 24,709 | 23,849 | 22,475 | 23,710 | 26,384 |
| | 3-years old | 71,530 | 70,717 | 69,519 | 72,108 | 73,997 | 79,025 |
| | 4- years old | 83,303 | 84,296 | 82,369 | 84,573 | 85,867 | 88,134 |
| | 5-years old | 85,961 | 85,193 | 85,883 | 85,866 | 87,273 | 87,927 |
| | 6- years old** | 22,454 | 21,315 | 20,093 | 19,997 | 19,896 | 19,699 |
| | Up to 6 years | - | - | 470 | 400 | 451 | 451 |

Source: database ÚIV

Note.

* In the 2003/04 and 2004/05 school years, including schools in health facilities.

** Children older than 5 years of age in 2003/04 and 2004/05.

**Kindergartens – percentage of children attending kindergartens in individual age categories of the population in school years from 2003/04 to 2008/09**

| Age of children | | 2003/04* | 2004/05* | 2005/06 | 2006/07 | 2007/08 | 2008/09 |
|---|---|---|---|---|---|---|---|
| including | Up to 3 years | 25.3% | 26.5% | 25.4% | 23.0% | 23.0% | 24.8% |
| | 3-years old | 80.0% | 77.3% | 74.6% | 76.6% | 75.3% | 76.5% |
| | 4- years old | 94.4% | 94.2% | 90.0% | 90.7% | 90.9% | 89.4% |
| | 5-years old | 96.0% | 96.4% | 95.8% | 93.7% | 93.2% | 92.8% |
| | 6- years old** | 25.0% | 23.8% | 22.7% | 22.3% | 21.6% | 21.0% |
| | Up to 6 years | - | - | 0.5% | 0.5% | 0.5% | 0.5% |

Source: database ÚIV

Note.

* In the 2003/04 and 2004/05 school years, including schools in health facilities.

** Children older than 5 years of age in 2003/04 and 2004/05.

**Annex 2**

**Rejected applications for enrollement of kindergarten based on the size of the group in the municipality (in %)**

| Rejected applications | Number of inhabitants in locality | | | | | | Total |
|---|---|---|---|---|---|---|---|
| | Up to 500 | 500 - 999 | 1,000-1,999 | 2,000-9,999 | 10,000 – 49,999 | 50,000 and more | |
| Yes | 10.8 | 22.2 | 30.2 | **53.2** | 45.8 | **70.5** | 36.8 |
| No | **89.2** | **77.8** | 69.8 | 46.8 | 54.2 | 29.5 | 63.2 |
| Proportion of rejected applications in the total number of applications in all localities* | 3.1 | 5.4 | 8.3 | 13.2 | 11.9 | **22.4** | 10.4 |
| Proportion of rejected applications in the total number of applications – only in localities where at least 1 application was rejected** | 26.6 | 24.8 | 27.3 | 24.6 | 25.5 | 31.2 | 27.5 |

Source: Kuchařová et al. 2008: 85

Note:

* the total percent of rejected applications expresses the proportion of rejected applications in total in the municipality of a given size. The total number of rejected applications is related to the total number of applications in municipalities of a given size.

** the percent of rejected applications is counted only from those kindergartens where some applications were rejected. The average percent of rejected applications in facilities where all the children were not accepted is statistically undifferentiated in its relation to the size category of the municipality.

**Annex 3**

**Criteria for accepting children to kindergarten (in%)**

| | | | |
|---|---|---|---|
| No criteria | 13.1% | **If they have some criteria, including:** | |
| 1 criterion | 3.9% | Age of child | 93.2% |
| Combination of 2 criteria | 2.8% | Permanent residency | 83.9% |
| Combination of 3 criteria | 9.5% | Working parents (both) | 77.7% |
| Combination of 4 criteria | 15.6% | Attendance of child's sibling | 66.1% |
| Combination of 5 criteria | 24.4% | Full-time attendance | 61.8% |
| Combination of 6 criteria | 16.7% | Single parent | 49.1% |
| Combination of 7 criteria | 8.0% | Family in need | 34.5% |
| Combination of 8 criteria | 4.7% | Other | 19.5% |
| Combination of 9 criteria | 1.1% | Czech citizenship rights | 13.6% |
| **N** | **639** | Family with 3 children or more | 7.0% |

Source: Kuchařová, et al. 2008: 86

**Annex 4**

**Number of nurseries and placements from 1990 to 2009**

| | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Number of nurseries** | 1,043 | 486 | 381 | 247 | 235 | 207 | 151 | 101 | 79 | 67 |
| **Number of placements in nurseries** | 39,829 | 16,628 | 13,196 | 9,265 | 8,565 | 7,574 | 5,551 | 2,965 | 2,191 | 1,913 |
| **Rise/Fall of placements between years (%)** | - | - 58.3% | - 20.6% | - 29.8% | - 7.6% | - 11.6% | - 26.7% | - 46.6% | - 26.2% | -12.7% |
| | **2000** | **2001** | **2002** | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** | **2009** |
| **Number of nurseries** | 65 | 59 | 58 | 60 | 58 | 54 | 48 | 49 | 47 | 46 |
| **Number of placements in nurseries** | 1,867 | 1,717 | 1,674 | 1,770 | 1,708 | 1,671 | 1,567 | 1,587 | 1,413 | 1,419 |
| **Rise/Fall of placements between years (%)** | - 2.4% | - 8.0% | - 2.5% | + 5.7% | - 3.5% | - 2.2% | - 6.2% | + 1.3% | -11% | +0.4% |

Source: ÚZIS [*Czech Institute for Health Information and Statistics*], Aktuální informace ÚZIS o činnosti kojeneckých ústavů a dětských domovů pro děti do tří let a dalších zařízení pro děti, 1990-2009 [*Activity of institutes for infants and homes for children up to 3 years of age and other institutions for children, 1990-2009*].

Note: Since 2000, nurseries and micro-nurseries include other children's facilities. Until 1999, the figures include only nurseries and micro-nurseries.

**Endnotes**

1 The research was conduced thanks to support from the Institute for Research on Social Reproduction and Integration (IVRIS) funded by the Ministry of Education, Youth and Sports of Czech Republic.

2 For example, in Brno, the fee has depended on family income and unlike the case of kindergartens, there is no legislatively determined maximum fee that the parents pay for the nursery. Generally, nursery fees are around 2,000 CZK per month per child (Klíč k jeslím 2007). However, since 2012 fees will probably escalate dramatically to 6,000 CZK per month for all income groups of families in Brno and also in some other cities (information from provider of nurseries).

3 Most of the existing laws apply in principle only to health and dietary requirements – e.g. Act No. 258/2000 Coll. on the protection of public health, as amended. Furthermore, there are other related legal conditions: Decree No. 135/2004 Coll., on the health requirements for swimming pools, saunas and the sanitary levels of outdoor playing surfaces (as amended), the implemented regulations to Act No. 258/2000 Coll., Special Decree No. 137/2004, on the hygiene requirements for food services, and the principles of personal and operational hygiene of activities of epidemiological importace, and Decree No. 195/2005 Coll., on the prevention and spread of infectious diseases and public health requirements for the operation of medical facilities and welfare institutions, in their valid version.

4 Act No. 561/2004 Coll., on pre-school, elementary, secondary, college and other education.

5 The lower age limit of a child is not firmly set.

6 In the case of private kindergartens, such facilities must meet the conditions defined by the Education Act (No.561/2004 Coll.) and therefore the requirements of the Framework Educational Program for Pre-chool Education (2004).

7 A person conducting a business under the trade licence "Day-care for children under three years" is required under paragraph 7 of Act No. 258/2000 Coll., as amended, to meet the requirements of the premises in terms of their sanitary conditions, equipment, operation, lighting, heating, micro-climatic conditions, water supply, cleaning and use of laundry, as prepared by the implemented legislation (Decree No. 410/2005 Coll., on hygiene requirements of the premises and operation of equipment and facilities for education of children and youth). Furthermore, the operation of this trade is also affected by Decree No. 137/2004 on hygiene requirements for food services and principles of personal and operational hygiene in epidemiologically related activities, as amended.

8 Government Directive No. 209/2001 Coll., setting the list of professions whose operation the entrpreur is obliged to provide strictly through physical personal fulfillment of the professional competence set by this directive. The content of this profession is set by Government Directive No. 469/2000 Coll.

9 The history of negotiations is quite long. Till now, any binding legislation has not been approved yet. The first document was so called Pro-family Package (MŠMT 2008), which was approved only by the government of the Czech Republic in 2009. After the political crisis in 2009, the new government changed the first draft law. Their plans are described in this article according to available sources. However, I would like to point out that all proposed childcare arrangements are not still clear in many aspects and could be different after completion of the entire political and legislative cycle.

10 *The explicit familialism* "not only strengthens the family in caring for children, the handicapped and the elderly through familialistic policies. It also lacks the provision of any alternative to family care. This lack in public- and market-driven care provision together with strong familialization explicitly enforces the caring function of the family" (Leitner 2003: 359). Austria, Germany, Italy and Netherland

belong to this type of family policy (ibid.).

11 The *implicit familialism* neither offers de-familialization nor actively supports the caring function of family through any kind of familialistic policy. Nevertheless, the family will be the primary caretaker in these welfare regimes since there are no alternatives at hand" (Leitner 2003: 359). Such a regime is present in Greece, Portugal and Spain (ibid.).

12 " Within *optional familalism* services as well as supportive care policies are provided. The caring family is strengthened but is also given the option to be (partly) unburdened from caring responsibilities" (Leitner 2003: 359). Right to care is not equated with the family's obligation to care compared to explicit familialism (ibid.). The representatives are Belgium, Denmark, France, Sweden and partially Finland (ibid.).

13 *De-familialism* "would be characterized by strong de-familiazation due to the state or market provision of care services and weak familialization. Thus, family carers are (partly) unburdened but the family's right to care is not honoured" (Leitner 2003: 359). Ireland and Great Britain belong to this regime (ibid.).

14 For comparison, between the two world wars, about 20% of the children in relevant age group attended kindergarten (Hašková 2007).

15 Unfortunately, since 2009/2010 *The Yearbook of Education Development in the CR* has ceased to publish this indicators per age group.

16 Fees for the nursery are approximately 2,000 CZK per child/month in average. However, it may vary considerably across regions (eg in Brno, the maximum fee is about 4,500 CZK) (Klíč k jeslím 2007). In comparison to the fees in kindergartens, there are also no limits given by law in nurseries. Fees for kindergarten are also different in different locations, however, they range between 500 to 700 CZK per child/month (including subsistence and fees for other activities) in average (Kucharova, Svobodova 2006).

17 Since 1.1.2008 parental leave and parental allowance are arranged in the Czech Republic as follows (MPSV 2009): "a parent who personally and duly cares for a child who is the youngest in the family is entitled to parental allowance. Parental allowance is provided at four rates that are set at fixed monthly amounts according to duration of drawing – increased rate (11,400 CZK), basic rate (7,600 CZK), reduced rate (3,800 CZK) and lower rate (3,000 CZK). A parent may elect to draw parental allowance for a period of up to two, three or four years of the child. By selecting the period of support, the parent also selects the amount of the allowance, as follows:

(1) *faster draw-down* – after maternity benefit (hereinafter referred to as MB) at the increased rate (11,400 CZK) until the child is 24 months old; only parents who are entitled to MB of at least 380 CZK per calendar day may request this form of draw down;

(2) *standard draw-down* – after MB at the basic rate (7,600 CZK) until the child is 36 months old; only parents who are entitled to MB may request this form of draw down;

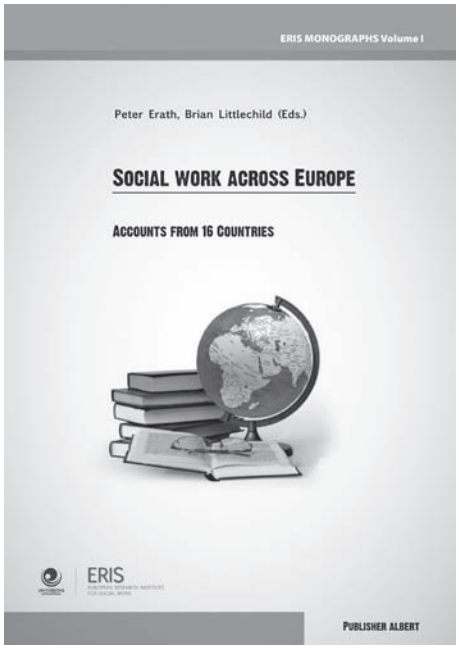
(3) *slower draw-down* – after MB or from the birth of the child (if the parent is not entitled to MB) at the basic rate (7,600 CZK) until the child is 21 months old and after it at the reduced rate (3,800 CZK) until the child is 48 months old.

18 However, we can talk only about alleged practise because there is no research that would confirm its existence and the level of its using.

## Book Reviews

# Peter Erath and Brian Littlechild (Eds.): **Social Work Across Europe. Account from 16 Countries.** Ostrava, University of Ostrava – ERIS with Albert Publisher, 2010.

The book takes on the ambitious task to collect accounts of the history, development, current status and future challenges of social work in selected European countries. Sixteen countries (Austria, England and Wales, Finland, France, Germany, Hungary, Italy, Netherlands, Norway, Poland, Romania, Slovak Republic, Spain, Sweden and Switzerland) are represented in this book and therefore the reader gets a comprehensive overview of the variety and diversity of social work, social welfare and social policies in Europe.




According to the introduction of the book written by the editors themselves the different national authors of each chapter were given systematic guidelines on writing the country specific account. However after receiving the chapters it became clear that it was virtually impossible to use the same structure for each country. The national and cultural traditions of each of the sixteen countries were so diverse that following the same structure would mean to compare apples with oranges.

For that reason each chapter reflects this given diversity by using its own style, structure and approach in describing social work in the particular countries. Some accounts are focussing on the social policy and social welfare system and are therefore describing the place of social work in the social system (i.e. Austria or Spain). Some are emphasising more on the development of social work education within their countries (i.e. France). Others again are picturing the national characteristics of social work in their country by focusing on social work itself and are therefore describing theories, methods and values of social work, detailing user groups and social work organisations and reflecting on the professional status of social work within the country (i.e. England, Germany).

The plurality of these approaches can be seen as an asset and drawback at the same time. It is a weakness of the book because it makes it hard to compare one country to another. The book will disappoint readers who are looking for that

kind of a comparative approach. But this is not the aim of the book and neither the editors nor the authors of each chapter are promising such kind of comparison. For that reason one has to focus on the strength of the book. Social work across Europe is influenced by a plurality of cultural, historical and ethical factors. The accounts from the sixteen countries given in this book are reflecting this diversity and the reader is therefore presented with a tremendous chance to learn more about other European countries. And that is exactly what the book was getting at. And knowing more about other European approaches to social work might be a first step to pave the way from "Social Work across Europe" to an "European Social Work".

*Stefan Borrmann*

# Kenneth McLaughlin: **Social Work, Politics and Society. From radicalism to orthodoxy.** Bristol, The Policy Press, 2008.

Kenneth McLaughlin in his book ´Social Work, Politics and Society´ critically discusses the development and current trends in social work in the United Kingdom. Particularly he points out the issues of excessive politicisation and professionalisation of social work.

In his approach, the interaction between the political and social dimension and its historical context are crucial aspects of the analysis. Therefore the first chapter (´**Understandings of and developments within social work**´) introduces us to the historical context of social work in the United Kingdom.

In the second chapter (´**Politicising social work**´) McLaughlin describes the beginnings and roots of the radical social work movement during the 1960s, including the ways it has been influenced by Marxism, feminism and Standpoint theory. Further on the development of anti-discriminatory, anti-racist and anti-oppressive practices and their main ideological differences are discussed.

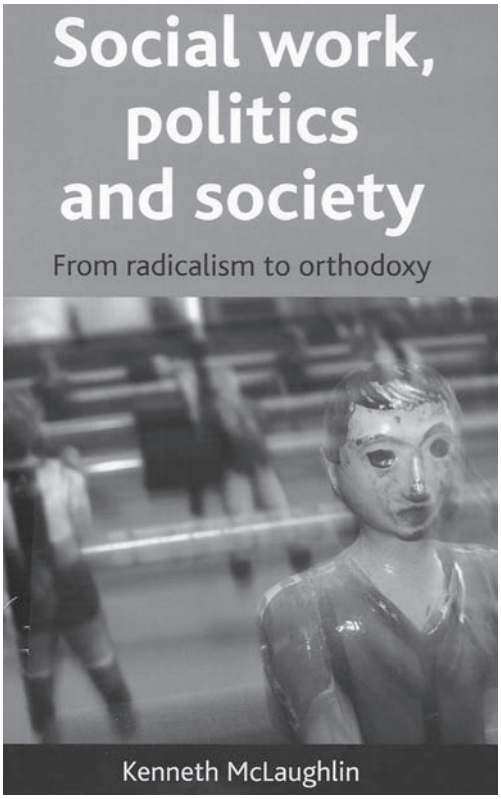
In the third chapter (´**Depolicising´ social work**´) the author explains the causes and effects of politicisation and depoliticisation. He argues that although the emergence of approaches such as the ´competence-based´ model or ´new managerialism´ might be interpreted as part of the backlash against the anti-oppressive practice, as a matter of fact it was the general loss of political confidence within left-wing thought and the sense of pessimism for wider social change which caused the shift from the macro analysis of society and power relations to the micro level of personal change and interpersonal relationships. Also he demonstrates how the anti-racist and anti-discriminatory language became part of the public rhetoric and that it is not only the social workers, but also the state, government, courts or police who are seen as responsible for the solution of problems of oppression. For these reasons McLaughlin sees it as rather problematic to insist on further politicising of social work, as it became part of the system which was initially criticised and examined with great suspicion.

In the fourth chapter, ´**Agency, pathology and abuse´,** McLaughlin notices the negative aspects of exceeded professionalisation of social work. He is critical about the professional arrogance expressed through the underlying assumptions that people are not able to cope with their problems or make important decisions and changes without professional input and generally the increasing level of professional intervention in people´s lives.

Another point of criticism is that the exercise of professional power over clients restricts or denies their agency. Although McLaughlin acknowledges that by shifting the attention to

a more interactive/person-in-environment view social workers manage to oppose the medical discourse in many ways, he remains critical towards adopting concepts such as addiction or abuse as being deterministic and denying clients´ agency. Last but not least McLaughlin points out that the role of social workers is not only to avoid such reductionist categories, but also to critically examine how the individual and social problems and the ´objects of social work interventions´ are constructed. He gives the example of a case where the ´hearing of voices´ was not interpreted as a clear symptom of mental disease, but in the context of the client´s life as actually a result of his past experience with abuse. Although we can see an important shift in the way the client´s situation is interpreted, McLaughlin stresses that it still does not take into account the wider cultural and historical context and therefore fails to recognise the role discourse plays in the interpretation and understanding of who we are or what we have experienced. By uncritical acceptance of alternative discourse we run the risk of merely replacing the label of pathology with the image of victim, which are both still not empowering the client. Here anti-oppressive social work is discussed as a possible solution, as it is based on criticism and resistance to the dominant discourses and the social worker´ s task is to support clients in developing their own interpretations of their experiences. But at the same time, McLaughlin avoids falling into the trap of offering easy but vague solutions and reflects that the shortcomings of the anti-oppressive approach are actually not in its radical theoretical claims, but exactly in the successful implementation to in the everyday practice, which would cause not only proclaimed but also real empowerment of the client.

In the fifth chapter (´**The politics of risk and mental health**´) the author shifts his focus to more particular issues. Firstly he describes the construction of the feelings of fear, vulnerability and danger in contemporary society and consequently its obsession with risk minimisation, which has a crucial impact also on social work and social policy. Seeing clients as dangerous legitimises the coercive power of professionals and the restriction of individual rights and liberties in order to avoid possible dangers or risks. In the sixth chapter (**´The subject of stress´)** he similarly analyses the construction of ´stress´ and ´bullying´.




The seventh chapter (´**From at risk to a risk: regulating social work**´) is concerned with the regulation of the social care workforce. Although the focus here is exclusively on the current situation in the United Kingdom, it can be interesting also for practitioners from other countries such as, for instance, Czech social workers who have to face similar problems and tendencies connected with the implementation of the inspections of social services.

In the last chapter ´**Politics and social work**´ McLaughlin underlines his emphasis on the depoliticisation of social work and the importance of social work being defined by its value base rather than its functions for the state. How far we manage to critically examine the dominant discourses and support clients in their own interpretation of their problems and needs, or how far social work has become over-politicised are challenging questions also in the context of Czech social work. McLaughlin offers us some thought-provoking reflections and ideas for answering them.

*Magda Frišaufová*

# "Housing First" as an approach to homeless people with co-occurring disorders

There is a rising concern about street homeless people with mental health issues in the Czech Republic. Mental health issues often co-occur with substance misuse. What comes first in the situation of a person living on the street is not of much importance. The response of social work to co-occurrence seems absolutely crucial.

There are many links available, connecting mental health, substance misuse and homelessness, through numerous researches.

### Homelessness and Mental health

Bines (1994) in his research report states that the number of those with mental health issues among homeless population is eight times higher than in the rest of the population. Depression, anxiety and neurosis are mental health issues related to homelessness. Also the occurrence of schizophrenia is higher than in populations with stable housing. Fitzpatrick, Kemp, Klinker (2000) point out there is a high percentage of homeless people with mental health issues displaying heavy alcohol addiction. Research reports from the Czech Republic (Dragomirecká, Kubisová, 2004; Barták 2005) show that many homeless people suffer from serious mental health issues.

### Homelessness and Substance Misuse

The Advisory Council on the Misuse of Drugs identifies a key role of substance misuse in the field of homelessness (ACMD, 1998). Homelessness can lead to problematic drug use (Randall and DrugScope, 2002). Many homeless problematic drug users have problems related to an extensive consumption of alcohol (Randall, Brown, 2002). Another research report from 1998 states that drug related problems affect one in five street homeless people, and one in three young street homeless people (aged 26 and less) (Randall, 1998). Czech researches (Barták, 2005; Šupková, 2007) prove the similar in the Czech Republic.

### Housing first

The Housing First approach was pioneered by Sam Tsemberis who established the Pathways to Housing program in New York, in 1992. This program is aimed at "hard-to-serve" clients, thus including those with psychiatric disabilities, substance misuse, criminal history and other serious difficulties. The Housing First approach is based on two important principles. The first is: housing is a basic right for all people. That means housing and treatment are two separate domains. Housing is not connected to a client´s consent to treatment; this means that active substance misusers, for example, are not excluded from housing. The second principle is that the choice to change must be the client's choice. To go with client´s choice is a fundamental aspect of Pathways to Housing program. Rough sleeping homeless people most express their need for housing. Hence, the Pathways to Housing program provides housing first, because it is the client´s first choice. Atherton and Nicholls (2008) note housing itself is not enough. There needs to be an "integrated care package" in order to maintain stable housing.

That is reflected within Pathways to Housing program by implementing assertive community treatment provided by assertive outreach teams. These are multidisciplinary outreach teams consisting of a psychiatrist, psychiatric nurse, social worker, substance misuse worker and peer supporters. The teams´ application of the above principles is incorporated using the following work methods: psychiatric rehabilitation, motivational interviewing, harm reduction practice, community integration, client advocacy and recovery knowledge. A provision of assertive community treatment leads to adequate work with social and health problems the clients face. Therefore housing within the Housing First approach takes the form of "supported housing". (Tsemberis in Levinson, 2004) The apartments in the Pathways to Housing program are rented

privately, but Pathways holds the leases and manages the properties (Atherton, Nicholls, 2008). Clients lose their housing only in ways other tenants lose their housing (e.g. by not paying the rent, causing disturbances intolerable to neighbours) (Tsemberis in Levinson, 2004). There is an ongoing discussion about the Housing First model´s effectiveness, especially compared to the widespread continuum of care model (Atherton, Nicholls, 2008). Clients housed within the housing first approach had around an 80% retention rate in housing over a two-year period. In addition to successful maintenance of a tenancy, health and well being of clients also seem to benefit (Tsemberis et al, 2004 in Atherton, Nicholls, 2008).

This article describes the Housing First approach with homeless people with co-occurring disorders, but the philosophy is applicable to work with any homeless individual or homeless family.

The question remaining is in what way could the Housing First model be implemented within the Czech social work?

The author suggests that further research on the Housing First approach within the Czech environment needs to be conducted.

*Eliška Lindovská*

**Literature:**

ADVISORY COUNCIL ON THE MISUSE OF DRUGS. **Drug misuse and the environment: a report by the Advisory Council on the Misuse of Drugs.** London: The Stationery Office, 1998.

ATHERTON, I., NICHOLLS, C. **„Housing First" as a means of addressing multiple needs and homelessness.** European Journal of Homelessness, vol. 2, 2008.

BARTÁK, M. a kol. **Zdravotní stav populace bezdomovců v ČR a jeho determinanty II.** Kostelec nad Černými lesy: IZPE, 2005.

BINES, W. **The Health of Single Homeless People (1st ed.).** York: Centre for Housing Policy, University of York, 1994.

DRAGOMIRECKÁ, E., KUBISOVÁ, D. **Bezdomovectví a duševní zdraví.** Česká psychiatrie a svět. Praha: Galén, 2004, s. 31-34.

FITZPATRICK, S., KEMP, P., KLINKER, S. **Single Homelessness, an overview of research in Britain.** Bristol: The Policy Press, University of Bristol. 2000.

RANDALL, G. **Rough sleeping: A review of research,** DETR, 1998.

RANDALL, G., BROWN, S. **Helping rough sleepers off the streets.** ODPM, 2002.

RANDALL, G. and DrugScope. **Drug services for homeless people: a good practice handbook.** ODPM, 2002.

ŠUPKOVÁ, D. et al. **Zdravotní péče o bezdomovce v ČR.** Praha: Grada. 2007.

TSEMBERIS, S. **„Housing first" approach.** In LEVINSON, D. **Encyclopedia of homelessness, vol. 1.** London: SAGE Publications, 2004, p. 277 – 281.

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