ZDRUŽENJE ZA SOCIALNO PEDAGOGIKO
ZZSP
KARDELJEVA PLOŠČAD 16,
1000 LJUBLJANA

Revijo Socialna pedagogika izdaja Združenje za socialno pedagogiko - slovenska nacionalna sekcija FICE. Revija izhaja četrtletno. Vse izdajateljske pravice so pridržane.

Socialna pedagogika is a quarterly professional journal published by Association for social pedagogy - Slovenian national FICE section.

Naslov uredništva je:
Addres of the editors:

Združenje za socialno pedagogiko
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Naslovnica: Beograjsko romsko naselje Deponija, foto Andreja Gimpelj

Lektorirala: Katarina Mihelič
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Letnik XIII, 2009, št. 2
Vol. XIII, 2009, No. 2
ISSN 1408-2942
Spletni naslov: http://www.zzsp.org

Naročnina na revijo za leto 2009 je 25 EUR za pravne osebe. Naročnina na revijo je za člane Združenja vključena v članarino.

Izdajanje revije v letu 2009 finančno podpirata Agencija za raziskovalno dejavnost Republike Slovenije ter Ministrstvo za šolstvo in šport RS.

Članke v reviji abstrahirata in indeksirata *Family Studies Database* in *Sociogical Abstracts*.

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ISSN 1408-2942

Social pedagogy for the Reduction of Social Exclusion

Socialna pedagogika za zmanjševanje socialne izključenosti

Darja Zorc-Maver

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The texts featured in this issue reflect some of the major recent lines of research in the field of social pedagogy. All the studies carried out, except for one that is limited to the Croatian space, refer to the Slovenian space. Social pedagogy comprises a broad field of identifying and researching social problems in society and represents a scientific discipline which tries to reduce the social exclusion of social groups at risk (the homeless people, the unemployed, children and youth with problems). Looking at it in the broadest sense, it could be said that social pedagogy is a scientific field that strives to attain greater social justice. Its contribution is precisely in the fact that it tries to contribute to better living conditions and to develop a greater coping with life in the aforementioned social groups at high risk. This also represents the focal and common theme of the contributions published.

The article by Špela Razpotnik and Bojan Dekleva titled »Homelessness and the Accessibility of the Health Care System« represents the first Slovenian research of this kind. The authors, on the basis of data obtained, show the deficiencies of the health care system for groups at risk and point to the need to change it in terms of lowering the entrance threshold to access health services and to create a more integral, individualized treatment of the individual groups of homeless people.

The second cluster of studies is about the research of children/youth and the various forms of risky behaviour. Within this framework special attention is paid to children/youth with behavioural and emotional

problems, who are due to various circumstances placed into specialized institutions such as juvenile home institutions and residential groups.

In the article titled »Changes in the Behaviour of School-aged Children: new old Educational Challenges« Helena Jeriček analyzes the changes in the behaviour of children/youth, experiencing school and the spreading of forbidden substances. In the research she particularly emphasizes the feeling of greater burdening of children/youth in school and a greater degree of violence especially present among girls, whereas in the features of forbidden substances consummation there are no basic changes among youth, except for the decrease in the use of canabis. The contribution by Matej Sande »The Use of Alkohol among Secondary School Students on Gradiation Tours« is likewise centred on the alcohol use research at final secondary-school graduation excursions, which represents a specific and a widespread phenomenon of risky behaviour of youth. Prevention in order to lower the damaging consequences in this field represent a new challenge for social pedagogy.

Mitja Krajnčan presents the results of a research in the field of children and youth with bahavioural and emotional problems who are placed in the various residential institutions. He tries to ascertain the criteria that make the experts in the Centres of Social Work decide about the need to place a child/youth into a special institution. He comes to the conclusion that in Slovenia there are no clearcut criteria and models and pleads for more transparent criteria in this field and a greater participation of a child/youth and parents in this decision.

The contribution by Zdravka Poldrugač and Dejana Bouillet is a Croatian view of social pedagogy and its future development. The authors research the various competences which are typical of the various fields of social pedagogy activity and on this basis postulate the scientific grounding and future development of social pedagogy in Croatia.

We believe that the existing social problems are not exclusively limited to the Slovenian space, although they do have certain specificities of this socio-cultural system: perhaps this is precisely what makes them interesting for the broader European space of social pedagogy. This issue in English aims exactly at this, namely to enable the broad professional community to gain access to the results of Slovenian research and to attain greater international connections and exchanges in this scientific field.

Ljubljana, June 2009

Homelessness and the Accessibility of the Health Care System

Brezdomstvo in dostopnost zdravstvenega sistema

Špela Razpotnik and Bojan Dekleva

Abstract

The article describes the results of the first Slovenian research of the health situation of the homeless people, with a special emphasis on the accessibility of the health care system. A field survey was carried out on 122 homeless persons from six Slovenian towns. The analysis has shown that the experience with the accessibility of the health care system by the homeless people is not optimal and that the accessibility of this system is smaller for those with greater risk factors. Particularly threatened in this sense are the individuals with the so-called double diagnoses. On the basis of this analysis recommendations are given for lowering the threshold in health organisations, for a more integral and individualised approach to the homeless persons, and for the development of outreach (health) work.

Key words: *homelessness, social exclusion, health, accessibility of the health care system, discrimination, mental health problems, alcohol, drugs, low threshold field work, proactive work.*

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Povzetek

Članek opisuje rezultate prve slovenske raziskave zdravstvenega stanja brezdomcev s posebnim poudarkom na dostopnosti zdravstvenega sistema. Izvedeno je bilo terensko anketiranje 122 brezdomnih oseb iz šestih slovenskih mest. Analiza je pokazala, da doživljanje dostopnosti zdravstvenega sistema s strani brezdomcev ni optimalno ter da je dostopnost tega sistema manjša za osebe, ki imajo več ogrožajočih dejavnikov. Posebej ogroženi so v tem smislu posamezniki s t. i. dvojnimi diagnozami. Na osnovi analize so podana priporočila za nižanje praga v zdravstvenih organizacijah, za bolj celosten in individualiziran pristop k brezdomcem ter za razvoj terenskega (zdravstvenega) dela.

Ključne besede: *brezdomstvo, socialna izključenost, zdravje, dostopnost zdravstvenega sistema, diskriminacija, težave z duševnim zdravjem, alkohol, droge, nizkopražno delo terensko delo, proaktivno delo.*

Introduction

Homelessness in Slovenia is a relatively new phenomenon, which, as recently as a few years ago, was accompanied by rather astonished reactions of the media and the public, while there had been practically no publications on the topic of homelessness in the Slovenian expert and scientific press until the end of the previous millennium. A turning point occurred mostly in the past five years when homelessness became – within the social issue – one of the more frequent topics, first in mass media and then increasingly also in the professional journals.

In the last 20 years, and particularly intensively in the last five, a network of organisations operating in the field of homelessness has also been developing. With the heterogenising of the phenomenon of homelessness (the representation of an increasing number of different specific populations according to gender, status, age,

origin …) this network has also expanded and heterogenised itself. Both the expanding and the heterogenisation of the organisational network, in relation to the expanding and heterogenisation of the phenomenon of homelessness itself, are naturally carried out slowly and with a time lag.

The organisational network in the field of homelessness is developed best in the capital Ljubljana, and has also been developing in other Slovenian towns in the past few years: Maribor, Celje, Koper, Slovenj Gradec, Murska Sobota, Kranj … While the European trend lies mostly in the surpassing of shelters and their replacement with more permanent, stable, and in the long run more promising forms of housing for the individual, such that would enable the individual a starting point for organising other areas of his or her life as well, in the mentioned smaller Slovenian towns, on the other hand, mostly shelters have been set up in the past years.

During the wave of a new interest in homelessness in 2005 and 2006 the first larger and more complex research project was carried out specifically on the topic of homelessness (Dekleva & Razpotnik, 2007; Razpotnik & Dekleva, 2007). In the period after this research more specific topics began to open up, new expert activities and work models developed, and an awareness of new topics still left to be treated began. Among such topics are for instance the model of the housing support to the homeless in their inclusion into a more conventional way of life, the models and approaches of outreach work, the issue of the development of the model or the (internationally comparable) system of counting the homeless (which is becoming topical with Slovenia's inclusion in various European projects) and the topic of the development of the standards of treating homelessness or in general of the development of politics in this area.

One of these more specific topics also concerns the health care issue or the question of the health situation of the homeless population, the question of their health care treatments, the question of how the homeless experience the health care system, what they think of its accessibility and what its attitude is towards them. The health care's attention was turned in this direction, in the broadest sense of the word, when we began to contemplate which the particularly vulnerable and threatened groups within healthcare are, and connect this concept with the notion of social

exclusion. In connection with this topic the Slovenian Ministry of Health ordered the elaboration of an analysis on the topic of Homelessness and Health. This article discusses a part of the results of this analysis[1].

Homelessness and the Health Care Issue

One of the most pressing problem themes, connected with homelessness, is the health care issue. It also presents one of the key challenges in the forming of a policy in the field of homelessness. Numerous research in this field (for example, Riley et al., 2003; Masson & Lester, 2003) reports on the relation between homelessness and the poor medical condition or on the worse medical condition of the homeless in comparison with the general population. At the same time, this research also testifies of the more serious disease patterns within the homeless group. The medical problems of the homeless are said to be, according to the findings of much of the foreign research (for example Carter et al., 1994, and Grumbach et al., 1993; both quoted by Savage et al., 2006), mostly of a chronic nature and not as urgent, which is why long-term care and nursing is more suitable for them than an urgent one.

According to the findings of numerous surveys there are three key medical problems that can be understood as causally connected with homelessness or with extreme social exclusion: mental illnesses (or in a broader sense, mental health problems), addiction to alcohol and addiction to illegal drugs. Various surveys thus find among the homeless, in addition to worse physical health, also a high level of mental health problems. Certain surveys records as much as 80 to 95 % of the homeless with mental health problems (Riley et al., 2003). Other authors report that mental health problems (often measured with a prevalence of former psychiatric hospitalisations or treatments in general) are present in 10 to 60 % of the entire homeless population and that 70 % of the homeless or more are addicted to different psychoactive substances (Scott, 1993; Savage

[1] More complete information on this analysis is available in the publication »Brezdomstvo, zdravje in dostopnost zdravstvenih storitev« (Razpotnik and Dekleva, 2009), where certain segments of this article are also published.

et al., 2006). All of the problems listed, of course, condition the creation of new ones and enable the deepening of the vicious circle of social exclusion, which in turn conditions also the exclusion from health care systems and the deepening of an unhealthy life style, thus only increasing the medical problems listed, as well as others. In addition to the three areas mentioned, within the field of homelessness/health care, infectious diseases (tuberculosis, certain liver diseases, sexually transmitted diseases) are also often discussed in professional articles, mostly from an epidemiological perspective, the risk of which increases in poor living conditions, such as that of the homeless.

Research on other threatening factors frequently connected with homelessness has shown that the issue of homelessness is often connected with childhood abuse (Mounier & Andujo, 2004) and with disfunctional families (Tyler, Cauce & Whitbeck, 2004). In Scotland, for instance, among the homeless youth there is a third of those who had spent their childhood living outside the family, in an institution or a foster family (Jones, 2003). Very often the issue of homelessness and the use of various substances and addiction is connected with increased medical risks and a risky sexual behaviour (especially among the young), which increases the risk for this population to become infected with the HIV virus (Bell et al., 2003). With the latter, prostitution is also connected (Gwadz et al., 2004).

Likewise, the issue of homelessness is also frequently specifically connected with the affiliation to subcultures (ethnic, cultural, regarding sexual orientation, or others) and disability (Whitbeck et al., 2004). The differences are naturally derived from the unequal position of different social groups within different societies, are connected with obstacles in the accessibility of important social sources and with the discrimination which one or the other subcultural group experiences in the (non)treatment within the health care system. The consequences of the above-mentioned characteristics are manifestly often shown as psychological peculiarities of individuals, which hinder them from establishing permanent and satisfying social relationships with others and indirectly also affect their life style, which brings health risks and worsens the accessibility of health care services.

The poor medical condition of the homeless is most often contributed by authors (for example Riley et al., 2003) to the

following factors:

- less suitable medical care,
- financial obstacles in the use of health care services,
- nonfinancial obstacles in the use of health care services, such as problems (psychological, relationship, social …) deriving from mental health problems and/or addictions to psychoactive substances.

Masson and Lester (2003) add that much of the research confirms that the attitude of the medical staff towards the homeless creates important obstacles in the accessibility of the health care system to these people. It would be reasonable to add to this list at least one more item, namely, the health threatening life style of the homeless, which is represented by the absence of a safe residence or living in an unstable, insecure and dangerous environment, exposed to unpredictable weather and social influences. This is therefore more of a secondary consequence of the way of life itself than an independent factor.

The authors Turnbull, Muckle and Masters (2007) find that despite a higher level of different illnesses and diseases the homeless, often due to different reasons, do not use medical services or feel there is a lack of effective medical services for them. The lack of medical care which the population in dicussion would feel and label as suitable is evident in the fact that the homeless visit medical institution less often than needed, resulting in their medical problems becoming accumulated, remaining untreated, often becoming old and consequently harder to solve. The lack of accessible medical care is also shown in an often mentioned phenomenon (for example Savage et al., 2006), that is, in the use of urgent help (emergency unit) as the source of basic or any kind of medical care. In other words, this means that from various reasons the homeless acquire medical care only when their medical condition is so poor that they are brought there by others or when in distress they come there themselves looking for urgent help. Many articles include contributions expressing the need for adapting the health care system, which is in many places directed towards stratification, to the most vulnerable part of the population, to which health care is the least accessible. This need is being realised across the world in the formation of proactive services accessible to the homeless and

incorporated into the community, whose workers do not wait for the homeless to start looking for their services themselves, but make the first step and come to the environment of those that need help. Such services ought to be founded on forms of work that are based on individualised, non-discriminatory paradigms, integrated in the living space. In Slovenia as well the appearance of dispensaries intended for citizens without health insurance has taken this path, however, the problem is that these dispensaries are not included in the public health care system.

When contemplating the attitude of the medical staff towards the homeless the results of the study by Masson and Lester (2003) from Great Britain deserve mention. The authors researched the attitude of medical students towards the homeless at the beginning of their study and at the end. The results have shown that within the five-year period of study the attitude of the students towards the homeless becomes worse, which mostly points to a need for programmes that educate medical workers to also include in their curriculum the issues of social exclusion, the equal treatment of all pacients and the understanding of their peculiarities. Melvin (2004) reports that the homeless feel unwelcome in general medical practices, while many have also felt an unwanted, patronising attitude of the medical staff towards them.

Within the already threatened group of the homeless there can also be identified the particularly threatened groups and their specifics contemplated and discussed. As has already been said, many authors report on a high degree of mental illnesses among the homeless. Many believe that such widespread mental health problems among the homeless are a result of the disintegration of a system of institutions that were decades ago still intended for the long-term stay of people with mental health problems. Craig and Timms (1992) believe that the roots of the problem are much more complex than the mere deinstitutionalisation or breakdown of asylums. They are of the opinion that the increased extent of mental health problems among the homeless has been contributed to by the tendency towards the shortest and most intense treatments as possible, also in the events of serious, protracted and complex mental health problems. The need for medium-term and long-term care of such mental health problems and for (social) rehabilitation remains unsatisfied. And the homeless patients with mental health problems who would require a more lasting rehabilitation, and above

all continuous social care, are often designated as those that only "occupay the beds in today's often crowded health care system". The same authors (Ibid.) identify the main cause of the problems with the accessibility of suitable medical services for homeless people (with mental health problems) also in the lack of assertive field services. Melvin (2004) similarly finds that effective outreach work is recognised by many authors in the discipline today as the most successful form of engaging and including an otherwise hidden segment of users.

With the change of social circumstances the structure of the population, threatened with homelessness, changes as well, including its characteristics and needs. An always interesting and important view within this is, among other things, the age structure of the homeless population, since the group of younger homeless people has different needs than the group of older ones, while the needs of both are connected with the physical health of the individual and the sociological characteristics of an individual generation. A survey performed in the USA (Garibaldi, Conde-Martel & O'Toole, 2005) dealt precisely with the comparison of the medical condition and the unsatisfied medical needs between the groups of younger and older homeless persons. The researchers included persons aged from 18 to 49 in the younger group, and persons aged 50 and above in the older group. They discussed the researched topics with the homeless in interviews. The need for medical care ranked second among the most urgent needs within the older group, right after the need for housing support. The older group reported 3.6-times more often chronic diseases, the older ones had arranged health insurance 2.8-times more often than the younger group and were addicted to heroin 2.4-times more often than the group under the age of 50 (this finding is unusual from the Slovenian viewpoint and is probably connected with the fact that the tradition of the use of heroin is much longer in the USA than in Slovenia). Those over 50 also used medical care intended especially for the homeless more often than the younger group, for instance shelter-based clinics and street outreach work. However, the older homeless persons reported rarely on the need for treating addiction with different substances (despite a greater degree of substance abuse among them).

The study by Crane and Warnes (2001) has confirmed that people with combined problems, double diagnoses or the coexistence

of problems with alcohol abuse and other drugs are particularly problematic from the point of view of the accessibility of health care services. This study has also determined that services which would fully take care of this segment of the users, that is, people with combined problems, or that would assume responsibility for them are either nonexistent or too few. Providing the users with combined problems integral care in one place would, due to their way of life, marked precisely by their lack of looking for various clinics or using their services, be of key importance.

Purpose of the Research and the Methodology Used

The purpose of the aforementioned analysis was to study the basic area of the medical needs of the homeless, their experiences with the health care system and their impression of the system, including the accessibility of the system, the level of their trust in this system and the experience of the attitude of the system towards them. This contribution reports only on the experiences of the accessibility of the health care system among the Slovenian homeless and on which – as regards the accessibility of the health care system – the especially threatened groups of the homeless are.

The data has been obtained with individual field surveys of 122 homeless persons from six Slovenian towns. In Ljubljana the search for respondents was carried out in different locations, among which often on the streets, while in the five smaller towns only in the local homeless shelters. Our definition of homelessness which was read in the beginning to the persons surveyed goes as follows:

> *You are homeless if you sleep outside, in basements, vestibules, bases, temporary sanctuaries, shelters or other temporary housings intended for the homeless, in housing groups for the homeless; if day to day you do not have a guaranteed roof over your head or a home of your own and have nowhere to go even if you are facing eviction.*

The interviewers were specially trained persons with plenty of past experience in field work with the homeless.

In addition to demographic questions and many questions on the various aspects of the medical condition, the survey also included

another 40 questions on the experience with the accessibility of the health care system.

Results of the Analysis

The experiences with the health care system and its own treatment within it was determined with the use of two scales or item groups. The first (Table 1) was comprised of eight statements on the topic of the accessibility of medical help, information, the possibilities of participation and respectful treatment. This set was named in short »integral evaluation of the quality of medical treatment«. The respondents could choose within every item among five answers ranging from »not true at all« to »very true«. Table 1 shows the percentage of answers expressing disagreement with the claims and therefore an explicitly negative experience of the health care system. The repondents with such an experience of the system ranged from 11.6 to 26.9 %. It could be concluded in a simplified way that approximately a fifth of the respondents evaluates the possibilities of the accessibility of medical help, the possibilities of participation and of respectful treatment within it as poor.

Table 1: Percentages of the repondents in disagreement with individual claims of the scale of experiences with the health care system

Claim referring to the experiences with the health care system	**% of those who replied »not true at all« or »not true«**
Medical help is accessible enough when I need it.	11.6
The questions that I had posed to the medical staff were answered in an understandable way.	15.0
Before the beginning of treatment, the process of the treatment and the risks connected with the treatment were clearly explained to me.	23.1
I always participated in the decisions regarding my treatment whenever I wanted to.	26.7
I was treated with dignity and respect.	26.9
I was ensured privacy during talks and the performing of procedures.	15.1
I was acquainted with the rights and obligations as a pacient.	16.7
I evaluate the treatment I received as good.	25.8

The second scale was comprised of 23 claims, with a two-level option of answering, YES or NO. This scale (Table 2) contains more specific and concrete views of (mostly) negative characteristics of the operation of the health care system, again from the point of view of the persons treated within it, the accessibility, adaptation and attitude of the medical staff. It has been named »obstacles in the accessibility of medical services«. This term, of course, includes both the objective and the subjective aspects, in addition to the awareness of the fact that this is a process which is realised with the cooperation between users and individual segments of the health care system. The percentages of the critical respondents vary in the case of individual items from 15 to 70 %, with approximately 45 % on average. Some of the items may not have much to do with the health care system directly (for example *I have problems with transportation to the place of help* or *The location of the institution is unsuitable for me*); others are of a sort of subjective nature (for example *I do not know how to seek help*); the third could be called systematic (for example *The entry waiting line is too long*); while the fourth allegedly reflect both the conduct of the staff as well as the experiences of the users, most likely precisely in connection with the special characteristics of the homeless (for example *I feel discriminated in the medical institution*). Three of the claims express a positive evaluation, while the remaining 19 express a negative one (if the respondents agree with them). Viewed on the whole, a majority of the viewpoints that the scale inquires about is perceived negatively by between 30 and 50 % of the users, which is most certainly worrisome.

Table 2: Percentage of the repondents in disagreement with individual claims of the scale of experiences with the health care system

Claim referring to the experiences with the health care system	**% of those who agree with this claim**
The health care workers are not kind or friendly.	37.8
The health care workers do not properly understand my needs, problems …	50.8
The health care workers assess and judge me too much.	37.8
I have problems with transportation to the place of help	32.5
I do not have the necessary documents to enter a programme (for example health insurance).	31.1
The location of the institution is unsuitable for me (hard to access …).	16.8
I do not know how to seek help.	15.3
I feel discriminated in the medical institution.	33.3
I have bad experiences with experts/I do not trust them.	34.5
The entry waiting line is too long	69.7
The time for a checkup/conversation is limited.	65.5
Medical institutions cannot help me.	21.3
Medical services are too expensive.	63.6
The atmosphere in medical institutions is too chaotic.	55.5
The employees do not possess enough knowledge to work with the homeless.	58.5
The expectations and demands of the medical institutions are too great (for example abstinence).	55.1
No confidentiality.	42.0
The programmes are not adapted enough to special groups (for example the homeless, users of illicit drugs …).	61.9
Limited working hours of the services.	65.5
I have the option of filing a complaint against the medical services I have received.	66.1
The preparation period for the inclusion into a treatment programme that I need is too long.	56.4
I am satisfied with the attitude of the doctors towards me.	63.2
I am satisfied with the attitude of other health care workers (nurses, technicians …) towards me	67.8

A few separate questions also inquired about the specific (critical) aspects of treatment within health care. Two of these questions explicitly inquired about the experience of discrimination, namely, one question asked about an experience regarding the homeless status, and the other regarding the status of a drug user. Answers

in Table 3 show that both statuses are largely connected with discrimination in the experiences of the users, and in a far greater degree with the status of the drug user than with the homeless one. A certain not negligible portion of the respondents was of the opinion that they had been discriminated positively, however, there were approximately four times less of them than of those who had experienced negative discrimination.

Table 3: Answers of respondents (in percents) to two questions on discrimination, connected with two stigmatised statuses (the answers to both similarly set questions shown separately in two columns).

Have you ever had the feeling of being treated differently in medical institutions because you are homeless/a drug user? \ **To whom or what does the question refer?**	**Refers to the homeless status**	**Refers to the status of drug user (N = 44)**
Yes, in a negative sense (stigmatisation, isolation, avoidance, insults …).	33.9	50.0
Yes, in a positive sense (special privileges, extra attention of the medical staff and social service …).	8.3	11.4
I did not have a feeling of being treated differently because I am homeless/a drug user.	36.4	13.6
In my opinion the medical staff did not know I was homeless/ a drug user.	14.0	9.1

After reviewing the distribution of answers to the questions on the accessibility of the health care system we tackled the question of whether there are any systematic differences in the perception of the health care system between individual groups of homeless persons.

Two key indicators of the experiencing of the health care system have been chosen, namely:

- on the basis of the set of questions shown in Table 1 a composite variable has been formed, called »integral evaluation of the quality of medical treatment«. The scale has proved to be very reliable (Cronbach alfa amounted to 0.91), which is why this indicator was formed by adding up the values of the answers to all eight questions:
- on the basis of the set of questions shown in Table 2 a second composite variable has been formed, called »obstacles in the accessibility of medical services«. In the case of this scale as

well a high Cronbach alfa (0.87) was reached, which is why we have added up the values of the answers to all the 23 questions in the scale.

Table 4 shows the correlations between 18 independent variables (characteristics of the subgroups of the homeless persons) and between these two criterion indicators. In the cells of the table the degree of statistical importance has been entered (where the difference between groups was statistically important on the level of at least 0.100) and a description of the relation between the independent and criterion variable. If this relation was not statistically important the appropriate cell only contains the dash mark (–). Seen on an example: in the cell defined by the fourth row and second column, the value of 0,000 is written, which indicates that the groups of homeless persons, which differ according to the age at which they had experienced their first period of homelessness, differ greatly as regards their average integral evaluation of the quality of medical treatment, namely so that the higher age of the first homelessness is connected with a higher evaluation of the integral evaluation of the quality of medical treatment.

Table 4: Relation between 18 independent variables and two criterion indicators of the experiences with the health care system. Each cells contains the statistical probability of error (if smaller than 0.10; ANOVA) and a description of the direction of the correlation (if it is statistically significant).

Characteristics of subgroups of the homeless	**Integral evaluation of the quality of medical treatment**	**Obstacles in the accessibility of medical services**
Gender	–	–
Age	–	–
Higher education	0.096 A higher evaluation of quality.	–
Higher age of first homelessness	0.000 A higher evaluation of quality.	0.003 Experiences less obstacles.
Total duration/state of homelessness	–	–
Visited a doctor in the past year.	–	–
Resided in a youth home.	0.031 A lower evaluation of quality.	0.031 Experiences greater obstacles.
Spent time in prison.	–	0.009 Experiences greater obstacles.

Continuation of table 4:

Higher social support	0.027 A higher evaluation of quality.	0.013 Experiences less obstacles.
Addiction to alcohol (by their own evaluation)	0.001 A lower evaluation of quality.	0.002 Experiences greater obstacles.
Higher result on the AUDIT scale (harmful drinking of alcohol)	0.000 A lower evaluation of quality.	0.000 Experiences greater obstacles.
addiction to drugs (by their own evaluation)	0.003 A lower evaluation of quality.	0.075 Experiences greater obstacles.
Has tried heroin.	0.009 A lower evaluation of quality.	0.041 Experiences greater obstacles.
Resided in a unit for treating addiction.	0.075 A lower evaluation of quality.	0.086 Experiences greater obstacles.
Higher number of signs of mental problems/ psychiatric treatment	0.000 A lower evaluation of quality.	0.001 Experiences greater obstacles.
Resided in a psychiatric hospital.	0.003 A lower evaluation of quality.	0.020 Experiences greater obstacles.
Has in addition to mental problems (at least one sign of four) at least one more diagnosed addiction (either to alcohol or to illegal drugs).	0.000 A lower evaluation of quality.	0.000 Experiences greater obstacles.

The results in Table 4 can be briefly (and in a simplified manner) summed up as follows: the more of the different threatening factors a subgroup of homeless persons has, the worse it evaluates the quality of the health care system, the more obstacles it experiences in the use of it and the harder accessible it seems.

If we analyse Table 4 in greater detail, we see that:

– persons who had experienced the first period of homelessness earlier in life evaluate the health care system as worse and experience it as less accessible. This result can be interpreted in at least three ways. The first being that perhaps those who had first become homeless in a lower age are more often users of illicit drugs, while those who had first become homeless when older are users of licit drugs or nonusers. The obtained result can be explained with the supposition that the health care system is less inclined towards the users of illicit drugs or is not adapted enough to them. The other possible explanation is that the

homeless who had become such later in life have a longer period of experience with conventional life and were socialised in a way that also implies a greater acceptance of a (conventional) health care system. The third explanation could be that in the case of the homeless who had become such earlier in life there are several types of the threatening and disadvantageous bio- and psychosocial factors present and more of them, giving them more characteristics today, which means that the health care system accepts them with greater difficulty, and is at the same time harder to access;

- persons who had already resided in a youth home, an teratment establishment or prison evaluate the health care system as worse and experience it as less accessible. Residing in one of the mentioned institutions also indicates the existence of several types of the threatening and disadvantageous bio- and psychosocial factors present and more of them, which are obviously connected with worser accessibility of the health care system;
- persons with worse social support networks evaluate the health care system as worse and experience it as less accessible. The problem here is that the formal networks (among which belongs the health care one) could – ideally – compensate for the worse developed and active informal social networks, however, our data does not point to such an effect;
- persons who are addicted to alcohol and use it in more harmful ways evaluate the health care system as worse and experience it as less accessible;
- persons who are addicted to illicit drugs and use them in more harmful ways evaluate the health care system as worse and experience it as less accessible;
- persons who show several signs of mental health problems or have already been psychiatrically hospitalised evaluate the health care system as worse and experience it as less accessible;
- persons with the so-called double diagnoses, comorbidity or a simultaneous presence of addiction and certain other mental problems/illnesses particularly obviously (statistically significantly) evaluate the health care system as worse and experience it as less accessible.

Conclusions

The basic finding of the analysis is that the health care system is less accessible and of lesser quality for those homeless persons who are by themselves more at risk, more burdened with disadvantageous factors, with a worse medical condition (here mostly mental problems and addictions were checked), with an otherwise worse psychosocial support and less (positive) experiences with conventional life and would therefore need a better, increased and easier accessibility of the system. Such a result is in accordance with most of the research in this field.

For the successful use and operation of the health care system there is hence a multitude of social and individual suppositions for which we assume are realised for all users, however, it has turned out that in the case of the homeless this is often (or even as a rule) not valid. The reflection on the medical treatment (or on the handling of the health care issue) of the homeless people must therefore include more than just a reflection on the »treatment« in the narrow sense of the word, that is, more than just offering relatively narrowly defined health care services. Thus it is not enough to offer professionally suitable procedures of diagnosis and treatment, but it must be actively (actually »proactively«) reflected on how the homeless will understand and use the medical options and offers, and then, naturally, take action in accordance with the actual living situation of the homeless. Our survey has shown (as had much of the other quoted surveys) that in this case the persons particularly at risk are the ones with the so-called double diagnoses or combined problems or that these persons should be offered special care.

In literature several models of proactive and special, specific health care for the homeless are often mentioned. In Slovenia a model of a »social dispensary« has been developed, which on its own already sets certain eliminating entry criteria (the use of illicit drugs!). The key recommendations deriving from our analysis show the need for:

– lowering the threshold for entry into the health and dental care system;
– integral treatment or at least the integral acceptance of an

individual within a single (medical) organisation (nonstigmatising and nondiscriminatory treatment);

– a more individualised help and one adapted to the individual; in particular the specific groups of the homeless ought to be emphasised (the young homeless, users of illicit drugs, individuals with double diagnoses, the elderly, the infirm and invalid homeless);
– developing models of outreach work with the purpose of reaching the hidden subgroups of the homeless and placing such work within the public health and social security.

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Changes in the Behaviour of School-aged Children: new or old Educational Challenges

Spremembe v vedenju šoloobveznih otrok: novi ali stari vzgojni izzivi

Helena Jeriček

Summary

The article presents a result comparison of the international study Health Behaviour in School-aged Children, relating to children aged 11-, 13- and 15- (n=5130). The purpose of the research study is to gain insight into and to increase understanding of children's and adolescent's health, well-being, health behaviour and social context. The article focuses on some important differences between the years 2002 and 2006 regarding leisure time, school-related stress, bullying, physical fighting and risk behaviours – alcohol, tobacco and cannabis use among children and adolescents. It ascertains that children spend their leisure time more passively, they are less physically active, are less sociable and more aggressive in

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their behaviour and feel more burdened with school than back in the year 2002. Moreover, the use of tobacco and cannabis is less frequent, while alcohol consumption remains more or less the same. These changes present new – old educational challenges for social pedagogues.

Key words: *leisure time, television use, computer use, socializing, violence, school-related stress, tobacco, alcohol and cannabis consumption.*

Povzetek

Članek predstavi primerjavo rezultatov mednarodne študije Z zdravjem povezano vedenje v šolskem obdobju med 11-, 13- in 15-letniki pri nas (n = 5130). Namen raziskave je dobiti vpogled ter bolje razumeti vedenja otrok in mladostnikov. Članek se osredotoči na nekatere pomembne razlike med letoma 2002 in 2006 v preživljanju prostega časa, obremenjenosti s šolo, trpinčenju, pretepanju in tveganih vedenjih: uporabi alkohola, tobaka in marihuane pri otrocih in mladostnikih. Ugotavlja, da otroci preživljajo svoj prosti čas pasivno, se manj gibljejo, manj družijo z vrstniki, se bolj nasilno vedejo in se čutijo bolj obremenjeni s šolo kot leta 2002. Poleg tega jih manj uporablja tobak in marihuano, medtem ko pri opijanju ni bistvenih razlik z letom 2002. Te spremembe so za socialne pedagoge novi – stari vzgojni izzivi.

Ključne besede: *preživljanje prostega časa, gledanje televizije, uporaba računalnika, druženje z vrstniki, nasilje, obremenjenost s šolo, uporaba tobaka, alkohola in marihuane.*

Introduction and purpose of the research study

Children and adolescents are the group most frequently dealt with and discussed by social pedagogues in their educational, preventive, consultative and group work (e.g. Poljšak Škraban, 2003, Rozman, 2003, Plajnšek, 2004). That is why it is important to be familiar with typical features of their lifestyle and habits, as well as with the changes having occurred within this population group over the recent years. In this way we can gain a better understanding of their world and emotional responding, be better prepared to work with them, gain target training for certain skills, and react more adequately in case of problems.

The article presents results of the international study Health Behaviour in School-aged Children: a WHO collaborative Cross-National Study (acronym HBSC). This is an international research project taking place every four years; Slovenia first participated in the year 2002, and the second round was made in 2006 (including fourty-one states). The aim of the research is to gain more profound understanding of life and health of children and adolescents in the broadest sense. The notion of health in this research study is not understood as absence of disease in individual, but rather as his prosperity, full use of personal potentials, as satisfaction and successful tackling everyday problems, good relations, communication skills, etc. The research study includes different indicators, i.e. demographic data, nutrition habits, oral health, physical activity, smoking, alcohol and cannabis consumption, life satisfaction, self-rated health, stress in school, violence, injuries and other behaviour types, reflecting children's and adolescent's lifestyle. My article refers only to a certain types of behaviour, relevant for the work of a social pedagogue and pointing to educational shifts and possible directions of future activities.

Methods

HBSC is a research project, carried out every four years in schools and based on data, acquired by a questionnaire, completed by elementary/secondary school pupils in classrooms. The age of

target groups is 11,5, 13,5 and 15,5 years, respectively. According to international standards, the sample includes about 1.500 representatives of each age group in every participating state.

The research project applies quantitative methodology, i.e. a standard international questionnaire, based on the questions from former rounds, each round also going through a few corrections. The questionnaire results from cooperation between members of the HBSC research network, including all the member states. The questionnaire should imply all the obligatory questions in the sequence and form, prescribed by the research protocol, except for some inevitable translation adjustments.

As Slovenia has been going through a reform of the school system in recent years – the introduction of a nine-year elementary school – the sampling was more difficult than in the schoolyear 2001/2002. The sampling unit was class/department; a sample numbering over 6000 children and adolescents (about 2000 from each age group) was randomly selected from the list, comprising 280 classes. The final structure of the base was 5130 children and adolescents, about half of them were boys.

The anonymous opinion poll took place in classrooms, during classes. It was carried out by the consultative workers we contacted when preparing class lists. After examination of the collected questionnaries and data insertion, the base was organized in accordance with international standards and sent to Norway for purification. When it came back cleaned, it was submitted to the SPSS program processing.

Results

As already mentioned, a limited number of behaviour types will be discussed, i.e. leisure time activity, violence, school-related stress and risk behaviours.

Leisure-time activity

Leisure time is the time when an individual is free to do whatever he likes, i.e. engage into activities he enjoys and finds interesting as well as relaxing. Research studies indicate that the way how

children and adolescents spend leisure time largely depends on sex, age, school success, socio-economic status of their families, as well as on schoolmates and friends (Derganc, 2004). The data on family structure show that in the year 2006 statistically significant lesser number (2,6 %) of respondents lived with both parents (84,3 %). On the other hand, the share of children and adolescents living with one parent only (mostly mother, 86%) increased (by 1,5 %), as compared to the year 2002.

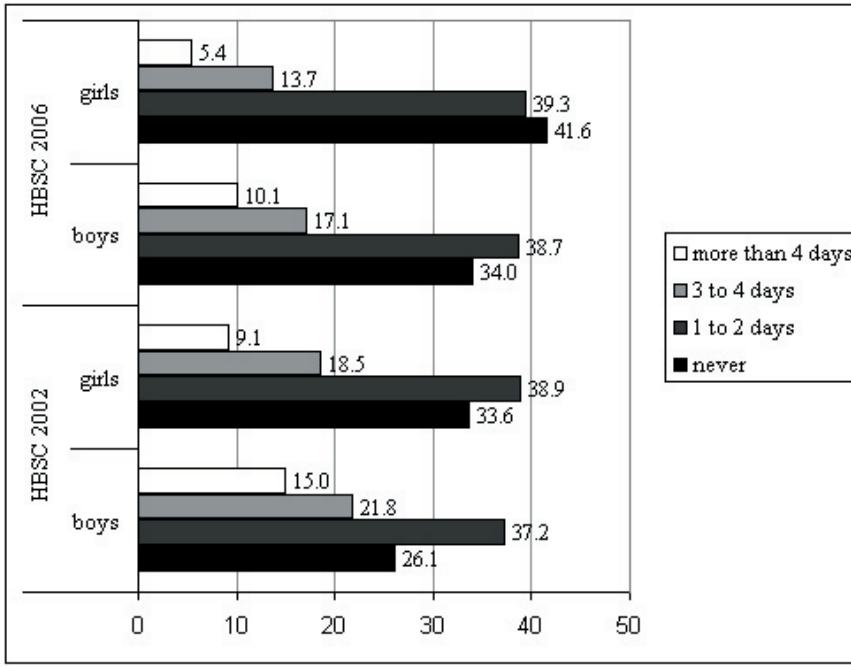
Different research studies refering to the youth of Slovenia ascertain (Ule, 1995; Ule, 1996; Ule & Rener, 1998; Ule, 2000; Ule & Kuhar, 2002; Gril, 2004) that their leisure time is mostly dedicated to associating with friends, TV watching, listening to music and sports. These activities were also included into the HBSC researchstudy, where our main interest was how much of their after-school time was spent on social activities, TV watching, games, computer use and physical exercise.

a.) Associating with friends

Associating with friends is an important aspect of adolescence and emancipation, affecting child's and adolescent's identity, self-image, emotions, behaviour, social contacts, etc. Children and adolscents were inquired about size of peer group affiliation – about numbers of close friends, about frequency of meeting them, as well as about other forms of communicating – by phone, SMS messages and email.

Compared to the year 2002, in the year 2006 there was a significant increase in the share of adolescents (by 8 %, HBSC 2002 29,8 %, HBSC 2006 37,8 %) never associating with friends in their leisure-time (in the evenings). The share of adolescents getting together with friends more often than 4 days a week decreased by almost 5 % (HBSC 2002 12,1 %, HBSC 2006 7,8 %). This means that the youngs are now less sociable than in the year 2002 (graph 1). Likewise, it is interesting that the number of respondents without any friends appears to be slightly higher than in 2002, although this difference is not statistically significant. Compared to boys, girls have less friends of both sexes. The share of 15-year olds spending 4 or more evenings a week with friends (14,9 %) is higher than with 13-year olds (11,7 %) or 11-year olds (10,8 %).

Graph 1: Proportion of young people, associating with friends in leisure-time in the evenings, comparison between HBSC 2002 and HBSC 2006 by gender (HBSC 2002, n=3956; HBSC 2006, n=5064, p<0,05).



Peer contact in the evening frequency	HBSC 2002				HBSC 2006			
	Boys		Girls		Boys		Girls	
	F	%	F	%	F	%	F	%
Never	520	26.1	657	33.6	854	34.0	1061	41.6
1 to 2 days	740	37.2	761	38.9	972	38.7	1003	39.3
3 to 4 days	434	21.8	361	18.5	430	17.1	349	13.7
More than 4 days	298	15.0	179	9.1	256	10.1	145	5.4

Majority – 80 % of boys and 88 % of girls – communicate with friends at least once a week by phone, written messages or internet; 39,6 % of girls and 30,8 % of boys do that every day, and 10,1 % of male and 13,1 % of female respondents do that five or six times a week. The use of electronic communication media increases with age. Compared to the year 2002, the share of adolscents having daily communication with their friends increased by almost 2 %.

b.) Physical activity

Contemporary way of life with all the social, cultural and technological changes is leading to an increasingly sedentary lifestyle, so with young people as with adults (Elgar, Roberts, Moore and Tudor-Smith, 2005; Koprivnikar, 2005), despite the fact that regular physical activity appears to be a significant protective factor against bad health and development of different noncontagious diseases. One of the questions of our research study was how many days per week – before answering the questionnaire – were you physically active of at least moderate intensity for at least 60 minutes per day?

Compared to the year 2002, respondents were less physically active than in 2006. The number of boys and girls who were not physically active in the week before questionning was higher (3,2 % of boys and 5 % of girls in the year 2006; 2,9 % of boys and 3,8 % of girls in the year 2002); on the other hand, the number of those having at least one hour of physical exercise every day decreased (21,9 % of boys and 13,3 % of girls in the year 2006, 29,0 % of boys and 16,4 % of girls in the year 2002). The average number of active days per week (see table 1) thus decreased. 15-year olds were the least and 11-year olds the most physically active among our respondents.

Table 1: Mean number of days when adolescents are physically active per week – comparison between HBSC 2002 and HBSC 2006 by gender (HBSC 2002, n=3859; HBSC 2006, n=5063, p<0,05)

Year	Gender	
	Boys	Girls
HBSC 2002	4.59	3.83
HBSC 2006	4.26	3.62

c.) Television and computer

TV and computer are the favourite media of young people. Children and adolescent use these two mostly at home, which is why family environment plays decisive role in one's susceptibility to a sedentary lifestyle (Salmon, 2005). Our research study focused on the amount of leisure-time dedicated to television and computer games, as well as to chatrooms, internet, email and homeworks, during weekends and through the week.

The data indicate (table 2) that the number of young people not watching television during the week was higher in 2006 (4,6 %; boys 3,4 %, girls 5,7 %), although, on the other hand, the number of those watching TV more than 6 hours a day was also higher (4,6 %; boys 5,6 %, girls 3,4 %). Slightly less than half of the respondents watch TV two to three hours a day, so during the week as during the weekends, whereby the share of during-the-week decreased by almost 4,0 % (HBSC 2002 49,8 %, HBSC 2006 46,1 %), while the weekend share increased by almost 2 % (HBSC 2002 43,1 %, HBSC 2006 45,0 %). There are no other significant differences regarding weekends between 2002 and 2006. It is interesting, though, that boys are keener TV viewers and game players than girls.

Table 2: Frequency of television watching among young people during the week and during weekends by gender – comparison between HBSC 2002 and HBSC 2006 (HBSC 2002, n=3956; HBSC 2006, n=1530, p<0,05)

	HBSC 2002				HBSC 2006			
Television use on weekdays	**Boys**		**Girls**		**Boys**		**Girls**	
	F	**%**	**F**	**%**	**F**	**%**	**F**	**%**
None at all	42	2.1	85	4.2	86	3.4	146	5.7
30 minutes to 1 hour	526	26.5	566	29.0	771	30.4	866	33.9
2 to 3 hours	998	50.2	968	49.5	1195	47.2	1150	44.9
4 to 5 hours	341	17.1	294	15.0	336	13.2	310	12.1
6 hours or more	82	4.2	43	2.2	144	5.6	88	3.4
Television use on weekend	**Boys**		**Girls**		**Boys**		**Girls**	
	F	**%**	**F**	**%**	**F**	**%**	**F**	**%**
None at all	46	2.3	61	3.1	55	2.2	64	2.5
30 minutes to 1 hour	286	14.5	366	18.8	412	20.7	389	15.2
2 to 3 hours	830	42.0	862	44.1	1090	43.0	1201	47.0
4 to 5 hours	572	29.0	491	25.1	661	26.1	670	26.2
6 hours or more	242	12.3	172	8.8	314	12.4	232	9.0

d.) Watching television during weekends

The 2002 – 2006 comparisons regarding game playing and the use of computer for chatting, internet, email and homeworks are not possible as these very questions were not posed in 2002. The data for 2006 indicate (table 3) that boys are more frequent game players than girls; on the other hand, the share of girls using computer for internet, chatting, email and homeworks is higher than with boys. Almost half of the girls (49,5 %) don't indulge in playing computer

games on weekdays, this percentage being considerably lower with boys, i.e. 15 %. Game playing is more frequent on weekends, so with boys as with girls. There are 12 % of boys playing games for six hours or more on weekends. The highest share of those not playing computer games is among the 15-year olds.

It is interesting that on weekdays 31,4 % of boys and 28,4 % of girls do not use computer for chatting, internet, email and homeworks. The corresponding shares for weekends are 31,2 % and 26,8 %, respectively. The highest share of children not using computer for these activities is among the 11-year olds.

Table 3: The frequency of computer use for playing games and for chatting, internet, email and homeworks among young people on weekdays and weekends in 2006 by gender (HBSC 2006, n=5130, p<0,05)

	HBSC 2006 - on weekdays				HBSC 2006 - on weekend			
Playing computer games	**Boys**		**Girls**		**Boys**		**Girls**	
	F	**%**	**F**	**%**	**F**	**%**	**F**	**%**
None at all	379	15.0	1267	49.5	274	10.9	944	36.9
30 minutes to 1 hour	1004	39.9	975	38.1	641	25.4	1008	39.4
2 to 3 hours	756	29.2	246	9.4	885	35.2	421	16.5
4 to 5 hours	239	9.5	57	2.2	416	16.5	138	5.4
6 hours or more	146	5.7	17	0.6	301	12.0	44	1.7
Using computer for internet, chatting,...	**Boys**		**Girls**		**Boys**		**Girls**	
	F	**%**	**F**	**%**	**F**	**%**	**F**	**%**
None at all	794	31.4	726	28.4	787	31.2	684	26.8
30 minutes to 1 hour	977	38.6	1060	41.5	750	29.7	816	31.9
2 to 3 hours	812	19.6	540	21.1	657	22.5	645	25.3
4 to 5 hours	156	6.2	251	6.1	231	9.1	276	10.8
6 hours or more	80	4.3	72	2.8	190	7.5	131	5.1

Violence (bullying, physical fighting and victimization)

Violence and its growth – so among schoolmates as within family (Kordič, 2007) – is nowadays a very widely discussed topic (Dekleva, 1996; Antončič, 2006; Chapell et al., 2006). The HBSC research study also focuses on this kind of violence, i.e the frequency of fighting, bullying and victimization. The latter was defined as violence which can either be verbal (pricking, abuse), or

psychological (intimidation, threats, exclusion from the peer groups or rejection), and physical (kicking, boxing, beating), including unbalance of strength between victim and attacker.

According to the obtained results, violence among young people is increasing. The share of children and adolescents involved in bullying over the last 12 months increased by almost 4% in 2006. The increase is higher with girls than with boys. Thus, 45,1 % of the respondents were involved in fights in 2006 (61,5 % of boys and 28,7 % of girls). There were 14,3 % of frequent bullies in the sample (20,6 % of boys and 8 % of girls). The share of frequent bullies was highest among 13-year olds (16,7 %) and lowest among 15-year olds (10,6 %).

The increase was also observed in the share of children and adolescents having responded they were victims of bullying over the last few months, i.e. by 2,2 % (from 22,4 % to 24,8 %). The share of respondents who had taken part in bullying also increased by over 4 % (from 23,1 % to 27,8 %, see table 4). Those most often involved in bullying were 13-year olds.

Table 4: Proportion of young people who bully others and who are being bullied – comparison between HBSC 2002 and HBSC 2006 (HBSC 2002, n=3956; HBSC 2006, n=5130, p<0,05)

Being bullied	**HBSC 2002**		**HBSC 2006**	
	F	**%**	**F**	**%**
Never	3054	77.6	3790	75.2
1 or 2 times	603	15.3	781	15.5
2 or 3 times a month	99	2.5	141	2.8
About once a week	81	2.1	144	2.9
Several times a week	99	2.5	182	3.6
Bullying others	**F**	**%**	**F**	**%**
Never	3009	76.9	3634	72.1
1 or 2 times	692	17.7	1033	20.5
2 or 3 times a month	86	2.2	158	3.1
About once a week	60	1.5	123	2.4
Several times a week	67	1.7	89	1.8

School pressure

Apart from family school has a major role in child's and adolescent's development (Samdal, Nutbeam, Wold and Kannas, 1998).. Out of the cluster of questions concerning school we selected the question on whether and to what degree respondents consider themselves pressured with and how they like school. According to the HBSC research results, Slovenian parents' expectations regarding school success are high, as 97 % encourage their children to work well at school.

According to our findings respondents feel they are now more pressured with school than in the year 2002. The share of respondents claiming they find school rather burdensome increased by almost 5 %; on the other hand, the number of respondents not suffering from school pressure at all decreased (Table 5). There are no statistically significant differences regarding sex, but only age. 11-year olds are the ones least pressured by schoolwork.

Table 5: »How pressured do you feel by the school-work you have to do?« - comparison between HBSC 2002 and HBSC 2006 (HBSC 2002, n=3912; HBSC 2006, n=5115, p<0,05)

Pressured by schoolwork	HBSC 2002		HBSC 2006	
Not at all	444	11.3	370	7.2
A little	1656	42.3	2113	41.3
Some	1245	31.8	1864	36.4
A lot	567	14.5	768	15.0

Girls like school better than boys (34,8 % of girls and 28,3 % of boys responded they like school very much); 13-years olds are most and 15-year olds are least happy with school. Compared to the year 2002, respondents enjoyed school less in the year 2006. The share of respondents who do not like school at all increased (from 9,7 % to 10,3 %), same as the share of those who do not like it very much (from 11,1 % to 19,3 %).

Risk behaviour (tobacco, alcohol, cannabis)

The use of tobacco, alcohol and psychoactive substances is one of the behaviour forms helping adolescents find their place, understanding and approval within their generation. However, such behaviour can become dangerous if it starts too early in child's development, if it becomes habitual and is no longer limited to occassions and special events, and also if it involves a lifestyle that is unsuitable for an adolescent, aggravating and preventing constructive activities (Tomori et al., 1998), or even leading to addiction. That is why it is highly important to have control over the use of these substances. Children and adolescents were asked if they ever smoked tobacco, got drunk or tried cannabis; we were also interested in their favourite alcohol drinks, etc.

Table 6 presents data on tobacco smoking and alcohol intoxication. According to these data, the share of those who have already smoked tobacco decreased by 5,4% in the year 2006; regarding alcohol intoxication there were no essential differences between the two years.

Table 6: Proportion of adolescents who had contact with the listed risk behaviour types – HBSC 2002 and HBSC 2006 comparison by gender (HBSC 2002, n=3956; HBSC 2006, n=5130, p<0,05)

Risk behaviours	**HBSC 2002**				HBSC 2006			
	Yes		No		Yes		No	
	F	%	F	%	F	%	F	**%**
Have you ever smoked tobacco?	1437	36.4	2541	63.6	1584	31.0	3538	69.0
Have you ever had so much alcohol that you were really drunk?	1243	31.6	2693	68.4	1576	31.0	3501	69.0

The question on the use of cannabis was only posed to 15-year olds. According to the obtained data, the share of those who didn't tried it yet, is higher in 2006 than in 2002. Boys are more frequent consumers of cannabis than girls.

Table 7: The frequency of cannabis use anytime in life among 15-year olds – comparison between HBSC 2002 and HBSC 2006 (HBSC 2002, n=1059; HBSC 2006, n=1524, p<0,05)

Cannabis use in lifetime	HBSC 2002		HBSC 2006	
	F	%	F	%
Never	759	71.7	1252	82.2
Once or twice	92	8.7	117	7.7
3 to 5 times	49	4.6	41	2.7
6 to 9 times	26	2.5	33	2.2
10 to 19 times	40	3.8	23	1.5
20 to 39 times	27	2.5	16	1.0
40 times or more	66	6.2	42	2.8

The importance of the HBSC research study for the work with young people

The HBSC research study provides an insight into behaviour, emotions and views of children and adolescents in Slovenia. Moreover, data resulting from such representative studies, attempting to simulate longitudinal studies, provide ground for:

- keeping abreast with development trends of certain behaviour types among young people,
- comparing data according to sex, age, socioeconomic status, etc.
- comparing data with other states (with some time difference).

All this is a highlly valuable information for experts dealing in one way or another with children and adolescents, especially for those engaged in preventive and promotional activities, based on population approach. These experts use the acquired data for priority setting, planning, intervention evaluation and activities aimed on entire population. Such approach is reflected in the activities, embracing all or most schools, like children's parliament, healthy schools, compulsory optional subjects, etc. Unfortunately, behaviour of concrete individuals or groups cannot be foreseen on the basis of such and similar studies.

People are alive, unpredictable, unique, constantly changing and free in their choice of lifestyle, responding and understanding.

The work with people (including children and adolescents) is very unpredicatble, evading generalizations and demanding a high degree of adaptability and flexibility. An expert has to deal separately with each individual, and get to know his emotions, thinking, actions, wishes, problems, etc. Yet even an expert can never be quite familiar with another person's emotions and reactions, nor can he foresee tha nature of interaction. This uncertainty is a cause of permanent tension and fear on the part of experts, generating a wish for clear standards, rules and recipes for action. But, is this (rules, standards, set procedures) really a way to get rid of insecurity, or is it just shifting responsibility for our actions on other people or external factors?

Personally I believe such quantitative research studies to be useful, especially if they are international and carried out periodically.

Conclusions

The HBSC research study includes 11-, 13- and 15-year olds, categorized, according to some theories, into preadolescent and early adolescent period. This is a difficult period of adolescence, often characterized by psycho-social crisis and identity confusion, when the adolescent is neither sure who he is nor what he would like to become. Children are more sensitive and emotional in this period, having conflicts inside themselves and with others. Apart from physical and emotional changes, their thinking and behaviour is also affected by family patterns, social climate, media and society values. Development trends and changes of certain behaviour types and emotional responses of children and adolescents, proceeding from the research study, therefore also reflect wider trends in families and society, which are not altogether new. Considering the contemporary trends of social, technological and economic development, generally accepted values, as well as increasing carreer- and school-pressure, the acquired data are no longer so surprising. The increasing use of contemporary technologies generates an ever more sedentary lifestyle, as well as passive leisure-time spending in the safe shelter of home. This is the probable cause of less frequent »in vivo« associating with friends and classmates, as well as of growing popularity of phone contacts, internet chatrooms

and email. Since certain types of behaviour are group related only – smoking, alcohol consumption, cannabis use – this might be the reason of their decrease in the year 2006. Another surprising trend is the increase of violence, especially among girls. On the one hand, violent behaviour can result from increasing burdens and pressures (so in school as from parents), and on the other hand it can also serve as a kind of defence. However, a more detailed research study would be necessary to confirm or disprove these hypotheses.

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Empirical article, submitted for translation in January 2008.

Behavioural and Emotional Disorders of Children and Adolescents in Slovenian Juvenile Educational Institutions

Vedenjske in čustvene motnje otrok in mladostnikov v slovenskih vzgojnih zavodih

Mitja Krajnčan

Abstract

Children and adolescents with behavioural and emotional disorders are very inconsistently placed in juvenile educational institutions. For some, it is the case of stable and consistent long-term difficulties, for others, one incident of escalation of deviant beaviour is enough to make placement in a juvenile educational institution an option. The article deals with the underlying causes behind behavioural and emotional disorders in children and adolescents on the premise that they have decisive influence on the child or adolescent's placement into extra-familial care – a juvenile educational institution, a youth home or a residential group.

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The results have shown that possible causes of behavioural and emotional difficulties, as seen by social worker. These can stem from social, psychological and biological factors, which has also been established by comparable etiological classifications. The author emphasize that making a detailed analysis of the child with the help of the presented indicators can fundamentally contribute to making carefully considered decisions.

Key words: *Juvenile educational institutions, child and adolescent, behavioural and emotional disorders, Social Work Centre, aetiology.*

Povzetek

Otroci in mladostniki z vedenjskimi in čustvenimi motnjami se zelo neenako nameščajo v vzgojne zavode. Za nekatere so lahko to stabilne in dlje časa trajajoče težave, drugim je dovolj le ena eskalacija in že je možna namestitev v vzgojni zavod. Zanimali so nas vzroki vedenjskih in čustvenih motenj otrok in mladostnikov, za katere predvidevamo, da ključno vplivajo na oddajo v zunajdružinsko vzgojo - vzgojni zavod, mladinski dom ali stanovanjsko skupino. Rezultati so pokazali, da je mogoče vzroke za vedenjske in čustvene težave iskati v socialnih, psiholoških in bioloških dejavnikih, kar so dokazovale že primerljive etiološke klasifikacije. Avtor si prizadeva, da bi detajlno spremljanje otroka s prikazanimi kazalci lahko temeljiteje prispevalo k preudarnim odločitvam.

Ključne besede: *vzgojni zavod, otrok in mladostnik, vedenjske in čustvene motnje, center za socialno delo, etiologija.*

Introduction

In this postmodern age, a child is faced with risks and decisions, which require him to face many factors of uncertainty. The causes of behavioural and emotional disorders in the children and adolescents of the population, who require specially adapted professional upbringing in juvenile educational facilities, represent only the tip of the ice berg that consists of various multifaceted problems. Research shows that the factors causing behavioural and emotional disorders can be divided into biological, social and psychological (Farrington, 2001a; Myschker, 2002; Schrader, 1991; Doef, 1992; Bregant, 1987; Bürger, 1998a).

The consideration of a child for this kind of care calls for familiarity with the child's biography. Psychosocial and hermeneutical diagnostics are helpful. Classifications of behavioural and emotional difficulties are necessary because they build a bridge between:

- detection and diagnostics,
- triage,
- the course of education or psychosocial assistance, and
- social integration as the goal of the assistance.

Systematic action calls for categorization as the basis for data analysis and its systematic evaluation, where it is particularly important to examine the family system. Even if the expert does adhere to a specifically set type of classification or systematization in his approach, he relies on his own knowledge, derived from experience. Post (1997, p. 79) calls these facts inescapable and unavoidable. In professional communication, even subjective concepts can be useful if it is clear how information from various areas was acquired. The necessary data is revealed by the central question: on the basis of which reasons and in which particular fields is educational assistance required because the parents are not providing adequate upbringing? Along with the explanations of the current problems, finding links and explanations in the child's biography is always important (certain illnesses, preoccupation and strain, crumbling relationships and other relationship disorders, for example separation). In general, the status of the family, the social

environment, financial, material and housing conditions have a significant influence on the child or adolescent's development. The educational style of the parents, their educational capabilities and upbringing in general must not be overlooked. The data must clarify evaluation concepts and educational goals, common points and differences, mistakes, drawbacks and disturbances. Extra care has to be taken in evaluating the individuals' behaviour to establish that a behavioural disorders are not just a result of the nature of a particular situation.

The following is a shortened presentation of Bregant's classification.

Bregant's etiological classification schematic of dissocial disorders is based on the research findings and models of dissocial disorders found in A. Aichorn, G. H. Brandt, F. Redl, I. Bennet, A. Dührssen and E. Künzl (in Bregant, 1987). Bregant (1987, p. 8) divides the etiological classification of dissocial disorders into five groups:

1. situational, reactively caused disorder caused by severe strain with a normal personality structure;
2. secondary peristatic disorder caused by disruptions in emotional development

a. with a neurotic personality structure,

b. with a dissocial personality structure;

3. primary peristatic disorder caused by direct environmental corruption and deception;
4. primary, biologically conditioned disorder caused by a damaged central nervous system and psychosis;
5. developmental impairment without the presence of dissocial disorders.

Indicators which influence behavioural and emotional disorders that are explored in the majority of the research (Blandow, 2000; Bürger, 1998a; Farrington, 2001b; Myschker, 2002; Ule, 2000) have been divided into the following groups:

- socio-economic circumstances (demographic characteristics, population density in the region, unemployment, housing conditions and spatial concentration of social deprivation);
- family (structure, relationships, lifestyle, single parenthood, education, migration);

- school (productivity and efficiency – criteria for children's success rates (Thiersch, 1998), education as risk (Beck, 2003), reinforcement of social differences (Ule, 2000);
- personality characteristics (differences in constitution, particular personal features, endogenous specifics of a person's reactivity (cannot be classified as mental illnesses or as organic brain dysfunctions). Intelligence is also often singled out as a factor. Elliott (2002) claims that intelligence varies with delinquents in the same manner as with the general population.)
- Peers (youth subcultures, aimless groups, supportive groups... (Ule, 2000).

In our research, we are interested in social workers' perceptions of causes of behavioural and emotional disorders in children and adolescents placed in juvenile educational institutions, residential groups and community homes (all of the institutional forms of aid for children and adolescents with behavioural and emotional disorders for extra-familial upbringing in Slovenia). The goal is to research the causes of behavioural and emotional disorders based on the views of social workers, who decide on a child's placement in the aforementioned institutions.

Method

Description of the studied population

The basic population consists of all the experts working in Slovene Social Work Centres.

There are 61 Social Work Centres in Slovenia. The information about the number of experts working in Social Work Centres, as well as the number of children and adolescents placed in juvenile educational institutions, youth homes, residential groups and community homes was acquired through telephone conversations. According to the collected data, there are 83 experts working in Social Work Centres in the field of adolescence, and 428 children and adolescents suggested for placement in juvenile educational institutions, youth homes, residential groups and community homes.

Measurement instruments

In the research, various measuring instruments are used to establish the causes behind behavioural and emotional disorders used as the criteria for placement in juvenile educational facilities. To fulfil the goals of the research, certain standard instruments and procedures have been used. The Instruments is derived from a German source, originally entitled "Ursachen der unterschiedlichen Inanspruchnahme von Heimerziehung" (Bürger, 1998b), which translates as "The causes behind different utilization of institutional education." The instrumentation has been translated and adapted to our circumstances. Several experts from both practical and research fields participated in the writing of the questionnaire. We have also established the measurement characteristics of the questionnaire using trial testing. The general information about the number of children and adolescents in juvenile educational facilities was acquired through telephone conversations with the directors of the educational institutions and Social Work Centres, with experts responsible for the field of adolescence. The questionnaire covers the following thematic units:

- relationship and behevioural problems of children and adolescents,
- problem of dissocial behaviour,
- specific personal and emotional difficulties, and psychosomatic problems,
- intimidating events that lead to a decrease in self-respect,
- difficulties connected to school, and
- other problems.

Procedure

In collecting the data, the standards of the Personal Data Protection Act (Zakon o varstvu osebnih podatkov, 2007) were applied and the anonymity of the participants was insured. The questionnaires were filled out voluntarily and anonymously.

Our research instruments were first tested on a sample of 30

Social Work Centres. A thorough analysis of the research instruments was completed and all methodological criteria were satisfactorily fulfilled. Only then were all of the other Social Work Centres in Slovenia included.

The information was entered into a database and processed with the SPSS statistics computer package.

Results and discussion

Factor analysis was conducted to establish the causes of emotional and behavioural disorders as seen by social workers in children and adolescents placed in educational institutions. The data was processed on a multivariate level – we have conducted the Kaiser-Meyer-Olkin measure of sampling and Bartlett's sphericity test, calculated the communality, explained variance and factor analysis according to the Oblimin rotation method with Kaiser normalization – with the purpose of finding out about:

- the relationships between parents and children,
- violence among children and adolescents,
- their attitude towards peers and school,
- intimidating events that lead to a decrease in personal self-respect,
- attitude problems of children and adolescents,
- dissocial difficulties,
- specific personal and emotional difficulties, and psychosomatic problems,
- difficulties with school, and
- other difficulties.

In continuation the above mentioned categories shall be analyzed.

Relationships between children and parents

When it comes to the relationships between parents and children, the factor analysis provided us with a clear, theoretically logical structure with the following six factors, which manage to account for 43.971 % of the variance.

The first factor is the most complex and accounts for 20.8 % of the variance. It is comprised of the following variables: beating the child, fear of the parents, hostile rejection of the child, assigning guilt to the child, inappropriate demands of the parents, double-tracked upbringing. According to its content, the first factor is termed non-acceptance (rejection) of the child.

The second factor explains 9.3 % of the variance of the entire system. It is mostly connected with insufficient parental control, permissive upbringing and deficient parental competence. The second factor is called educational powerlessness / incompetence of the parents.

The third factor explains 4.3 % of the joint variance and includes the following variables: a shortage of warmth in the child-parent relationship, little time spent together and disharmonious relationships between the adults of the family. The third factor is called emotional coldness of parents.

The fourth group accounts for 4.1 % of the joint variance and includes the following variables: living conditions with psychosocial imperilment, socially isolated family, deviating behaviour of parents, events causing a decline in self-respect and deficient education of the person who does the housekeeping in the child's family. The fourth factor is called negative identification factors.

The fifth factor explains 2.9 % of the joint variance and is comprised of the following variables: parents' disinterest in the child's school and poor school achievements. We have called it no parental support at school and correspondingly poor social achievement (unsuccessful schooling and parental indifference).

The sixth factor presents 2.6 % of the joint variance and includes the variables: overly demanding upbringing and overly concerned parents. We have called it overly demanding parental upbringing.

With oblimin rotation, we have made it possible to establish 6 factors despite the homogenous structure. The factor correlation matrix also shows that the factors are interconnected and that this is a complex issue. The inter-factor correlation matrix points to mainly insignificant correlations between factors, which attests to the clarity of the factors and the clear structure of the variables. The highest rate of interconnectedness (0.4) between the first factor (non-acceptance of the child) and the fourth factor (negative identification factors) is in view of the content both appropriate and understandable. The

negative correlation (- 0.297) between the first factor (non-acceptance of the child) and the sixth factor (overly demanding parental upbringing) is also theoretically understandable, as is the 0.293 correlation coefficient between the fourth (negative identification factors) and third factor (emotional coldness of the parents).

Theories in the field of criminology are finding that poor relationships between parents and children, as well as poor treatment of children, opens at least three doors which lead to the group of children and adolescents with emotional and behavioural disorders (Haralambos and Holborn 1999):

a) it reduces the level of attachment children feel towards parents; individuals without close social bonds with their parents risk considerably less with delinquency[1] than those that have good relationships with them, because they do not fear they will be judged: the theory of being deprived of motherly contact, psychoanalytical theories, theories of objective relationships, and various others;
b) implicitly reveal that it is normal, even acceptable to express hostility and contempt for others and ignore their wishes and interests: the theory of social learning (Bandura);
c) cause strong negative emotions, frustration, anger and hatred, leading to various inappropriate behavioural patterns: the theory of frustration.

In studying the evaluations of experts working at the Social Work Centre (Jugendamt), Bürger (1998b) discovered a statistically relevant significant high level of correlation (.92) between children and adolescents who are placed in juvenile educational institutions and the unsuitable attitude of parents towards their children.

In our interpretation of the results concerning family structures, we would last but not least like to point out that rather than a 'perfect' family, a family with healthy relationships, regardless of its structure, is more important.

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[1] The group of children and adolescents in the category of delinquency has been expanded into the group of children and adolescents with emotional and behavioural problems; we define delinquency as one of the manifestations (forms) of emotional and behavioural problems.

Violence

With four factors, we have managed to explain 46.949 % of the variance.

The first factor is the most complex and explains 30.8 % of the variance. It is comprised of the following variables: making fun of the child, humiliation by peers and by adults, extortion by adults, physical violence of peers, psychological violence, enticing the child to drug use and arguing with siblings. Because of its themes, we call the first factor *extra-familial torment of the child (demeaning and violent relationship)*.

The second factor explains 7.6 % of the entire system's variance. It correlates most predominantly with the alcoholism of one of the parents, problems in the family due to unemployment, arguing between the parents, inappropriate communication in the family and long-lasting illness. The second factor is called *endangering family environment.*[2]

The third factor accounts for 5.6 % of the joint variance and includes the following variables: no sexual violence of adults, peers or parents. The third factor is called *child did not experience sexual violence.*

The fourth group accounts for 2.9 % of the joint variance and includes the variables: physical violence of parents and humiliation by parents. The fourth factor is called *familial torment of the child (psychophysical maltreatment by the child's parents)*.

The inter-factor correlation matrix points to mostly insignificant correlations between factors, which attests to the clarity of the factors and the clear structure of the variables.

Marvin (1975) writes that assessing the validity of violence always depends on the perspective of the assessor. Our perspective is clear: we are concerned with children and adolescents, placed in juvenile educational facilities, who have been (or still are) victims of torment and violence. In the surveyed literature, we have only come across Bürger's (1998b) information regarding violence of families and other people, inflicted on children and adolescents

[2] Variables included in the factor analysis are not necessarily connected to violence in content, but include a theoretical link, also shown by the results. The same variables were included in Bürger's research (1998a).

placed in juvenile educational institutions. Other research of violence was connected with other target groups, mostly elementary and secondary school students.

Bürger (Ibid.) writes that according to the evaluation of experts, 40.3 % of children placed in educational institutions were tormented and 27 % were victims of psychophysical violence.

We see torment as a hypernym, a wider category than psychophysical violence.

Our primary interest was not establishing the percentages of children and adolescents placed in juvenile educational institutions that have been victimized. Our focus was directed towards finding those variables, which are statistically relevant and represent decisive reasons for placing a child in a juvenile educational institution.

We intuitively presuppose that more violence is present with children and adolescents placed in educational institutions. On the basis of their research in the field of sexual violence, Weber and Rohlander (1995) discovered that there is a higher than average degree of sexual abuse present with girls placed in these types of educational facilities.

Unfortunately, in view of a shortage of research in this particular field, our theory cannot be confirmed or denied; therefore, we will provide information regarding the extensiveness of these phenomena with the entire population of children and adolescents.

Dekleva (2002a, p. 160) shows which characteristics of adolescents and their families tend to be strongly and systematically linked with violence (in both roles – as the violator and the victim).

- biological variables (male gender,[3] outwardly aimed aggression as a form of subjectivity as a personality characteristics, proneness to risk as a form of subjectivity);
- family variables (life in a bad family atmosphere, upbringing with the use of physical violence, violence between parents, double-tracked upbringing);
- behavioural signs, social position (lower level of integration at school, low level of general integration, conflicting stance of the peer group, avoidance strategy to protect against violence, use of weapons);

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[3] Bönisch (1998) wonders if violence has a male face.

- viewpoints, values (positive Attitudes towards violence, deviating peer values, more traditional view of Masculinity);
- skills (lower level of empathy, poorly developed skills for non-violent solving of conflicts).

Dekleva (2002b) says that in secondary school population, the two best predictors of various forms of violence are the male gender and being part of less demanding school programmes. He writes that at the elementary school level, both the agents as well as the victims of violence are at a level that is somewhat lower than average when it comes to academic achievement.[4] Olweus (1995) writes that every seventh student is subject to torment. Bönisch (1998) defines violence as something directed towards strangers and the weak.[5]

Violence that children and adolescents in juvenile educational institutions are exposed to is probably part of a type of violence we know very little about. The factor structure has shown us that this area needs a lot more attention, as violence is an important indicator when it comes to causing behavioural and emotional disorders (Downes, 2003; Farrington, 2005).

To conclude, we would like to say a few words about the legitimate violence of societal norms (nationalism, sexism, racism, the ideology of a healthy and beautiful body…), cited by several authors, for example Barker (2000), Beauvoir (2000), Beck (2003), Bourdieu (2001), Smith and Johnston (2002), Willett (1998), Miščevič (2001); this leads to exclusion, it pushes the young to the sidelines, foreigners into ghettos, the unattractive into their apartments, the young with various particularities into special institutions, gypsies out of the country etc. We feel that when excluding young people with behavioural and emotional disorders, it is also necessary to take a thorough look at ourselves (and our professional viewpoint) in connection to adherence to institutional demands.

Attitude towards peers and school

We have managed to account for 48.579 % of the variance with three factors.

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[4] This corresponds to Dekleva's finding that secondary school students are part of a less demanding school programmes.

[5] The research concerns the German environment.

The first factor is the most complex and explains 27 % of the variance. It is comprised of the following variables: gets along well with classmates, causes disarray at school, conflict with classmates, has friends, teachers making fun of the child. In view of its content, we termed the first factor *endangering role of the student at school.*

The second factor explains 12.1 % of the variance of the entire system. It correlates most predominantly with the following: spends little time with friends and is not a member of a youth gang. The second factor is called *loneliness, isolation from friends (does not take part in society and does not socialize with friends).*

The third factor explains 9.5 % of the variance and includes these correlating variables: does not get along with teachers, experiences school as something negative. The third factor is called *negative attitude towards school.*

The endangering role of the student at school, conflict with school and classmates and a negative attitude towards school point to the fact that the child is unsuccessful at school and therefore also views himself as incompetent, removed, inferior or even entirely bad. The experience (usually comprised of a list of painful and agonizing defeats) of not fulfilling the expectations of his environment and those he is closest to can seriously threaten his self-respect and gradually penetrate all aspects of his self-image. From there it is only a short path to seeking validation in negative, even destructive ways.

Tomori (2002) says that being unsuccessful in school at a global level reduces the quality of life for both the child and those he is closest to. It decisively threatens the individual's integrated personality development and increases the child's susceptibility to other harmful threatening factors.

Mencin Čeplak (in Ule, 2000) claims that being unsuccessful in school is not the consequence of a random link between an individual's circumstances and institutional conditions (of the system), but rather is the product of every school system and its circumstances of social inequality, unequal distribution of power.

Tivadar (ibid.) find that students who perceive unequal treatment in school are more prone to delinquency. They feel less well at school and are also less successful in their studies. Therefore, school achievement has indirect significance. Otherwise, the level of correlation between the way one experiences school and delinquency

is very low (r = -0.18), and even lower when excluding the influence of school achievement (r = 0.06). An individual who does not feel well at school will also try to leave as soon as possible.

Bürger (1999) also calculated a high level of correlation between being unsuccessful at school and being placed in a juvenile educational institution. The correlation coefficient was 0.77. Disagreeable, even painful experiences from school can serve as a metaphor and be transferred onto the individual's attitude towards any and all social systems.

Intimidating events leading to a decrease in self-respect

With these six factors we have managed to account for 43.451 % of the variance.

The first factor accounts for 18.4 % of the variance. It is comprised of the following variables: difficult material situation of the family and difficult housing situation. In view of its content, we have called the first factor *difficult material situation of the family (bad socioeconomic circumstances of the family).*

The second factor accounts for 7.8 % of the variance of the entire system. It correlates the most with: no chronic physical maltreatment, no maltreatment of the child, no chronic sexual abuse, no chronic extreme neglect. The second factor is called *no chronic maltreatment of the child.*

The third factor accounts for 5.8 % of the joint variance and includes the following variables: the child repeated a grade, the child transferred to another school, the child received disciplinary sanction at school. The third factor is called *unsuccessful at school.*

The fourth group accounts for 4.6 % of the joint variance and includes the following variables: mother's loss of employment and the unemployment of the mother. The fourth factor is called *unemployment of the mother.*

The fifth factor accounts for 3.6 % of the joint variance and is comprised of the following variables: unemployment of the father, father's loss of employment, and criminal offences of parents. We have called it *existential problems and criminal offences of parents.*

The sixth factor represents 3.3 % of the joint variance and includes the following variables: serious accident, illness of the mother, psychological illness of a relevant person, serious accident, illness of the father, and serious accident, illness of the child. It is called *accidents and illnesses in the family.*

Attitude problems

The following seven factors explain the 56.846 % of the variance.

The first factor is the most complex and explains 35.8 % of the variance. It is comprised of the following variables: selfishness, negativity and pragmatic behaviour. In view of its content, we have called the first factor *obstinate self-centred behaviour (egocentric tendencies).*

The second factor explains 8.9 % of the variance of the entire system. It correlates the most with: demure, distant, gloomy, distrustful, cold, socially withdrawn and lonely. The second factor is called *social anxiety.*

The third factor accounts for 3.4 % of the joint variance and includes the following high correlating variables: reduced distance, disapproval by peers, unbalanced behaviour, unpopularity, not establishing distance, undefined social behaviour and repulsive behaviour.

The third factor is called *conflict social behaviour.*

The fourth group explains 2.8 % of the joint variance and includes the following variables: a lack of interpersonal connectedness, communication difficulties, difficulties with relationships, weakened links with those one is close to, social behaviour problems, difficulties adapting, oppositional behaviour. The fourth factor is called *difficulties maintaining relationships.*

The fifth factor explains 2.4 % of the joint variance and is comprised of the following variables: looking for fights, verbal aggression, explosiveness and provocation. We have called it *verbally uncontrolled (aggressive, provoking behaviour)*

The sixth factor represents 2 % of the joint variance and includes the following variables: lying, irresponsible behaviour, disobedience and restlessness. We have called it *irresponsible, infantile attitude.*

The final, seventh factor accounts for 1.6 % of the joint variance; the following variables correlate highly: irritability and mood swings. We have called it *mood swings (neurosis).*

We can see quite clearly that the acquired factors themselves could represent secondary causes as they are the same as the consequences, the behavioural manifestation (of behavioural and emotional disorders) of a certain cause. Therefore, we can conclude that they are – despite the fact that they already seem to be the consequence or behavioural manifestation – suitable for defining the group of children and adolescents placed in juvenile educational institutions, and can be classified among the criteria for such a placement.

Myschker (2002) discovered dimensions of personality on the FPI scale (Freiburg Personality Inventory) that define a child or adolescent with behavioural disorders as aggressive, emotional immature, impulsive, while at the same time as an individual with a limited capacity of concentration, low level of frustration tolerance, who is irritable and intolerant, and also an individual with a strong need to assert himself and a high level of mistrust and egocentrism. The behaviour of children and adolescents in juvenile educational facilities is unpredictable; they lack social self-control, have a reduced level of frustration tolerance, limited capability of controlling and integrating behaviour, the feeling of insecurity and discontent; they find it more difficult to put off having their needs met, they have a tendency to overestimate themselves, they want to be the centre of attention at all costs and they are insecure in social situations. Van der Doef (1992) also points out that behavioural disorders can manifest themselves as primarily a deficit when it comes to emotions, even though a cognitive deficit is also possible. Emotionally contradicting the rules of the environment, egocentricity and viewing others as a means of satisfying one's own needs all manifest themselves in children. The attitude problems of children and adolescents are the recurring element of all the accumulated difficulties, caused by various reasons, which have been thoroughly evaluated in the theoretical part. We would like to stress that attitude problems can further incite new difficulties, unsuitable behaviour that is harmful to the individual, as well as enhance behavioural and emotional disorders.

Dissocial difficulties

The following five factors account for 60.873 % of the variance.

The first factor is the most complex and explains 41.7 % of the variance. It is comprised of the following variables: eruptions of rage, fighting, physical aggression, destroying, smashing, irritability, destructiveness and excessive conflict behaviour. We have called the first factor *distinct aggressive behaviour.*

The second factor explains 7.1 % of the variance of the entire system. It correlates the most with: theft, fraud, petty theft, bicycle theft and breaking into cars, apartments, shops. The second factor is called *dissocial behaviour.*

The third factor accounts for 5 % of the joint variance and includes the following high correlating variables: disregard for norms, breaking rules, rebellious behaviour, non-acceptance of social rules, apparent disobedience and no remorse. The third factor is called *dissocial normative orientation.*

The fourth group explains 4 % of the joint variance; it includes the variables: driving fast on motorcycles, in cars, and driving a car without a licence. The fourth factor is called *looking for adrenaline highs by committing criminal offences.*

The fifth factor explains 3.1 % of the joint variance and is comprised of the following variables: physical torment of others, tyrannical behaviour, psychological torment of others, extorting peers, group fights and attacking people in the street. We have called it *physical and psychological maltreatment of others.*

The factor analysis shows that the scale is one-dimensional. Only those correlations above 0.50 are shown in the factor matrix. By using oblimin rotation we have made it possible to acquire 5 factors despite the homogenous structure. The factor correlation matrix also shows that the factors are interconnected and that this is a complex issue.

The saturated variables point to dissocial disorders in children and adolescents. The factors acquired fit predominately into the first three groups of Bregant's classification of dissocial disorders: situational, reactively caused disorder as the consequence of extreme strain on a normal personality structure; secondary peristatic disorder as the consequence of problematic emotional

development (with a neurotic and dissocial personality structure) and primary peristatic disorder as the consequence of direct environmental corruption and deception (Krajnčan 2006). Schrader (1991, p. 310) presents a similar structure of dissocial disorders, adding social rage and destructive behaviour towards people and objects. Schrader also confirms our theoretical findings: the cause of the dissocial behaviour can be found in parental education, orientation and climate; he adds a multitude of socioeconomic (or socio-ideological in the widest sense) and ecological factors, factors connected to school and of course personally specific factors, as well as certain other factors; yet if we wanted to create a schematic of the causes behind these disorders, they would prove to be insufficient and routine. Bürger (1998c) classifies dissocial behaviour as one of the factors that decisively influence some social workers when deciding to place a child in a juvenile educational institution.

Specific personal, emotional and psychosomatic difficulties

We have managed to explain 44.506 % of the variance with six factors.

The first factor is the most complex and accounts for 24 % of the variance. It is comprised of the following variables: lasting affective disorders, disorders of volition, attention-span and concentration disorders, low frustration tolerance, abnormal habits and impulse control disorders, tiring easily, daydreaming, age-inappropriate behaviour, reactions to sever strain, negating real events, emotional disorders in childhood and emotional poverty. In view of its content, we have named the first factor *specific psycho-pathogenic deviation.*

The second factor explains 5.7 % of the variance of the entire system. It correlates the most with the following variables: sexual disorders, sexual maturity crises, sexual identity disorders in childhood and pronounced sexuality (e.g. excessive masturbation…). The second factor is called *sexual development (maturation) crisis.*

The third factor explains 5.2 % of the joint variance and includes the following correlating variables: drinking, drinking

alcohol mixed with energy drinks, smoking marijuana, hashish, taking ecstasy, smoking cigarettes and taking heroine, crack, LSD. The third factor is called *consummation of illegal psychoactive substances.*

The fourth factor explains 3.9 % of the joint variance and includes the following variables: dejection, generalized fear, worrying, depressive / sad moods, common physical problems, indisposition, sleep disorders, weepiness, sense of inferiority, unhappiness, common illnesses, forced actions, thoughts, organic and symptomatic psychological disorders, social fear, issues with health, anorexia and age-inappropriate fears / phobias. The fourth factor is called *depressive disorders (pre-psychotic problems).*

The fifth factor accounts for 3.2 % of the joint variance and is comprised of the variables: unusual behaviour, stereotypical speech, loud talking, disorders concerning distancing, ticks, stuttering, stereotypical movement disorders and social impairment in hyperkinetic disorders. We have called it *disorders caused by MCD (compulsive behaviour).*

The sixth factor represents 2.6 % of the joint variance; it includes encopresis and fear of defecation. We have called it *defecation disorders.*

On the basis of studying four hundred children in educational institutions in Switzerland, Meierhofer (in Schrader 1991) established what he calls "abandonment syndrome" on the following behavioural deficits found in the children: children presenting with motor agitation, restlessness, bedwetting, sleep and eating disorders, non-immunity to illness and forms of self-stimulation.

According to Van der Doef (1992), emotional disorders signify children's difficulties in assimilating into a new environment and they manifest emotional disorders if they have to function separately from their parents. Emotional disorders manifest themselves in three forms: separation anxiety, pronounced withdrawal from contact with other people and excessive fearfulness.

Myschker (2002) enumerates six significant drawbacks, disorders with minimal cerebral dysfunction (MCD): MCD can present itself in very different forms and doubles up with hyperkinetic disorders,

learning difficulties and behavioural disorders. Goddes (in Myschker 2002) calls them "*softsigns*" – soft symptoms:

1. symptoms connected with belated or decelerated speech, uncoordinated movement, perception disorders, orientation uncertainty (left-right), high level of motor irritability and tension;
2. with neurological factors: nystagmus, tremor, strabismus;
3. in a different tone of half of the body, a lighter form of asymmetry;
4. fluctuation in mental ability;
5. attention disorders, activity and stimulation regulation; and
6. affective disorders.

When it comes to the connections between behavioural disorders and early childhood brain damage, it is necessary to differentiate between primary and secondary symptoms, where behavioural disorders present themselves directly, for example in hyperactivity or attention deficit (Schrader 1991). Numerous authors see some signals as primary, others as secondary; certain scientists define the syndrome uniformly and ascribe it with the following phenomena (Lempp, Nissen, Göllnitz, Züblin, in: Schrader 1991, p. 343):

- attention deficit, hyperkinetic psychomotor functioning, emotional liability, apathy and reduced psychomotor functioning;
- affected concentration and memory ability;
- decelerated thinking;
- motor restlessness;
- stupor;
- disorder concerning establishing distance, uncertainty when having to adapt quickly to an alien environment (without 'critical' distance);
- disorder concerning social experiences (difficulties in defining one's own personality and the partner's signals in communication and interaction processes);
- impulsiveness;
- general communication ability impairment;
- relatively low frustration tolerance;
- reduced ability of stimuli selection; and
- impaired perception of visual, audio, kinaesthetic and proprioceptive signals.

Various interactions between the above-mentioned primary classification factors trigger secondary disorders and symptoms. This kind of disorder often acts as an impairment with learning difficulties, which also often cause behavioural difficulties and disorders. These children are also handicapped because they cannot separate important from less important stimuli, and are therefore in a permanent state of being flooded with various stimuli; this can manifest itself with impulsive, chaotic and agitated behaviour.

Myschker (2002) writes that depressive disorders can come into existence before the age of five; according to new data from Eisov (in Myschker 2002), it manifest itself in sleep and eating disorders, loss of interest, decreased participation in school, more permanent loss of joy or introversion. McKnew (in Myschker 2002) differentiates between three types of depression in children aged from 6 to 12 years: acute, chronic and masked – acute depression is connected to straining events; chronic continues for a longer period without any concrete triggering situations and is connected with similar disorders in close relatives; masked depression manifests in severely delinquent behaviour. According to McKnew's studies, approximately 5 to 10 % of children suffer from depression; with adolescents, the percentage is substantially higher, up to 18 %.

Myschker (2002) writes that drugs make us mentally and physically dependent (alcohol, opiates, cannabis, sedatives and hypnotics, cocaine, caffeine, tobacco, inhalants). According to Bohmn (in Myschker 2002), most studies have found that behavioural difficulties of children and adolescents that manifest themselves as impulsiveness, irritability, agitation and impatience are connected with the (ab)use of alcohol. We have called the second factor assessed by teachers (5.9 % of the entire system's variance) and the third factor assessed by social workers (5.2 % of the entire system's variance) "consummation of illegal psychoactive substances" (it is assessed very similarly by both types of participants).

Thiersch (1998) produced the following reasons behind specific behavioural and emotional disorders affecting children in educational institutions: learning difficulties (46.1 %), disorientation in everyday situations (27.5 %), developmental retardation (25%), psychological disorders (21.1 %), hyperactivity (7 %), addiction (7 %) and sexual development deviation (4.2 %).

Difficulties connected to school

We have managed to account for 59.331 % of the variance.

The first factor is the most complex and accounts for 40.9 % of the variance. It is comprised of the following variables: disinterest, lack of motivation, poor achievement at school, shortage of motivation for productive learning, sudden loss of interest, general lack of school achievement, learning difficulties and unexcused school absences. The first factor is called *unwillingness and an unsuitable attitude towards school.*

The second factor accounts for 11.9 % of the variance of the entire system. It correlates the highest with: calculation disorders, reading and writing disorders, combinations of learning skills disorders and articulation disorders. The second factor is called *specific learning difficulties.*

The third factor accounts for 6.5 % of the joint variance and includes the highly correlating variables: enjoys risky situations, impulsive behaviour, provoking, insulting teachers, hyperactive behaviour, school punishments, belonging to street gangs. The third factor is called *distinct excessive behaviour.*

Flosdorf (1988) finds that school, with its fixed demands for productivity, learning, discipline and social conformation, is often the decisive trigger that makes placement in a juvenile educational institution necessary. Those causes for deviancy or behavioural disorders that are linked to school are apparent in the following areas:

- socially established function of school,
- organizational and pedagogical influences of school and
- learning processes.

In a society aimed at productivity and efficiency, school acquires a selective function. It performs it in different forms: going from one year to the next, being held back, grading and acceptance procedures, the transition from lower to higher grades and a certificate, the end of schooling.

Long-lasting and extensive learning difficulties are clearly dependent upon behavioural and productivity disorders, which also manifests themselves in the psychological development

of a person (Schrader 1991). The connection between learning difficulties and behavioural disorders is also made because school demands are too high, because achieving standards is linked with the type of strain that leads to unwanted side effects in behaviour, experiencing and personality development. Baier and Heil (in Schrader 1991) stress that the fear that children and adolescents with learning difficulties and socio-emotional disorders acquire in school, manifest themselves in depression, aggression against classmates and teachers, as well as in destructive rage.

Conclusion

We have discovered, as was expected in view of comparable research, that children and adolescent with behavioural and emotional disorders are burdened by numerous factors of influence, and it is difficult to predict which will play a dominant role in the formation of a disorder. The following is an overview of the potential causes and behavioural phenomena that (according to our factor analysis) point to emotional and behavioural disorders:

Tabel 1: Potential Causes and Behavioural Phenomena

Etiological element	**Factors (symptoms)**	**Factors (symptoms)**	**Etiological element**
Relationship between children and parents	1. non-acceptance (rejection) of the child 2. educational powerlessness / incompetence of the parents 3. emotional coldness of parents 4. negative identification factors 5. poor school achievement 6. overly demanding parental upbringing	1. obstinate self-centred behaviour (egocentric tendencies) 2. social anxiety 3. conflict social behaviour 4. difficulties maintaining relationships 5. no verbal self-control 6. irresponsible, infantile attitude 7. mood swings	**Attitude difficulties**

Continuation of table 1:

Violence against children	1. extra-familial torment of the child 2. endangering family environment 3. child did not experience sexual violence 4. familial torment of the child	1. distinct aggressive behaviour 2. dissocial behaviour 3. dissocial normative orientation 4. seeking adrenaline highs by committing criminal offences 5. physical and psychological maltreatment of others	**Dissocial behaviour**
Attitude towards school and peers	1. conflicts with school and peers 2. negative attitude towards school 3. loneliness, isolation from friends	1. specific psycho-pathogenic deviation 2. sexual development crises 3. consummation of illegal psychoactive substances 4. depressive disorders (pre-psychotic difficulties) 5. disorders due to MCD (compulsive behaviour) 6. defecation disorders	**Specific personal, emotional and psycho-somatic difficulties**
Frightening events that lead to a decrease in self-respect	1. existential problems and criminal offences of the father 2. no chronic torment of the child 3. difficult material situation of the family and unemployment of the mother 4. poor achievement at school 5. accidents and illnesses of people the child is close to 6. separation problems (pressure on the child when the parents do not agree)	1. unwillingness and an unsuitable attitude towards school 2. specific learning difficulties 3. distinct excessive behaviour	**Difficulties connected to school**

It is dangerous to speak of causes or a cause that leads to placement in a juvenile educational institution. It is more prudent to discuss the structure or system of circumstances that leads to the decision to place a child or adolescent into such an institution. Personal, social and legal points of view are varied. The circumstances decide if a young person's path will lead to a juvenile educational institution. Sometimes the smallest details play the key roles: an impatient social worker, a telephone call to the Social Work Centre at an inopportune time, a notification about an available room at an institution, an annoyed neighbour etc. (Simmen, 1988, p. 129). Whether all other options have been explored and whether placement in a juvenile educational facility really is the most suitable form of help, in some cases only becomes clear in time. Simmen also states that decisions are often made by experts that try to keep people apart, rather than bring them closer. What is missing? There is a shortage of clear and lucid decisions that the parents and a team of experts reach by discussing and exploring all of the options, without losing sight of the child and his point of view.

Behavioural and emotional disorders are caused by numerous factors and the more we become aware of all possible forms of influence, the closer we are to understanding and consequently also to supporting young people that in all likelihood were not born this way. Even understanding an individual and his situation in life is sometimes enough to begin building bridges between those that have been cast aside, those that feel cast aside, and those that see themselves as beyond repair.

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Empirical article, submitted for translation in November 2008.

Social Pedagogues – from Knowledge to Faith in Change

Socialni pedagogi – od znanja do vere v spremembe

Zdravka Poldrugač in Dejana Bouillet

Abstract

This paper presents results of the research program 'Scientific foundations and development of social pedagogy in Croatia'. The project is primarily focused on finding answers to questions about the identity of social pedagogy. It is also focused on establishing scientific criteria that are fulfilled by social pedagogy, as well as on finding a model to form theories which can be empirically examined by scientific knowledge and practical experience. Therefore, it is important to describe the professional identity of social pedagogues which is defined by the professional competences these experts possess. This paper shows how social pedagogues, who are employed in different jobs and engaged in different areas of work in Croatia, evaluate professional competences (n =

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117). Competences are divided into metacompetences, cognitive, functional, behaviour and value competences. It has been established that all the mentioned elements form a system of professional competences of social pedagogues and that specificities in assessing the importance of certain competences derive from the content and level of intervention in which the examinees are engaged.

Key words: *social pedagogy, professional identity, professional competences.*

Povzetek

Članek predstavlja rezultate raziskovalne naloge Znanstvena podlaga in razvoj socialne pedagogike na Hrvaškem. Projekt je bil orientiran na iskanje odgovorov o identiteti socialnih pedagogov, poleg tega je usmerjen na vzpostavitev znanstvenih kriterijev, ki jih izpolnjuje socialna pedagogika, in na iskanje modela za tvorbo teorij, ki bodo preverljive z znanstvenimi metodami in izkušnjami iz prakse. Zato je pomembno opisati poklicno identiteto socialnih pedagogov, ki jo definirajo njihove strokovne kompetence. Ugotovitve članka pokažejo, kako socialni pedagogi na različnih delovnih mestih na Hrvaškem ocenjujejo poklicne kompetence (n = 117). Kompetence so razdeljene na metakompetence, kognitivne, funkcionalne, vedenjske in vrednostne. Ugotovili smo, da omenjene kompetence tvorijo sistem poklicnih kompetenc ter da so specifike ugotavljanja ocenjevanja pomembnosti posameznih kompetenc povezane z vsebino in ravnijo strokovnih intervencij, ki jih izvajajo strokovnjaki.

Ključne besede: *socialna pedagogika, poklicna identiteta, poklicne kompetence.*

Introduction

In most parts of Europe pedagogy is considered to be a special, comprehensive and personal educational model of work with children and young people in different pedagogical environments which is focused on their well-being and development (Petrie, 2005). In literature pedagogy is usually divided into 2 main parts: 'school of education' and 'school of life or pedagogy' (Frolov, 2003). 'School of education' is, on the one hand, primarily focused on knowledge acquirement and the development of a cognitive personality component. On the other hand, the 'School of pedagogy' is trying to affect the beliefs, attitudes and other conative aspects of behaviour. Although these orientations are interconnected, in some pedagogical environments it is possible to notice the domination of educational or pedagogical issues. Social pedagogy, for example, belongs to the pedagogies that are primarily oriented towards upbringing, but it also includes both pedagogic components (upbringing and education in a broad sense). It is, unlike 'private' family pedagogy, led by the interests of society and focused on work with vulnerable social groups (Petrie, 2005). This means that it is contextually adjusted to the needs of institutions which take care of children, work with young people, family support, juvenile court, institutional treatment and other ways of work with children and young people.

The disproportion of the development of social pedagogy in some countries has influenced the level of the development and understanding of the specific content of this young profession, its position within the system of science (from social to pedagogical scientific disciplines) and the development of the education system of social pedagogues. Regardless of the numerous differences, the development of social pedagogy can be noticed. It is becoming more influential with time among the so-called 'helping professions'. It encompasses a wider area of work, trying to form its own professional identity at the same time. The widening of the work area places a new challenge on the social – pedagogic profession and raises new questions for the creators and performers of the educational programme (Kobolt & Dekleva, 2006). Moreover, the search for identity within a professional

group is neither new nor surprising. In many professions it is a continuous process in accordance with the environment which is constantly changing (Knežević, 2003).

Anyway, every discussion about the identity of the profession begins with a definition of the work area, which is connected to the defining of the competences which make a profession recognisable in the real world. The competences are difficult to define unambiguously, especially when the professions concerned are those focused on the realisation of complicated tasks and when they ask for the implementation of other abilities. However, authors agree that professional competence includes one's ability to do, manage or work with a certain amount of knowledge, skills and abilities (Mijatović, 2000: 158). Although there is no distinction between 'competence' and 'being competent' in many dictionaries, Rowe (1995) emphasises the need to distinguish the two expressions. Therein, the term 'competence' refers to abilities and acquired standards of professional work. On the other hand, the term 'being competent' includes acquired standards of behaviour. In other words, competence defines what people can do and being competent the way certain things are done. Anyway, it concerns the ability to apply knowledge and skills in the real world which is seen in the results of practical work and includes integrated implementation of understanding, skills and system of values in educational practice.

Cheetham and Chivers (1996: 24) distinguish four main elements of professional competences: functional competences, personal or behavioural competences, cognitive competences and value or ethical competences. *Cognitive competences* imply proper knowledge and its efficient implementation. They also include practical, theoretical, procedural and contextual knowledge. *Functional competences* are defined as the ability to do different tasks successfully. They include specific abilities, psychosocial skills and organisational skills. *Personal or behavioural competences* include the ability to acquire adjusted and recognisable behaviour in professional situations. They refer to the professional, interprofessional and wider social area. *Value or ethical competences* are defined as the possession of suitable personal and professional values which ensure the ability to rationally judge different

situations whether in the private or professional life. The elements described form the main competences which are surrounded by the so-called *meta-competences*. They include communication skills, the ability of self-development, creativity, analyticity and the ability to solve problems. The special importance of meta-competences can be seen in the way they aid in the development of the main competences.

The described model of understanding professional competences can be applied to social pedagogy as well, which is in Croatia described as a science, theory and practice of the prevention of social integration difficulties of persons with behaviour disorders, especially by helping with the upbringing of individuals as well as specific society groups (Bouillet and Uzelac, 2007). The professional competences of social pedagogues are often grouped into three general parts - professional knowledge, professional skills and personal potentials, talents or personality characteristics. *Professional knowledge* includes knowledge about children, their development and needs, difficulties and problems in the process of their development and social integration, as well as knowledge which gives sense, supports professional forms of behaviour or makes the decision making process easier. *Professional skills* include specific cognitive, interpersonal, social and motor abilities which influence professional identity and the abilities to create a professional environment. *Personality* implies all other personal potentials - from the appearance and personality characteristics through life experience to special talents which a person uses every day by combining them with knowledge and skills (Žižak, 1997: 3).

Anyway, the education of social pedagogues has to focus on reflexive and practical knowledge, which means that the competence education frame stretches from the theoretical to the application dimension of bringing up an individual. This process includes understanding the way people see their own life, relations with other people, the way they function in different social groups, relations between groups and the relation of all the elements of their ecologic environment. Apart from that, psychosocial professions - one of them being social pedagogy – are, as regards their development, in the middle of the two demands of real social

circumstances and the need to protect social values, as well as the individuals' needs and demands for scientifically verifiable theories and the model of practical work (Kobolt and Dekleva, 2006: 172).

With the aim to find answers to numerous questions concerning the present state, but also to develop social pedagogy at the Faculty of Education and Rehabilitation Sciences, the scientific – research project is under way, called '*Scientific foundations and development of social pedagogy in the Republic of Croatia'* carried out by Zdravka Poldrugač, Ph.D., with the financial support of the Ministry of Education.

The research will contribute to finding answers to questions about the scientific foundations of social pedagogy as an interdisciplinary science. It will also point out its subject, tasks and methods. The social foundation of social pedagogy will be observed through social processes, especially those in Croatia which influence the higher need for social pedagogues. It will also try to answer the question on how the education of social pedagogues fulfils the needs of Croatian society and the needs of the individuals, groups and communities their work is focused on.

With this aim, in the empirical part of the research the most significant elements of the professional competence of social pedagogues for their successful work will be determined and evaluated. This aims at a contribution to the improvement of the university and other programs of enabling social pedagogues and the quality of professional social pedagogic work with persons at risk or behaviour disorders with the aim of improving the quality of professional and social activities focused on the social integration of deprived social groups.

This research is part of a scientific – research project and the shown results refer to the data received by the pilot research.

Aim and hypothesis of the paper

The main purpose of this paper is the attempt to elaborate the system of the professional competences of social pedagogues as a starting point in establishing scientific, theoretical and practical

foundations of social pedagogy and the grounds for its professional identity. On the basis of the information received from the pilot research, the paper shows how professional competences are evaluated by social pedagogues who work in different jobs and are engaged in different areas of social pedagogy.

Two hypotheses are examined in this paper. The first supposes that social pedagogues realise the importance of all theoretically suggested professional components which form the identity of that profession. The other hypothesis presupposes that the evaluation of the importance of certain professional competences is statistically dependent on the specificity of the interventions which social pedagogues take part in (the age of the population, the level of the prevention of behaviour disorders and the department the intervention is taking place in). By examining both hypotheses we will also examine whether the division of professional competences to metacompetences, functional, behavioural and ethical competences is applicable in social pedagogy.

Methods

The pilot research was carried out during 2007 among experts who work with persons with behaviour disorders on the level of prevention or treatment.

The research was carried out on 117 social pedagogues (99 or 84.6 % female and 18 or 15.4 % male). Most of them are employed in institutional treatment (39.4 %). This is followed by the group of social pedagogues employed in the social care system (11.1 %) and primary schools (11.1%), as well as employees at courts and the General Attorney's Office (8.5 %). Other examinees are employed in non-governmental organisations (4.3 %), medical institutions (4.3 %) and police (0.9 %). For 23.1 % of the examinees, this information is unknown. The sample covers the age from 23 to 60 with various work experience with the population suffering from behaviour disorders (aged 1 to 36).

Most examinees work with children and minors (49.6 %), or only with minors (35.9 %). The sample includes 7.7 % of examinees who work with adults and 6.8 % of examinees who work only with

children. 59.0 % of examinees are engaged in social-pedagogical treatment, in prevention 19.7 %, in diagnostics 15.4 %, and only 4.3 % of the examinees in detection. 12.8 % of the examinees would change their profession, 17.1 % of the examinees are not sure about that, 70.1 % of the examinees would not change their profession. 31.6 % of the examinees believe in the possibility of a change of behaviour after social pedagogic interventions, 24.8 % think this is likely to happen, and 43.6 % of the examinees consider such changes to be partially possible.

In this pilot research we used the modified questionnaire on the knowledge, skills and characteristics of social pedagogues as a measure instrument. The questionnaire consists of three parts which include three general elements of competence (19 for the area of knowledge, 22 for the area of skills and 33 for the area of personality and talents) and a part about the general information on the examinees and the specificity of their occupation or job. The importance of certain competences was evaluated on a three-level scale and questions about the general information were formed as variables with offered categories (closed type questions). In this analysis a part of the obtained information has been used. Competences which describe the most directly certain elements of the system of professional competence according to the Cheetam and Chivers (1996) model and the variables which describe the specificities of interventions that social pedagogues take part in (age, level of prevention, department of work). Professional competences which are included in the analysis are theoretically classified according to the chosen model and shown in Table 1.

The first hypothesis was examined by analysing the relative frequencies and arithmetic mean of examinees in particular groups of professional competences. The other one was examined by three discriminative analyses. Each analysis treats professional competences as a set of dependent variables. Independent variables are age, level of intervention and the department in which the social pedagogues are engaged.

Results

Table 1 shows the examinees who evaluate certain professional competences to be extremely important. It also shows the arithmetic mean of all the examinees' results. A smaller arithmetic mean implies a higher level of importance given to certain competences by the examinees.

Insight into the data shown in Table 1 tells us that the examinees consider the ability of self-knowledge to have the highest level. It is followed by dealing with conflicts, communication and the ability to prevent problematic situations. Other competences are considered to be important by half or less of the examinees. As far as cognitive competences are concerned, our examinees think that procedural knowledge is the least important. As regards practical knowledge examinees consider methods of individual work, group work and counselling to be significant. As far as contextual knowledge is concerned, they consider social pathology and psychopathology to be important; and as far as theoretical knowledge is concerned, more than one third of the examinees considers all that was listed to be important. As far as practical knowledge is concerned, the examinees consider the methodology of individual work to be the most important. As very important functional competences they regard active listening and first contact, the recognition of one's virtues, group leadership, setting the aims, and planning. Organisational abilities are considered to be the least important. Patience is mentioned as the most important personal/behavioural competence. Two thirds or more of the examinees consider persistence to be very important, as well as tolerance and the ability of team work. The lowest level of agreement among the examinees can be noticed at value/ethical competences which are considered to be very important by less than two thirds of examinees.

Table 1: Proportion of examinees which consider certain competences to be very important (%) and the arithmetic mean of all the examinees' results (M)

Content of competence	Variable/competence	% (n = 117)	M
1. METACOMPETENCES			
Communication skills	Communicativeness	62.9	1.41
Self-development ability	Personal experience	48.3	1.69
	Good opinion of oneself	41.4	1.73
	Self-knowledge	77.8	1.35
Creativity and analyticity	Intellectual creativity	51.7	1.60
Problem solving	Prevention of problematic situations	67.2	1.43
	Conflict settlement	74.1	1.35
2a. COGNITIVE COMPETENCES			
Practical knowledge	Methodology of diagnosing	69.2	1.52
	Methodology of institutional treatment	45.7	1.85
	Methodology of treatment out of institutions	29.3	1.96
	Methodology of post-treatment protection	25.9	1.98
	Individual work methodology	86.2	1.30
	Group work methodology	83.6	1.39
	Counselling methodology	83.6	1.31
Theoretical knowledge	Pedagogy of persons with behaviour disorders	84.5	1.45
	Psychology of persons with behaviour disorders	88.8	1.30
	Types of behaviour disorders	76.6	1.46
Procedural knowledge	Legal aspects of interventions	15.5	2.08
Contextual knowledge	Criminology	44.0	1.83
	Social pathology	69.8	1.56
	Psychopathology	64.7	1.60
2b. FUNCTIONAL COMPETENCES			
Specific abilities	Active listening	81.0	1.22
	Asking questions	55.2	1.43
	Giving and receiving feedback	54.7	1.49
	Goal setting and planning	63.8	1.38
	First contact establishment	75.0	1.35
Psychosocial skills	Recognising virtues	69.0	1.45
	Managing a discussion	76.7	1.30
Organisational skills	Group management	65.5	1.62
	Organisational skills	44.8	1.66

Continuation of table 1:

2c. PERSONAL/BEHAVIOURAL COMPETENCES			
Professional area	Persistence	75.9	1.37
	Tolerance	75.2	1.35
	Patience	82.8	1.28
	Thoroughness	54.3	1.46
Interprofessional area	Team work	72.6	1.41
Wider social area	Support of friends and relatives	25.0	1.99
	Satisfaction with personal life	48.3	1.70
2d. VALUE/ETHICAL COMPETENCES			
Judging area	Faith in people	50.9	1.66
	Faith in the possibility of a change of behaviour	69.8	1.45
Value area	Honesty	62.4	1.42
	Integrity	69.0	1.34
	Orientation towards positive thinking	63.8	1.50

Anyway, it can be concluded that most of the analysed competences are considered to be important for the social - pedagogic occupation which is in accordance with the results of the previously carried out surveys (Žižak, 1997). It can also be noticed that social pedagogy contains all the theoretically presupposed components of professional identity which is important to have in mind during this analysis.

Are there differences between examinees regarding the specificities of their jobs? We examined that with the use of three discriminative analyses. In them professional competences are treated as dependent variables. As independent variables we used the age of the population the examinees work with (children, minors, children and minors, adults), the level of intervention (diagnosis and detection, primary prevention and treatment) and the department in which the examinees are employed (social protection, education and the justice system). Table 2 shows the main statistical data of isolated discriminative functions. It can be concluded that as far as importance is concerned more than 95 % among groups arranged according to dependent variables, there are statistically significant differences in which professional competences they consider to be different.

Age and department have led to one statistically significant discriminative function, whereas each level of prevention has produced two statistically important discriminative functions.

Table 2: Statistical amount of discriminative functions

Function	Function value	% of explained variables	Canonic correlation	Wilks' Lambda	T-test	Statistical importance
AVERAGE AGE OF THE POPULATION						
1.	1.153	43.3	0.732	0.153	173.006	0.003
2.	0.925	34.8	0.693	0.328	102.455	0.063
3.	0.582	21.9	0.607	0.632	42.201	0.376
LEVEL OF INTERVENTION						
1.	1.888	47.6	0.809	0.084	222.900	0.000
2.	1.245	31.4	0.745	0.243	127.452	0.001
3.	0.836	21.1	0.675	0.545	54.674	0.061
DEPARTMENT						
1.	67.445	92.6	0.993	0.002	118.467	0.000
2.	5.355	7.4	0.918	0.157	36.059	0.419

Table 3 shows the structure of isolated functions which points at the professional competences considered not equally important by examinees with consideration to their jobs.

Table 3: Structure coefficients of statistically important discriminative functions – Coefficients which are included in the formation of functions are marked (*)

Professional competence	AGE	LEVEL OF INTERVENTION		DEPARTMENT
	1st function	1st function	2nd function	1st function
Communicativeness	0.034	0.097	-0.010	-0.001
Personal experience	0.126(*)	-0.004	-0.001	0.009
Good opinion of oneself	0.199(*)	0.126(*)	-0.035	-0.026
Self-knowledge	0.024	0.018	-0.099	-0.019(*)
Intellectual creativity	-0.067	0.047	-0.015	-0.161(*)
Prevention of problem situations	-0.135	-0.032	-0.077	0.017
Dealing with conflicts	-0.152(*)	-0.082	-0.012	0.008
Diagnosis methodology	-0.118(*)	-0.263(*)	0.053	-0.050(*)
Methodology of institution treatment	0.232(*)	-0.178	0.158	-0.065 (*)
Methodology of treatment out of institution	0.053	-0.109(*)	0.017	-0.041(*)
Post-treatment protection methodology	-0.018	-0.098(*)	0.033	-0.038
Individual work methodology	0.074	0.146	0.186(*)	-0.006
Group work methodology	-0.127	0.044	0.216(*)	0.022

Continuation of table 3:

Counselling methodology	-0.014	0.101(*)	-0.008	-0.029(*)
Pedagogy of persons with behaviour disorders	-0.002	0.024	0.154(*)	0.002
Psychology of persons with behaviour disorders	0.005	-0.096(*)	-0.075	-0.038
Forms of behaviour disorders	-0.251	-0.010	-0.050(*)	0.009
Legal aspects of interventions	0.069	0.161	-0.222(*)	-0.040(*)
Criminology	0.058	0.065(*)	0.024	-0.034(*)
Social pathology	0.034	-0.019	-0.017	-0.020
Psychopathology	0.004	-0.015	-0.070	-0.019
Active listening	-0.049(*)	-0.099(*)	-0.012	0.007
Asking questions	-0.150	-0.095	-0.053	0.015(*)
Feedback	0.189(*)	-0.162	0.198(*)	-0.033(*)
Setting aims and planning	-0.018	-0.010	0.218(*)	0.003
First contact establishment	-0.130(*)	-0.085	0.000	-0.007
Virtues	-0.080	0.107	-0.114(*)	-0.017
Managing discussions	0.070	-0.109	-0.025	-0.009
Group management	-0.099(*)	-0.060	0.117(*)	0.040
Organisational skills	0.063	0.122(*)	0.078	-0.035
Persistence	0.020	0.061	-0.026	0.004
Tolerance	0.028	-0.032	0.146(*)	0.012
Patience	-0.097	-0.029	-0.036(*)	0.019
Thoroughness	0.172(*)	0.105	0.115(*)	0.001
Team work	-0.063	-0.070(*)	-0.040	0.027
Support of friends and relatives	0.105(*)	0.023	0.041	-0.032(*)
Satisfaction with personal life	-0.134(*)	-0.045	0.004	-0.010
Faith in people	-0.052	0.032	-0.119	-0.028
Change in human behaviour	-0.196(*)	-0.073	0.016	0.054
Honesty	0.035(*)	-0.172(*)	-0.005	-0.050(*)
Integrity	-0.009	0.080	0.009	-0.017
Orientation towards positive thinking	-0.020	0.106	0.128(*)	-0.018

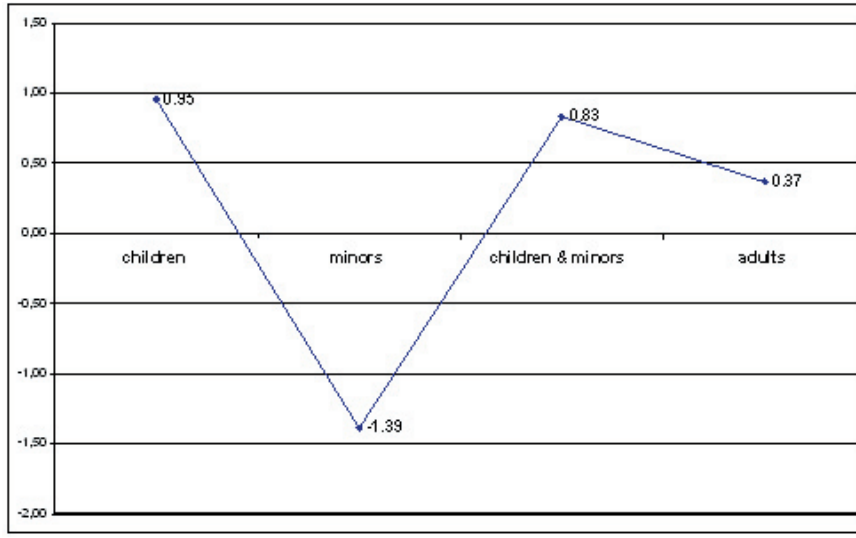
An integral analysis of the structure of all the shown discriminative functions brings us to the conclusion that among the examinees arranged according to the specificities of their jobs there are no differences in the evaluation of the importance of the eight analysed professional competences. These are: communicativeness, ability of prevention of problem situations, ability to discuss, knowledge of psychopathology, knowledge of social pathology, persistence, faith in people and honesty. These competences include all five elements and are evaluated as very important by more than two thirds of the examinees (exception is

faith in people which is regarded as important by more than half of the examinees). Therefore, we can conclude that these competences form a significant part of the identity of social pedagogues regardless of the specifics of their jobs.

It can be concluded that differences in the evaluation of the importance of certain competences are most expressed among examinees who take part in different levels of intervention (half of the analysed competences), whereas the age and department in which the examinees are employed lead to differences in the evaluation of the methodology of diagnosis, the giving and receiving of information and honesty.

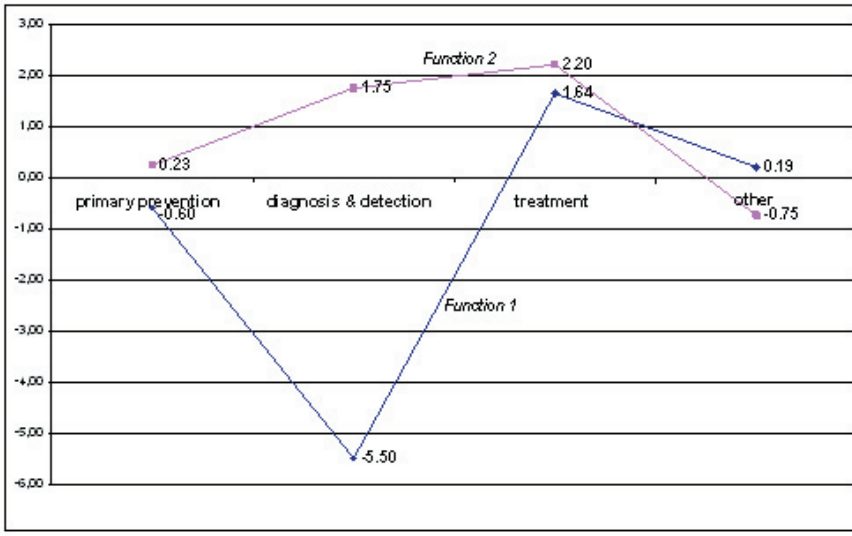
The age element leads to differences in the importance given to personal experience, good opinion of oneself, the ability to deal with conflicts, knowledge of diagnosis methodology, methodology of institutional treatment, the ability of active listening, giving and receiving feedback, first contact establishment, group management, thoroughness, support of friends, satisfaction with personal life, faith in the possibility to change human behaviour, and honesty. Personal experiences, good opinion of oneself, thoroughness, honesty, support of friends and knowledge of institutional treatment are considered to be more important. Less important is dealing with conflicts, active listening, first contact establishment, knowledge of diagnosis methodology, satisfaction with personal life and faith in the possibility of a change of human behaviour. The data shown in Graph 1 inform us about the differences in the age of the examinees. It shows us that the best results are achieved by examinees who work with children and minors; they are followed by examinees who work with adults, while the examinees who work only with minors have the lowest results. In other words, examinees who work with children and minors at the same time consider personal experiences to be very important, as well as a good opinion of oneself, thoroughness, honesty, support of friends and knowledge of institutional treatment. On the other hand, examinees who work only with minors (probably in an educational institution) consider dealing with conflicts to be important, as well as active listening, first contact establishment, knowledge of diagnosis methodology, satisfaction with personal life and faith in the possibility of behaviour change. Examinees who work with adults have average results in this function which implies that there is no significant agreement between them.

Graph 1: Centres of groups on a discriminative function formed according to the average age of those the examinees work with



The structure of the first function, in comparison with the level of intervention in which social pedagogues take part, implies that they distinguish between how important they consider good opinion is, diagnosis methodology, treatment out of institutions, post-treatment protection and counselling, psychology of persons with behaviour disorders, criminology, active listening, organisational skills, team work and honesty. The higher importance of the knowledge of treatment out of institutions, post–treatment protection, psychology of persons with behaviour disorders, active listening, team work and honesty are connected to the lower level of the knowledge of counselling methodology, diagnosis, criminology and organisational skills. On the basis of data shown in Graph 2 we can conclude that the highest results at this level are achieved by examinees who work in treatment and the lowest by those employed in diagnosis and detection.

Graph 2: Centres of groups on a discriminative function formed according to the level of intervention at which social pedagogues act.

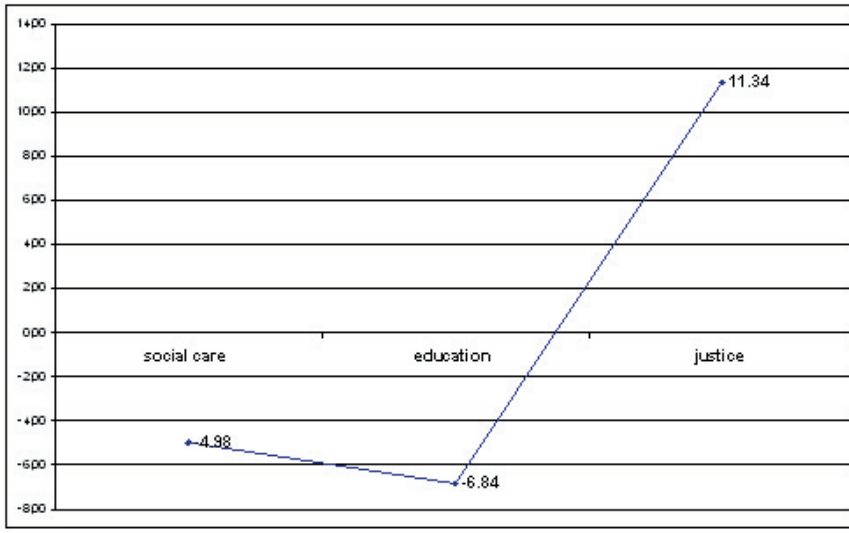


The other discriminative function is formed by variables which refer to the evaluation of the methodology of individual and group work, the knowledge of pedagogy of persons with behaviour disorders and its forms, knowledge of the legal aspects of interventions, giving and receiving feedback, setting the aims and planning, recognising one's virtues, group management, tolerance, patience, thoroughness and orientation towards positive thinking. Therein, a lower level of importance is connected to individual and group work methodology, knowledge of pedagogy of persons with behaviour disorders, giving and receiving feedback, setting aims and planning, group management, tolerance, thoroughness and orientation towards positive thinking. All this implies a lower importance of knowing about behaviour disorders, legal aspects of intervention and recognising virtues and patience. In this function (Graph 2) the highest results are achieved by examinees who work in the treatment of persons with behaviour disorders, whereas the lowest results are achieved by those who are employed in primary intervention.

The department in which social pedagogues are employed significantly contributes to differences in the evaluation of the importance of the following competences: self-knowledge,

intellectual creativity, diagnosis methodology, methodology of institutional treatment, methodology of treatment out of institutions, counselling methodology, legal aspects of intervention, criminology, asking questions, giving and receiving feedback, support of friends and honesty. All coefficients of forming functions are negative, except the one which concerns the importance of asking questions. This means that the lower importance the examinees give to the mentioned competences means a lower importance of the importance evaluation of the ability of asking questions.

Graph 3: Centres of groups on a discriminative function formed according to the department in which the social pedagogues are employed (social protection, education, judicial system).



In Graph 3 we can see how the department reflects the evaluation of these competences. The highest values in this function are achieved by examinees employed at judicial institutions, they are followed by those employed in the social care system and then by those employed in education.

Conclusions

This paper tries to contribute to the clarification of questions concerning specific professional competences of social pedagogues

within the wider discussion on the professional identity of that profile. Taking into consideration the complexity of the profession and the indubitable need for further specialised discussions about the scientific, theoretical and practical specificity of social pedagogy, it is questionable whether conclusions can be made on the subject. Making final conclusions is not appropriate when the results of a pilot research are concerned and which will be used as a ground for further analysis of the social pedagogy development in Croatia. The answer to this question is negative. Anyway, this pilot research opens a few important questions with the possibility of accepting a few starting theses for further research. Furthermore, the way in which certain professions will be regarded depends on the competences of its holders and their level of professionalism. Information received by this research comes from social pedagogues who are at the moment important promoters of social pedagogy.

First of all, it has been shown that one of the most important characteristics of social pedagogy is its close connection to the constructed reality, which means that it depends on the social conditions in which it exists and develops. The mentioned circumstance is recognised by social pedagogues themselves. They have shown they are aware of the need of the development of competences which are widely used and are not necessarily in relation to the treatment of persons who suffer from behaviour disorders. We can conclude that the need for social pedagogues is still increasing, if we take into consideration the fact that the spectrum of their jobs is also getting bigger. That mentioned above can be seen in the fact that social pedagogues are employed in social science (primary schools, health care institutions, non-governmental institutions, social care centres, children's homes, police and judicial systems, etc.) More social pedagogues can be expected to be employed in health care and educational institutions as well as in the non-governmental sector. This implies justification of more precise focusing of the programme for the education of social pedagogues on the development of competences which are necessary for prevention work (especially planning, realisation and evaluation of evidence-based interventions). Demands for evidence-based interventions are strongly expressed as well as those for the applicability of practice to the research results and sensibility to personal effects. All this is in relation to a greater number of

institutions and organisations that are qualified to provide service to the same users, and to the same pressure which agencies responsible for monitoring exert when documenting the positive outcomes of interventions and the satisfaction of users. During the last fifteen years these trends are felt in Croatia too. They can be felt through the aim of the government and civil sector institutions towards the same work area and what is even more important, towards the same financial resources (Bouillet and Žižak, 2008). At the same time we are talking about the need to get a basic research project which includes the research of environmental factors relations (including all components of intervention) and users' behaviour (Conroy, Stichter, Daunic and Haydon, 2008). Namely, in the history of the knowledge of social, emotional and behavioural problems of children and youth, there has never been so many new surveys, knowledge about characteristics, distribution and ways of identification and treatment. However, the effect of knowledge regarding the rising of the quality of everyday practice is not even close to agreement with the amount and quality of knowledge gained in such a way. (Kauffman, Brigham and Mock, 2004).

Within the context of the study programme changes, the need has occurred to intensify the education about the ethical aspects of the profession, organisational skills development and the importance of legally regulated interventions. It is clear that social pedagogues prefer client–oriented education. Most of the examinees emphasise the importance of methodical competences (for individual, group and counselling work) and communication competences (active listening and other communication components). Such an education programme is closely connected to a competence–oriented approach (O'Reilly and McCrystal, 1995). It is also mostly focused on the practical aspects of the profession. In our opinion the profession has to maintain the development of its scientific and theoretical component. Connection of theory and practice is a real challenge for creators and those who maintain the education of social pedagogues. Many researchers have confirmed that. (Jones, West and Stevens, 2006; Kauffman, Brigham and Mock, 2004.).

In short, the results are grounds for accepting the hypothesis which presupposes that social pedagogues see the importance of all the theoretically supposed components of the professional competences which form the identity of a profession. Therefore,

there is no doubt that social pedagogy is a specific help-providing profession. The question is, however, what makes it specific in comparison to other help-providing professions (especially social work, psychology and pedagogy). All help-providing professions are aimed at helping other people in solving their life problems, with a personal contact between the client in trouble and the 'helper'. (Ajduković & Ajduković, 1996). According to this, the specificity of social pedagogy must be viewed within the global concept of the development of professional and scientific disciplines framed by traditional segmentation and contemporary trends marked by interdisciplinarity and transdisciplinarity. Interdisciplinarity and transdisciplinarity are possible and even desirable, but always with an awareness of the character and the amount of participation of a discipline. A part of something clearly belonging to a rounded, coherent unit interlinks the value and continuity of the part to the value and continuity of the unit. In this respect, focus on the education and upbringing of persons who are at risk is emphasised as something specific for the development of behaviour disorder, regardless of the level of intervention.

The level and department of intervention, as well as the age of the persons involved in social pedagogic intervention cause this profession to be specific. This can be seen in the confirmation of the other hypothesis which presupposes that estimation of the importance of particular professional competences is significantly dependent on the specificities of the interventions in which social pedagogues take part. In this respect, the level of intervention is very important and is closely connected to the age of the users and the department in which it is taking place. Specificities can be seen in the evaluation of the self-development ability and the value competences which is in inverse proportion to the level of intervention (the highest is in primary prevention). They can also be seen in the evaluation of the importance of contextual knowledge and functional abilities which is proportional with the level of intervention (they are best valued by social pedagogues employed in treatment). These differences are good to have in mind during the preparation for college education in social pedagogy which is at the moment differentiated according to the age of the users in Croatia. It seems reasonable to examine differentiation according to the level of intervention that future social pedagogues will take part in.

Communication is of great importance for all social pedagogues, as well as the ability of the prevention of problematic situations, discussion management ability, psychopathology knowledge, social pathology knowledge, persistence, faith in people and honesty. Since we are talking about competences which encompass metacompetences, cognitive, functional, behavioural and value competences, we think that it is right to use this segmentation of competences in further research.

Finally, it should be said that this paper opens up many questions. Some of them will not be answered even after the research on the scientific grounds and the social pedagogy development in Croatia is carried out. However, it is already certain that social pedagogy will depend on the global social-political situation in certain environments. It will depend on the importance of the social situation. Social rights of the citizens will be important, the quality of social justice or social cohesion. This is connected to problems of social care and social safety systems, not only as jobs, but primarily as functions which are here for the citizens, their communities and societies. In this atmosphere, the future can be predicted with more reliability for the social pedagogic realism or optimism.

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Empirical article, submitted for translation in January 2008.

The Use of Alcohol among Secondary School Students on Graduation Tours

Uporaba alkohola med udeleženci maturantskih izletov

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Abstract

The article presents the results of a research paper on the use of alcohol and other drugs on graduation tours. The main purpose of the research paper was to determine the prevalence and the rules of the use of alcohol and other drugs among the participants of graduation tours. We were interested in what the peculiarities of the use of alcohol during a graduation tour were and to what kind of risks the young are exposed on tours due to the use of alcohol. The results are compared in a few items to other local surveys on the use of alcohol and other drugs among secondary school students. The presented results of the research paper indicate the possibilities and limitations of preventive work in the area of reducing the damages due to alcohol among adolescents. The article also briefly presents an evaluation of the Choose Yourself preventive project.

Key words: *alcohol, damage reduction, adolescents, graduation tours, prevention.*

Povzetek

V članku so predstavljeni rezultati raziskovalne naloge o uporabi alkohola in ostalih drog na maturantskih izletih. Glavni namen raziskovalne naloge je bil ugotoviti prevalenco in zakonitosti uporabe alkohola in drugih drog med udeleženci maturantskih izletov. Zanimalo nas je, kakšne so posebnosti uporabe alkohola med maturantskim izletom in kakšnim tveganjem so mladi na izletih zaradi uporabe alkohola izpostavljeni. Rezultati so v nekaj točkah primerjani z drugimi domačimi raziskavami o uporabi alkohola in drugih drog med srednješolci. Iz predstavljenih rezultatov raziskovalne naloge so nakazane možnosti in omejitve pri preventivnem delu na področju zmanjševanja škode zaradi alkohola med mladostniki. V članku je na kratko predstavljena tudi evalvacija preventivnega projekta Izberi sam.

Ključne besede: *alkohol, zmanjševanje škode, mladostniki, maturantski izleti, preventiva.*

Introduction

A few years ago a group of students in their second year of studying social pedagogy came to me with the idea of a preventive project in the area of alcohol. They said that they had noticed an increase in the use of alcohol among the youth and that it is a genuine problem and that together they would like to do something and make a difference. I was enthusiastic about the idea and asked them how they planned on doing this. They said that a great problem of the young is drinking during the weekend and that instead of drunkenness on Friday night they would like to offer the young a chance for a quality spending of free time. They suggested playing basketball and bowling on Friday nights as an alternative to drinking. As is the case with the start of any good project we first asked a target group about this. We formed focus groups with young secondary school students and inquired about a name for the project and whether they would be willing to participate

in such activities. They replied that they would like to have a good time without us and that we should leave them alone. The replies were certainly not encouraging and did not point to a joint playing of basketball and bowling. In the focus groups it turned out that only the abstinents would join us, who, according to their statements, have nowhere to party, because they do not drink alcohol. What has been said would surely present an opportunity for another project focused on providing entertainment for abstinents, however, after a thorough deliberation we have decided to build on the experiences from harm reduction and thus direct ourselves towards a reduction of the series of harmful consequences that can accompany the use of alcohol.

We planned an informative part of the campaign, which was directed towards the main problems that the young (according to the results of past surveys) could be exposed to due to the use of alcohol. The leaflets presented information on the risks connected with driving under the influence of alcohol, sexual relations under the influence of alcohol, mixing drugs with alcohol and general information connected with the use of alcohol. Together in three years on the Choose Yourself project we have distributed 30,000 leaflets on graduation tours and have included more than 1300 students in workshops at secondary schools.

Since until now no survey has been carried out in Slovenia that would measure the use and characteristics of the use of alcohol on graduation tours, we at the DrogArt Association have in 2007 planned a survey within the Choose Yourself project with which we wished to gain insight into the use of alcohol and illegal drugs among Slovenian secondary school students before and on graduation tours.

A review of the past surveys has shown that in Slovenia data on the prevalence of the use of alcohol and illegal drugs among secondary school students is available since 1992. The largest portion of the survey (Stergar, 1995; Stergar, 1999; Stergar, 2001; Hibell et al., 2004; Jerman, 2007) was carried out on a population of adolescents in the first years of secondary school; the survey was performed according to ESPAD[1] methodology on a national level from 1995 to

[1] ESPAD – *European School Survey Project on Alcohol and Drugs*. The survey was supported by the Pompidou Group, the Council of Europe and the Swedish Ministry of Family Affairs; the questionnaire was developed by the Pompidou Group (PG).

2007 (1995, 1999, 2003 and 2007[2]). In the area of the Municipality of Ljubljana the survey was carried out with ESPAD methodology or with ESPAD-comparable methodology on secondary school students in the first, third and final year of schooling. In 1995, 1999 and 2003 (Ibid.) the survey was carried out on a sample from the first years of the secondary schools in Ljubljana, and in 2002 on a sample from the final years (third and fourth year).

There were only two local surveys that had measured the prevalence of the use of alcohol and other drugs on older secondary school students (first and fourth year). The first, from 1992, was the secondary school research paper by Bulič and Vesel (1992; in Dekleva, 1998), whose emphasis lay on sex. The survey comprised a sample of 1248 Ljubljana secondary school students (a stratified typical sample). The second survey (Dekleva & Sande, 2003) was carried out according to an ESPAD-comparable methodology in 2002 on students of the final (third and fourth) years of Ljubljana secondary schools. This was the first survey that had studied the changes in the use of alcohol and illegal drugs on a representative sample of secondary school students between the first and final years of schooling (the research was carried out on the same generation, but not on the same population) and the prevalence of the use of alcohol and illegal drugs at the end of secondary school.

The main findings of the survey regarding the use of alcohol among the **third** years of Ljubljana secondary schools were (Ibid.):

- So far 95.6 % of the respondents have tried alcohol. In the past year 90.3 % of the respondents have drunk alcoholic beverages, and in the last month before the survey 72.5 %. The differences between the genders were statistically important; in all the three comparisons more boys drank alcoholic beverages and also drank them more often than the girls.
- Students that had already been intoxicated before the third year of secondary school amounted to 80.0 %. In the past year 68.6 % were intoxicated and in the last month 43.5 % of the respondents. In all three comparisons the differences between the genders were statistically important; more boys were intoxicated than girls.

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[2] At the time of the preparation of the report only the results of a part of the ESPAD 2007 survey were available for the area of the Municipality of Ljubljana.

- In the last month before the survey 49.5 % of the respondents drank five or more alcoholic beverages in a row (of which 19.3 % more boys than girls). The differences between the genders as regards the five or more alcoholic beverages consumed in a row were statistically important.
- The largest number of respondents of both genders tried alcoholic beverages at the age of 12 or less. The largest number of respondents of both genders tried spirituous beverages at the age of 15.
- The most common difficulty that had occured to the respondents due to drinking alcohol was damage to objects or clothes (36.8 %). 20.5 % of the respondents had driven a motor vehicle under the influence of alcohol, while 16.3 % had already had trouble with the police. As a result of drinking alcohol 11.4 % of the respondents had unprotected sexual relations, and 8.0 % of the respondents had unwanted sexual relations.

The main findings of the comparison between the **first** and **fourth** years or between the survey ESPAD 99 (Stergar, 1999) and ESPAD 02 (Dekleva & Sande, 2003) regarding the use of alcohol were as follows:

- Students in the fourth year tried alcoholic beverages in a slightly higher percentage (4.4 %) than in the first year.
- The share of students who tried alcoholic beverages 40 or more times has increased by 30.7 %.
- The percentage of students who had already been intoxicated or who had been intoxicated for 40 or more times has increased by 18 %.
- The percentage of students who had been intoxicated in the last month before the survey has increased by 11 in the fourth year. The percentage of students who had been intoxicated in the past month for 40 or more times has remained unchanged.
- Before the conclusion of secondary school students believe in an almost twice as high percentage than that in the first year that they will drink alcoholic beverages at the age of 25.

The findings of the survey ESPAD 02 (Ibid.) show that the use of alcohol among the final years of the secondary schools in Ljubljana is relatively high. In the case of third year students

the prevalence of use amounted to 95.6 %, while already 80 % of the respondents have been intoxicated. In the case of fourth year students the prevalence of the use of alcohol amounted to 96.5 %, while as much as 83.5 % of the respondents have been intoxicated. Likewise, the numbers of intoxicated students in the past month were relatively high, with 47.3 % among the fourth years and 43.5 % of intoxicated students in the third year. Also common were difficulties occurring due to the drinking of alcohol. Their frequency has increased substantially in the fourth year; most common were damages to objects and clothes (44.0 %), quarrels or arguments (35.0 %) and the loss of money or valuables (25.4 %). Common were difficulties with parents, accidents and fights (around 20 %). Surprising was the frequency of unprotected sexual relations (15.2 %) and unwanted sexual experiences (10.9 %).

The data of the ESPAD 02 survey has been presented in more detail because this is the only survey in our area with which we can in the continuation conditionally compare our MOND 07 survey on the use of alcohol among the participants of graduation tours. The comparison is merely conditional and orientational, since only the age or school year of the participants was the same, while the place and the procedure of the sampling differed. The ESPAD 02 survey was representative with a similar number, since the sampling was random, while our sample was based on self-selection.

Purpose

In the MOND 07 research paper we were interested in what the rules of the use of alcohol (and of certain illegal drugs) were among the participants of the graduation tours and what the peculiarities of the use of alcohol on graduation tours were, and to what risks in connection with the use of alcohol the young on the graduation tours are exposed. Are graduation tours trully characterised by debauched drinking and how do they differ from the use of alcohol during the year? On the basis of the results we were hoping to perhaps indicate a few possibilities for preventive operation.

Method

For the needs of the survey we have formed a sample ourselves, comprised by young people from different Slovenian regions that had attended graduation tours in 2007 with the Mondial Travel agency. The sample was based on self-selection and is, despite a large number, nonrepresentative, since random sampling had not been used and the sampling took place only in one (albeit the largest) specialised travel agency.

The data was collected with the use of a questionnaire, which had been created especially for the purpose of this survey. In order to enable at least a partial comparability of the results with the results obtained with ESPAD methodology, an ESPAD-comparable methodology was used (used in a survey on the use of alcohol and illegal drugs among Ljubljana secondary school students in 1998 and 2002). We have added specific questions regarding the use of alcohol on graduation tours, intoxication and seeking help.

The distribution of the questionnaires took place on the buses when the students were returning from the tour. The guide handed out the questionnaires, which in cooperation with the agency also contained a coupon for a prize game (the main prize was a New Year's trip for two), in which you could only participate if you also returned a filled out questionnaire. Thus we received the questionnaires, without the coupons (on which the young had written their personal information), for further processing. The distribution of the questionnaires took place from May to July 2007 on three graduation tours. The total number of distributed questionnaires equaled 5,100 (1,500/2,000/1,600). The return of the questionnaires was not obligatory (an informal environment) and we can therefore presume that we had reached a segment of the population more motivated for replying or for winning one of the prizes. In the 2006/2007 school year, according to data from the Ministry of Education and Sport, in all Slovenian regions 22,597 students were enrolled in the third years of secondary schools, and 20,237 students in the fourth years (the total data for three-year technical schools and gymnasiums). According to the data from the Mondial Travel agency annually between 12,000

and 13,000 students opt for a graduation tour, and 5,000 of them travels with their agency per year (around 40 %). They are mostly students of four-year and five-year programmes. We have received 1,742 filled out questionnaires. Upon review we have eliminated 64 questionnaires (missing answers, incompletely filled out questionnaires). For further processing we were left with 1,678 questionnaires.

Then we began checking the reliability and validity of the acquired data. The results (as regards the reliability and validity) are comparable to the results of the ESPAD 2002 (Dekleva & Sande, 2003) and ESPAD 2007 survey (Jerman, 2007).

Thus after checking the reliability and validity, and making corrections due to inappropriate age and missing gender information, we eliminated 48 questionnaires. In such a manner we finally formed a sample of 1,630 participants of graduation tours. The final sample formed therefore included students of Slovenian secondary schools of the age from 17 to 19. The sample was very balanced as regards gender and contained 49 % of boys and 51 % of girls. A majority of the respondents (average age of 17.5) attended the tour in the third year of schooling, and the rest (19 years of age) attended the tour in the fourth year.

Results

In the following the results are briefly presented and divided into different areas. The first part presents the findings on the use of alcohol, intoxication and a risky use of alcohol. The second part gives the main findings on the prevalence of the use of illegal drugs, and the third part on the awareness of the preventive programme Choose Yourself.

Main findings regarding the use of alcohol

The use of alcohol among the participants of the graduation tours was measured with questions on the use in their life (until now), the past months and the past week (graduation tour) before the survey, and with questions on intoxication, the use of alcohol in the future, and questions on the problems associated with the use of alcohol.

The main findings of the survey **regarding the prevalence** of the use of alcohol were the following:

- At least once in their lives 98.9 % of the respondents tasted alcohol; 98.4 % of them in the past year, and 96.4 % in the past month and week. In all four comparisons the differences between the genders are statistically important ($p = 0.001$); boys use alcohol more often than girls.
- According to the frequency of drinking the students of gymnasium and four-year technical programmes statistically importantly ($p = 0.05$) differ in the use in the past year and past month. In both comparisons alcohol was used more often by students of the gymnasium programmes.
- On the graduation tour alcohol was drunk every day by 53.1 % of the girls and by 72.4 % of the boys.
- On the graduation tour, in comparison with the last month before the survey, the number of abstinents (3.6 %) remains the same, while in comparison with the last year and month the students who use alcohol have increased the frequency of drinking.
- A majority (66.5 %) of the respondents believe that they will drink alcoholic beverages at the age of 25.

The main findings of the survey **regarding intoxication** were:

- Until now 93.2 % of the respondents have been intoxicated in their lives, 88.7 % in the past year, and 82.5 % in the last month before the survey.
- On the graduation tour 83.2 % of the respondents were intoxicated. The differences between the genders were statistically important; most often (6–9-times) there were twice as many boys intoxicated than girls.
- In the last month before the graduation tour three quarters of the respondents (76.4 %) drank five or more alcoholic beverages in a row. The differences between the genders are statistically important; the boys drank five or more alcoholic beverages in a row more often.
- On the graduation tour 83.9 % of the respondents used five or more alcoholic beverages in a row on one or more occasions; 17.2 % did so ten or more times.
- The girls remained more moderate on the graduation tour, since

the number of boys who used five or more drinks had increased more; likewise the number of those who did so on more occasions.

- On the graduation tour 36.4 % of the respondents got too drunk (so that they were nauseous, vomited or cannot remember what happened). Once again the boys were less moderate, since slightly less than half of them were highly intoxicated, and slightly less than a third of the girls.
- On the graduation tour 21.0 % of the respondents were so intoxicated that others had to help them (of which 22.2 % of boys and 19.8 % of girls).

Main findings regarding difficulties due to drinking alcohol

With two group of questions we asked the respondents what sort of difficulties they had encountered due to the use of alcohol in their lives until now and on the graduation tour. The most common difficulty that had occurred to the respondents was, both in the ESPAD 02 LJ survey and in the ESPAD 07 LJ one, damage to objects and clothes (51.6 %). The percentage is substantially higher than with the first years (ESPAD 07 LJ – 14.1 %) and third years (ESPAD 02 LJ – 36.8 %). This was followed by quarrels or arguments (46.5 %) and accident or injury (30.7 %).

Similarly, the lowest percentages are found in the case of difficulties in the relationships with teachers or places. In 2002 we were surprised by the high percentage of secondary school students who had unprotected sexual relations due to the use of alcohol (11.4 %) or an unwanted sexual experience (8.0 %). The results of our survey show similar, only slightly higher results. 10.2 % of the respondents had unprotected sexual relations, and 9.4 % an unwanted sexual experience. Due to drinking alcohol 8.7 % of the girls and 11.7 % of the boys had unprotected sexual relations, while 7.3 % of the girls and 11.7 % of the boys had an unwanted sexual experience. In the case of the unwanted sexual relations there were statistically important differences between the genders ($p = 0.001$).

Main findings regarding the use of other drugs

The questionnaire also included several questions on the use of other drugs, the use of which was also being checked in other local and foreign surveys on a similar population. The results regarding the use of drugs in our sample were as follows.

- Among the other drugs, about which we inquired in our questionnaire, the respondents most often tried marihuana (46.6 %), poppers (20.9 %), sedatives (8.1 %), amphetamines (6.8 %) and ecstasy (4.9 %). Other drugs (heroin, LSD, GHB) were used by less than 1 % of the respondents.
- Slightly more than a quarter of the respondents had used marihuana 6 or more times, while it had been used 40 or more times by 10.6 % of the respondents. Marihuana was used by more boys than girls, and until now the boys also used it on more occasions. The differences between the genders are statistically important.
- Ecstasy was used by 5.3 % of the boys and 4.9 % of the girls; as regards the use in their lives until now there are no statistically important differences between the genders.

The results once again point to a stable level of the prevalence of the use of marihuana among students in the final years of Slovenian (or Ljubljana) secondary schools (third and fourth years), which was one of the findings of the ESPAD 02 LJ survey (Dekleva & Sande, 2003). A review of the period from 1992 onwards naturally involves research carried out on different populations and samples, which is therefore only partially comparable. In Slovenia, together with the present survey, in the period from 1992 to 2007 only three surveys were carried out on students of third and fourth years. The first was the secondary school research paper by Bulič and Vesel from 1992 (Ibid.), and the other was a survey according to an ESPAD-comparable methodology (ESPAD 02 LJ) from 2002, carried out on students of Ljubljana secondary schools (third and fourth years). Taking into consideration the limitations in the comparability of the results, an evaluation can be obtained that the life prevalence of the use of marihuana among Slovenian (and Ljubljana) secondary school students of the final years is not changing. The prevalence of the use of marihuana among students of the 4th years of Ljubljana secondary schools amounted in 1992 to 46.9 %, in 2002 to 46.6

% among the third years, and 50.3 % among the fourth years, and in 2007 to 46.6 % among the participants of graduation tours in a comparable age bracket.

Comparison between different surveys

At the beginning of the article the Slovenian surveys on the use of alcohol and drugs, with which we wished to compare our data, were presented. In Table 1 the results of the prevalence of the use of alcohol from our survey are compared with three local surveys that measured the use of alcohol and illegal drugs on the secondary school student population. The results are not directly comparable, since the past surveys of the ESPAD methodology or of a comparable methodology were carried out on a population of the first years of Ljubljana or Slovenian secondary schools. The results of our survey are perhaps the most comparable with a survey of an ESPAD comparable methodology from 2002 (Dekleva and Sande, 2003) since it deals with a similar age group (third and fourth years). Despite this, one survey deals with Ljubljana secondary school students and the other with Slovenian ones. When comparing it needs to be taken into consideration that all three surveys that are being compared with our sample gained results with a chance selection, while ours was based on self-selection (see chapter Method). Any comparison or commentary therefore serves only for orientation.

Taking into account the above written limitations, it is clear from the results shown in Table 1 that the prevalence of the use of alcohol in the case of students who were schooled in Ljubljana (ESPAD 07 LJ) is higher than the prevalence measured on a sample of students from the entire country (ESPAD 03 SLO). Our data (MOND 07) indicates that the prevalence of the use of alcohol among Slovenian students is higher than the prevalence in the case of Ljubljana students of a comparable age (however, it must be taken into consideration that the surveys are five years apart, which may be the cause of the increased prevalence). The use of alcohol in the last month is understandably high in our survey, since the students were interviewed after the graduation tour. It is surprising that the prevalence of the use in their lives so far and in the past year is in our survey basically the same. According to the data from the surveys so far the prevalence in the past years was always lower than the life prevalence.

Table 1: The use of alcohol – comparison between different surveys. The ESPAD 07 LJ (Jerman, 2007) survey was carried out on a sample of the first years of Ljubljana secondary schools, and the ESPAD 03 SLO (Hibell et al, 2004) survey on the first years of Slovenian secondary schools. The ESPAD 02 LJ (Dekleva and Sande, 2003) and MOND 07 SLO surveys are more comparable to each other as regards the age of the participants, taking into account that one was carried out on a sample of Ljubljana secondary school students and one on a sample of Slovenian ones.

Use of alcohol / Survey	In one's life %	In the last year %	In the last month %
ESPAD 07 LJ (1st year)	94.0	86.9	64.5
ESPAD 02 LJ (3rd year)	95.6	90.3	72.5
ESPAD 02 LJ (4th year)	96.5	/	71.7
ESPAD 03 SLO (1st year)	91.7	83.1	59.9
MOND 07 SLO (3rd and 4th year)	98.6	98.4	96.4

Main findings regarding the awareness of the Choose Yourself preventive programme

22.5 % of the respondents were familiar with the holder of the project (DrogArt Association), while 16.6 % of the respondents were familiar with the Choose Yourself project (n = 1,615–1,611). On the tour 39.1 % of the respondents received preventive material (n = 1,585). Of those who had answered the question 48.5 % followed the instructions[3] of the preventive material (n = 738). More than half (65.4 %) of the respondents who answered this question liked this approach or manner of giving information (n = 837). In the case of the last two questions it must be acknowledged that only roughly half of all of the respondents answered them. More than half of the respondents who answered these two questions was satisfied with the design (61.7 %) and content (62.7 %) (n = 735–732).

[3] On a five-level scale of following the instructions, where the lowest value was »I did not follow them at all« and the highest »I followed them a great deal«. In all of the analyses the combined categories 4 and 5 (the highest values) were deemed as a positive answer (I liked it, I am satisfied). In the case of the answer to this question we must be aware that only half of the respondents answered it. The number in the case of the answer to the last question is probably smaller because not all of them had received the informative material and thus could not give their opinions on it.

By taking a look at a cross comparison between following the instructions and the characteristics of drinking alcohol on the graduation tour it can be concluded that those respondents who had followed the instructions of the preventive material on the graduation tour more are less often intoxicated (p = 0001), drank five or more alcoholic beverages in a row less often (p = 0.05) and were too drunk less often (nausea, vomiting) (p = 0.005). Greater following of the instructions is thus statistically importantly connected with a less risky use of alcohol. The results may indicate the effectiveness of the preventive material or the persuasion of the already persuaded (meaning those who would otherwise also be more careful). In the case of following instructions it must be understood that some people are more inclined to consider key information or are already informed of something and this only additionally confirms their belief. When comparing the comparison of the intoxication in the last year before the graduation tour (p = 0.001) and the frequency of drinking five or more alcoholic beverages in the month before the tour (p = 0.005), we likewise obtain statistically important connections between following instructions and a less risky use of alcohol. Apparently those who follow instructions more are generally more careful and use alcohol in a less risky way. This finding can be linked to Parker's, Aldridge's and Measham's (1998) thesis on the constant redefining of the status of the user (also of the cautious user) and abstinent. To an individual who is more cautious information on the risks may once again justify his or her cautiousness and serve as a confirmation of his or her right decision. The fact that almost half of the respondents who had received the informative material followed the instructions on the cards means that such informing can be useful.

Conclusions

With regard to the set purposes of the survey we were interested in the use of alcohol among the participants of the graduation tours, the rules of its use and the resulting problems. For the first time after 2002 we were interested in the use of alcohol and other drugs among older students (third and fourth years) of Slovenian secondary schools and the specifics of the use of alcohol on graduation tours.

Until now the information on the proverbially excessive behaviour of Slovenian secondary school graduates was available in the media

and through the oral tradition of former secondary school graduates who remembered the tour mostly due to the enormous quantities of consumed alcohol and irresponsible behaviour.

Our survey also did not provide an exact answer to what goes on and how much alcohol is consumed on graduation tours, however, a few conclusions can be drawn and with a more detailed and improved questionnaire the situation can be checked on the basis of the results of this survey on the coming generations of secondary school graduates. It is certain that considering the manner of the sampling we have received a rather large number of returned questionnaires and that the young can with proper motivation (the accompanying prize game) in a sufficiently large number reply to a less demanding questionnaire (8 pages together with a prize game). The answers regarding reliability and validity were within the limits we have so far been used to in Slovenia in the case of the research of the prevalence of the use of drugs and alcohol in the surveys according to ESPAD methodology and the comparable methodology, which is not a bad result for a questionnaire whose distribution took place on a graduation tour without any specially qualified interviewers.

The main findings of the survey connected with the use of alcohol on graduation tours were:

- that the already high prevalence of the use of alcohol is not increased on graduation tours but remains roughly at the level of the last year and month before the survey. Thus alcohol is very popular before and after the tour. On the tour 53.1 % of the girls and 72.4 % of the boys drank alcohol every day;
- that on every day of the graduation tour almost a third of the respondents was intoxicated, and a total of 83.2 % of the respondents were intoxicated on the tour;
- that on the tour 83.9 % of the respondents drank five or more alcoholic beverages in a row;
- that the most common difficulty that had occured to the respondents on the graduation tour was the damage to objects or clothes (17.4 %); 3.1 % of the students had unprotected sexual relations and 2.2 % of the students an unwanted sexual experience;
- slightly over a third of the participants became too intoxicated on the graduation tour (so that they were nauseous or that they vomited), while 21 % had to be helped by others due to intoxication.

In view of the main findings of our survey we can hardly be shocked by the fact that there is an increase in the use of alcohol on graduation tours, if we consider the data on the use in the past year. The use of alcohol and the frequency of intoxication is already so high during the year that on the graduation tour the situation when more of the young are intoxicated and more frequently intoxicated in a week occurs naturally. The distance from home and the supervision of the parents, a trip to another country, the accessibility of alcohol and the sense of freedom are surely factors that influence the rising number of the young drinking and becoming intoxicated more often. Similar findings would arise were we to research the characteristics of the use of alcohol and other drugs among the young or the adults during 'merry December'. These are precisely the situations which ESPAD methodology has tried to avoid until now, for research into the use of alcohol and other drugs never takes place before major holidays, during or before vacation, after concluded evaluation periods etc. Namely, these are the periods when the use of alcohol is expected to increase. Measuring the use of anything during a graduation tour is therefore a reflection of the special life situation that such a tour symbolises.

However, we cannot conclude under the pretext of a special life situation that affects the increase in the use of alcohol and intoxication. A problem on the graduation tours are, without a doubt, nearly three quarters of intoxicated and a third of highly intoxicated students. The troubles they had described as a result of this are otherwise relatively small in comparison with what they had already experienced in their lives due to alcohol, however, considering the results of the survey they are nonetheless exposed to damages to objects and clothes, quarrels, accidents and in a lesser degree unprotected or unwanted sexual relations.

The results show that the graduation tour is a time and place where it would be wise to operate systematically in a preventive way in the area of reducing the use of alcohol or reducing intoxication. This of course also means a great (perhaps even too great) preventive challenge. Operating abroad or in a place where the use of alcohol or the level of intoxication is increased, and with a relatively small chance of success.

Deriving from the results of the survey and the previous experience with the work on the Choose Yourself project a programme could be planned which would include care and informing before leaving for the tour (workshops, information, awareness of the parents),

cooperation with agencies, educating the guides and providing information in the field. Forming a working preventive programme with a presence on the graduation tour in the future still remains a great preventive challenge, since it concerns operation in an area where the risky use of alcohol is more of a rule than an exception.

Progress in the area of reducing damages or risks due to the use of alcohol can also be achieved by agencies or organisers of events. The Mondial Travel agency, with which we cooperate, is aware of the issue of alcohol and in its own way contributes to reducing the risks due to its use. An enlarged offer of the accompanying programme in the form of trips, preventing fun games with the use of alcohol, warning of the dangers on buses, educating the guides on the dangers of the use of alcohol and notifying the parents not to enable their children the use of alcohol. Surely the commercial interest of the agencies coincides with providing that there are the fewest possible difficulties and accidents due to the use of acohol on graduation trips and it is precisely due to this that the cooperation of the agencies with non-governmental organisations is in the interest of both partners and, ultimately, of the target group. The information provided by the guides was very valuable to us in the preparation of informative material. The guides told us that often quite simple information on the cause and consequence works. If you become too drunk you will not be able to approach the girl you like, and you will not be able to do … many things.

Even without carrying out the survey and project it is clear that in Slovenia the use of alcohol is completely normalised and accepted. Perhaps it is because we drink we also overlook the drinking of the young on the streets; perhaps it is due to national sport events with tents for incapacitated intoxicated adults that we overlook the dangers and the conducts on graduation tours. Hence the negative responses we received from the young, the parents and certain teachers, who understood the condoms enclosed with the informative material on the risks connected with sex and alcohol as a promotion of sex among the youth, are not surprising. Alcohol unfortunately remains a drug of which we know very little, although we use it a lot. Traffic accidents under the influence of alcohol are not primarily caused by young secondary school graduates. Because of the normalisation of the use it will mostly be (us) the parents who will help build the attitude of the children towards alcohol with our own example and send them off to graduation tours more competent and better equipped, since in the end the young will have to choose themselves.

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Empirical article, submitted for translation in May 2009.

Navodila sodelavkam in sodelavcem revije Socialna pedagogika

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ISSN 1408-2942