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PROMOTION OF MENTAL HEALTH AND SOCIAL INCLUSION IN THE ELDERLY THROUGH SOCIAL EDUCATION

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ABSTRACT

Objective: To understand how Social Education promotes the social inclusion and mental health of the elderly of a Unidade de Longa Duração e Manutenção of the Rede Nacional de Cuidados Continuados Integrados.

Methods: research study action in which data collection was performed through documentary research, direct observation, informal conversations, semi-structured interviews. It was counted on the participation of elderly women between the ages of 65 and 94 and employees of the unit.

Results: It was verified that the aging of the elderly is not happening in an active and successful way. In the application of Mental Health Inventory, two patients do not present symptoms, one presents moderate symptoms with values indicative of depression and the other patient presented total results of severe symptoms, with values indicative of lack of positive affection and emotional ties. In Barthel's Modified Scale only one user has a total dependency. The collaborators express difficulties in articulating social education activities that promote mental health and the inclusion of the elderly.

Conclusions: It was possible to understand the importance of the collaborators with competences that promote Social Inclusion and Mental Health, at a time when the physical and psychological losses of the elderly decisively influence the well-being and quality of life of the users.

Keywords: Aging, mental health; quality of life; social work.

INTRODUCTION

In today's society the more elderly constitute a population that is gaining more and more importance due to the increase of the average life expectancy. Currently, aging continues to be conceived as a social problem, which ultimately influences the motivation of the elderly in performing certain tasks and/or the enjoyment of their free time. This population feels often useless because society thus labels it. However, the vision you want to focus for old age goes by emphasizing the complementarity between two systems: first, the biopsychological system intrinsic to the human being; and the second system is the socioeconomic and political one that reports to an environment where contexts are inserted[1]. Aging is a process that involves gains and losses, whose adaption to it, includes variables intrinsic and extrinsic to the individual. The author[2] states that retirement is the stage that marks the transition to old age.

Through social education the person goes through a transformation process from the biological individual to the social individual, which allows the acquisition of abilities to participate and integrate into the group in which he corresponds to live[3]. Social inclusion seeks social stability through social citizenship, that is, all citizens have equal rights in society. Social citizenship is concerned with the implementation of the well-being of people as citizens[4].Therefore Social Education will be the way to find the path to social inclusion. For this it is essential to take into account the biosocial and psychological aspects related to the mental health of the elderly person.

The World Health Organization defines mental health as "the state of well-being in which the individual accomplishes his abilities, can cope with the normal stress of life, work productively and fruitfully and contribute to the community in which he operates"[5]. The present study aims to understand how this process can happen particularly in a ULDM (Unidade de Longa Duração e Manutenção) of Rede Nacional de Cuidados Continuados Integrados (RNCCI) of Algarve. According to art. 13th Decree-Law No. 101/2006 of June 6.

"A Unidade de Longa Duração e Manutenção is a temporary or permanent inpatient unit with it's own physical space to provide social support and maintenance health care to persons with chronic illnesses or processes, with different levels of dependency and who do not fulfil conditions to be cared for at home"[6].

Therefore, the general objective is to understand how to promote the social inclusion and mental health of the elderly through social education, thus reaching the specific goals of learning how to promote health (physical, mental and social); comprehending the social inclusion of elderly living in ULDM; understanding how social education can contribute to social inclusion and mental health of the elderly.

METHODS

Qualitative researchers who carry out their work in the field of education are continually questioning the research subjects, to understand "what they experience, how they interpret their experiences and how they structure the social world in which they live" (p.51)[7].

The action-research along with the case study were the methodologies chosen, since it is intended to support the opinion of the people so that they can contribute to the project, this way it is a joint effort, not only with the other professionals but also with the users. "Action-research involves gathering information with the aim of promoting systemic social change"[7]. The case study is described as a form of doing research in the social sciences,

suitable to answer the questions " how" and "why" (p.20)[8].This is also used when the researcher does not have total control over the events, when the goal is in contemporary phenomena inserted in some real-life context.

The evaluation instruments used were: the semi-structured interview on mental health and well-being of the elderly[9], the "Inventário de Saúde Mental" adapted from the Mental Health Inventory[10] and the modified Barthel Scale[11].

The sample focused on four elderly ladies, because they were the only ones who met the established eligibility criteria (age 65 or older, and cognitive abilities to respond – the Mini Mental State was used) and in five employees of that institution (Administrator; clinical-director – physiatrist; technical director - social worker; nurse; psychologist).

All data collection instruments regarding the users were applied three times, with a spacing of one week between each test, since it was not intended to overburden the users and/or discourage them, thus compromising the accuracy of the results.

After the application of the instruments to users, a script was created by the interview to perform the semi-structured interviews to collaborators with different functions in the institution. Subsequent to the application of the data collecting instruments and techniques, it was analysed (content for interviews and other qualitative and quantitative data for the indicators of the Modified Barthel Scale and Mental Health Inventory).

All ethical research procedures with human beings have been followed. Thus, all the necessary authorisations were requested, such as informed consent to the elderly and co-workers of the ULDM. All the conditions of anonymity and confidentiality of the answers obtained were also guaranteed.

RESULTS

From the analysis of the results of the Mental Health Inventory, representative graphic figures of each user were created. In figure 1 it is verified that the user 1 obtained a total result of 86 points. Through these data it is possible to affirm that the elderly woman does not present any symptomatology. In the graphical representation figure 2 it is possible to visualize that the user 2, presents a total result of 96 points, being possible to affirm that the user also does not present any symptomatology.

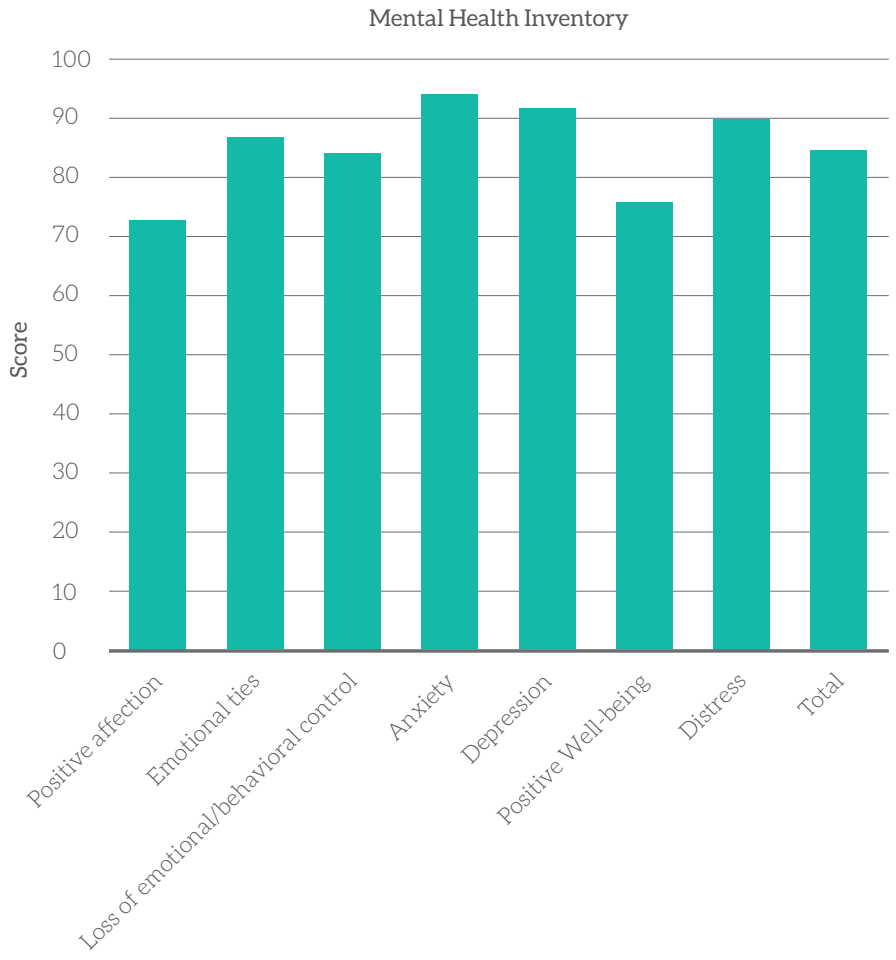

Figure 1 – Results of the dimensions and primary dimensions of the data collected from the user 1.

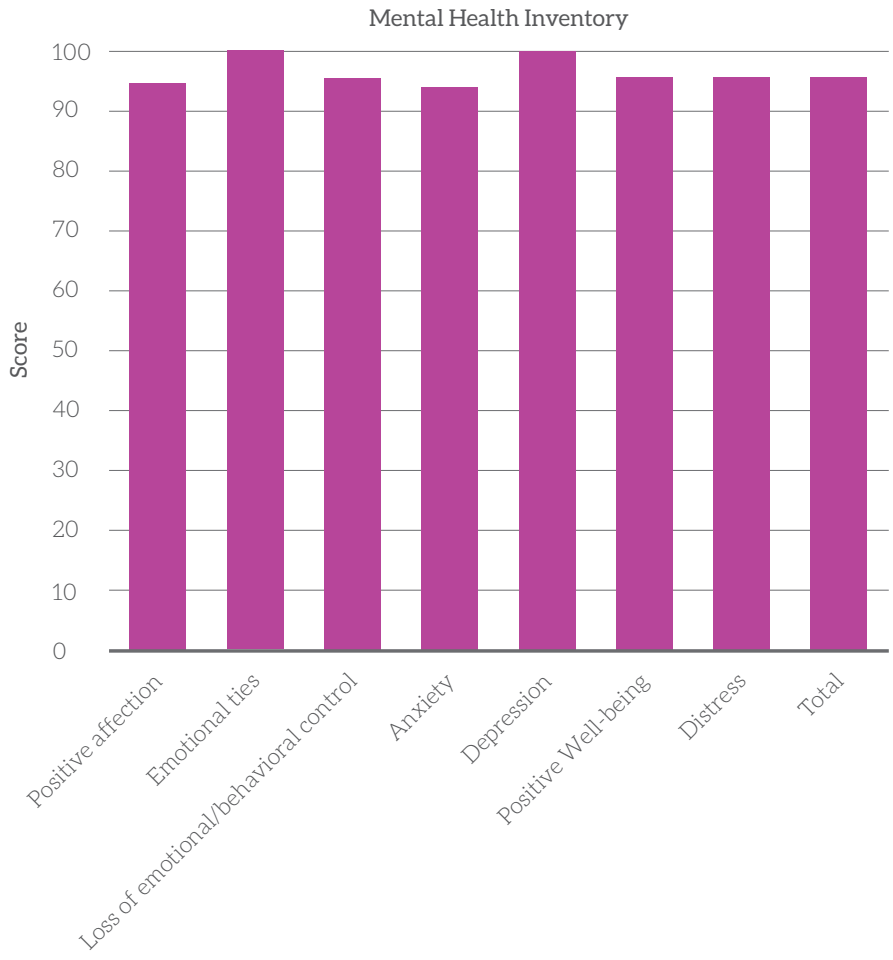

Figure 2 – Results of the dimensions and primary dimensions of the data collected from the user 2.

Figure 3 shows that user 3 has a total of 62 points. In these data it is possible to affirm that the patient presents total results close to moderate symptoms, presenting values indicative of depression. In front of figure 4 it was confirmed that the user 4 had a total result of 43 points. It is possible to say that this patient presents total results of severe symptoms, presenting values indicative of lack of positive affection, emotional ties which results in the low score in the level of positive well-being. It is emphasized that one of the factors that contributes to distress is the loss of emotional/behavioral control, which, in this case, presents a low value.

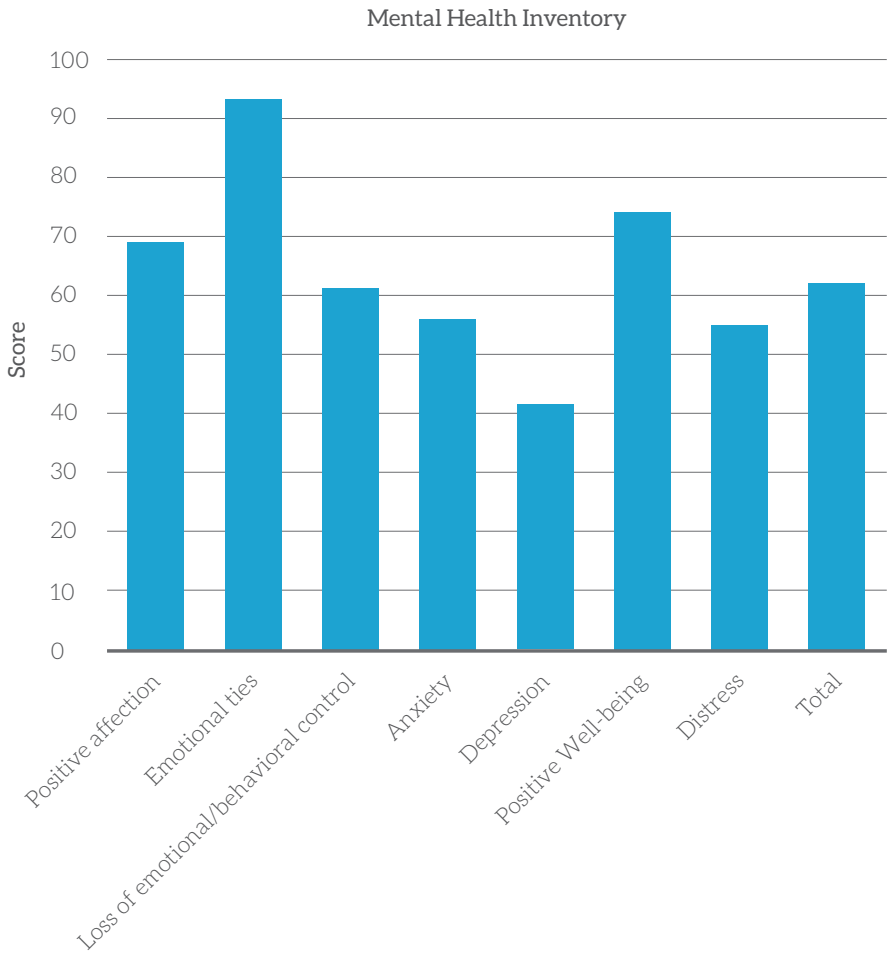

Figure 3 – Results of the dimensions and primary dimensions of the data collected from the user 3.

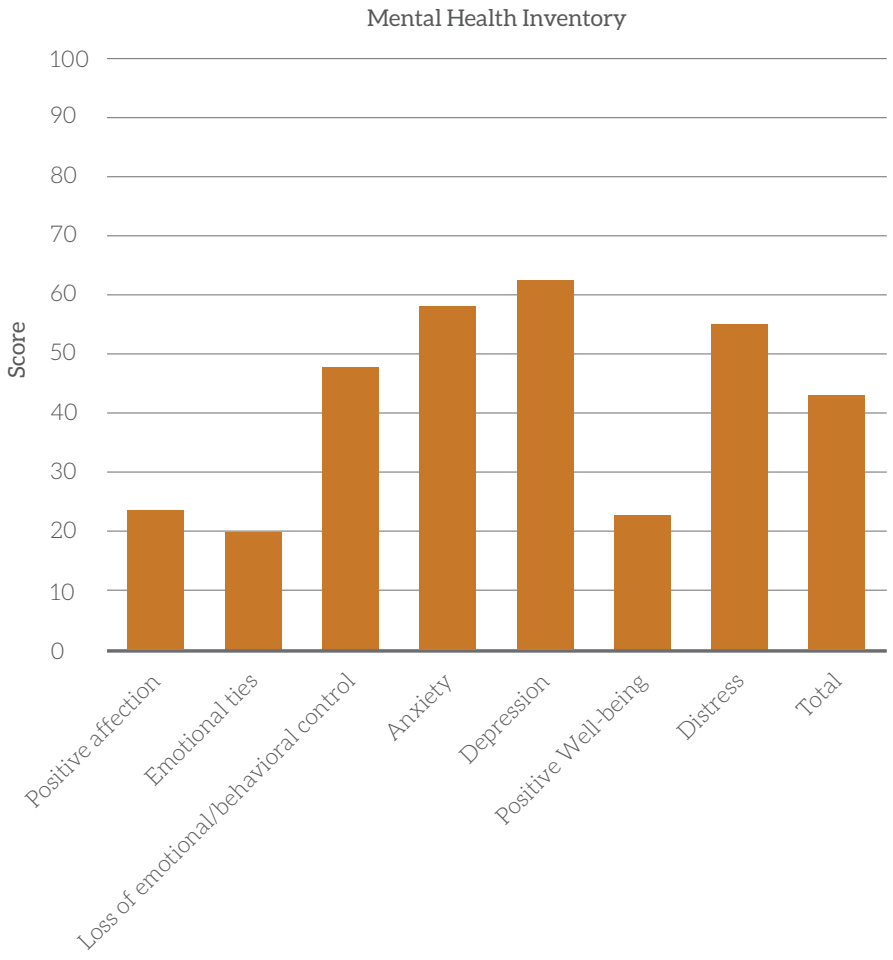

Figure 4 – Results of the dimensions and primary dimensions of the data collected from the user 4.

Table 1 shows the individual results of each of the users/participants. User 1 has a total score of 13 points indicating a total affection dependency with less than 25 points. Patient 2 has a total score of 39 points, pointing to a severe dependency between 26 and 50 points. The user 3 shows a total score of 51 points, pointing to a dependency between 51 and 75 points. Patient 4 displays a total score of 58 points, pointing to a dependency between 51 and 75 points.

Table 1 - Presentation of Barthel's Modified Scale Results

Categories	Score			
	Ut1	Ut2	Ut3	Ut4
1. Personal hygiene	0	1	1	4
2. Bath	0	3	1	3
3. Feeding	3	10	10	10
4. Bathroom	0	5	5	5
5. Climbig stairs	0	0	0	2
6. Clothing	0	8	5	5
7. Bladder control	5	0	5	5
8. Bowel control	5	0	8	8
9. Ambulation				3
9. Or wheelchair	0	4	3	
10. Transfer wheelchair/bed	0	8	8	12
Total	**13**	**39**	**51**	**58**

DISCUSSION

Functionality and mental health of users

It was verified that these 4 users present changes both in mental health as well as well as in their functionality. Through the semi-structured interview on elderly mental health and wellbeing, information was obtained "on motivational, cognitive, affective aspects, significant intergenerational and intragenerational differences", since all these knowledge are factors that will influence the level of participation of the elderly in the activities and permanent learning, which will contribute to the physical, mental and social health of the elderly (p. 53)[12].

Social Dynamics

For the analysis of the social dynamics promoted in the unit and tending to promote mental health and social inclusion, the interviewees (employees of the unit) were asked to characterize the social dynamics regarding the typologies of the activities. It was revealed to us by a respondent that activities are carried out: orientation, leisure and stimulation games according to the dependency of the people, referring: "(...) orientation activities, leisure activities, stimulation activities that are then worked in different ways by the entertainer, we also work mainly with groups according to the dependency independency (...) "(Int 1).

Another interviewee revealed that community life stimulation activities are being conducted at ULDM, as the team tries to get the people involved "to the maximum of age-appropriate capacities," suggesting: "(...) to stimulate (...) to a life for a community in which they essentially entered (...) activity (the Social-cultural Entertainer) activity of the (Social Worker) activity of the staff helpers (...) activity of the nurse to the activity of the medical physician (...) "(Int 2).

According to one interviewee and in relation to the social dynamics "(...) the entertainer answers to this part (...) through" arts and crafts, walks, social get-togethers among them "(Int 3). In turn, another respondent points out that the activities carried out are of a socio-cultural entertainment nature through dynamics of cognitive stimulation and group outings, physiotherapy and occupational therapy tech's develop individual sessions and group sessions. In agreement, another points out and adds that the sociocultural entertainer does individual and group recreational activities and the psychologist does individual and group therapy, noting that occupational therapy does useful activities for people and society related to the activities that people were involved previously.

"Gerontology is a multi and interdisciplinary area of intervention (...) a conduct in the sense of neuroplasticity and self-efficacy", in the sense that it becomes necessary to network creating synergies that benefit the elderly, which does not have as objective the learning of new matters , "but rather, being themselves, the contents of their learning from SI" (p.51)[13]. In this context, who should intervene with the elderly are all professionals from nurses, psychologists, medical-physicians, social educators, among others, however, these professionals must at that moment, grasp the role of the " entertainer " as an agent of educational action.

The interviewees also proceeded to characterize the activities developed in the unit. One interviewee qualifies them as group and individual activities of leisure and maintenance of the users' capacities. In turn, another interviewee characterizes them as motivational activities for their achievement, which develop cognitive stimulation, create goals and "attachment to life" (Int 2), in turn another respondent says to promote social get-togethers, in turn one interviewee characterizes the dynamics with specific objectives, " still too little established, they need to be better implemented" (Int 4), the last interviewee refers that the activities are great, but they can improve.

Regarding the assessment of the dynamics, they are described by the first interviewee, as positive and currently have been beneficial, sufficient; empowering and assigning more skills physically and mentally, with efficiency; underlining that the elderly participate within their limitations. With another interview it was possible to understand that the

dynamics are positive; they cover many users, since the elderly find themselves motivated and develop some skills. For another interviewee these dynamics are sufficient and effective. One respondent characterizes the activities as sufficient but with little effectiveness and the participation of the elderly is described with a reluctant beginning, but then when there are no more activities there is a feeling of absence. The last interviewee gives a good assessment of the dynamics carried out, but states that they can still improve, being sufficient and with periods of effectiveness; the participation of the elderly is dependent on their clinical situation.

Social Inclusion and Mental Health of the elderly

Regarding the activities that seek to promote social inclusion and mental health of the elderly and if it is possible to do it through Social Education, the interviewees spoke about the impact of the activities carried out in the Promotion of Social Inclusion. One interviewee gave us his opinion saying that it is difficult to promote inclusion in the community, but that inclusion in the group is promoted through activities. The perspective that another respondent gives us is different, in the sense that he admits that the activities carried out promote Social Inclusion, in a positive way since they give the chance of developing motor, cognitive and communication skills, he still said: " It is obvious that once they have intrinsic abilities, they develop a little of their possibilities ... not only motor but also cognitiveas well as communication, we are on the right track and that is what matters to us" (Int 2).

The view that two interviewees reveal is that activities are being developed to promote social inclusion. Another respondent opposes saying that "it is something which is difficult ... but there is no great integration in society" which conditions the inclusion (Int 4).

Concerning the impact of the activities carried out in the Promotion of Mental Health, one interviewee reveals that partly yes, with the activities of guidance and stimulation, two respondents oppose qualifying as positive saying that they are sure that the activities carried out promote mental health. Another interviewee states yes, but they could improve.

Taking into account these answers, we dared question the respondents concerning suggestions of activities that promote Social Inclusion, but these were not presented by two interviewees. One of the latter respondents gave as a suggestion the social interaction with other institutions and the sensorial stimulation through music. A respondent suggests such activities as setting up a theatre club, grandfather's club, buying magazines and drinking tea outside, and another refers as a suggestion the providing of support by local health authorities.

Concerning suggestions to promote Mental Health, these were not presented by a respondent; another suggests walks to promote interaction between them and the environment. The following interviewee suggests exclusively "to keep fellowship activities between them and the contact with society but after all this is achieved in a certain way" (Int 3). Another justifies that in promoting social inclusion we are promoting mental health, a different respondent in turn suggests outings, interaction with the families and/or group caregivers, group work in the institution as well as outside.

Promotion of Social Inclusion and Mental Health through Social Education

Since the objective was to understand how to promote Social Inclusion and Mental Health of the elderly through Social Education, the interviewees were asked about the importance of Social Education in promoting Mental Health. According to one of the respondents, Social Education could give a contribution to Mental Health, but in another typology other than ULDM.

"I'm not saying Education, this is an assistance because a person at that age is no longer going to be educated, if they already have these characteristics tucked inside, because this is not education, it is a support and what kind of support can we provide so that in the terms of the skills they had, they don't start fading away. It's essentially this, and if we have to try and maintain them on a certain level" (Int 2).

Affirming that Social Education helps, in the sense, of them maintaing the skills, the author contrasts saying that "education must be present in the life which is lived. Each moment is the moment of life until life itself is extinguished"[13].

Three of the interviewees assure that Social Education Promotes Mental Health. One of them mentions:

"Without any doubt, the fact that we have someone working in this area would mean that we would have people working on projects aimed at greater inclusion, aimed at further promoting the mental health and social level of these users and there we would have a more individualized and more specific follow-up." (Int 4).

In other words, the interviewed agree that Social Education by Promoting Social Inclusion will be promoting people's Mental Health.

Finally, the interviewees were questioned about the importance of Social Education for the Promotion of Social Inclusion. If one of the respondents reveals that in specific situations Social Education may exist, in the opinion of another respondent it is possible to verify that:

"To my understanding, it's not social education. It's not that support, it is however clear that when we support them we are in fact ensuring that potentialities that they have do not fade away and because they have that potential all the other potentialities may be used; one of them is pure and simply social inclusion, it's pure and simply the contact with others, it's the inclusion , they can only have inclusion if they have within a cognitive level that allows them to get there, if they don't have this there will be no possibility of social inclusion, we can do what we want that pure and simply there will be no chance, to my understanding" (Int 2).

Two interviewees also affirm that Social Education benefits from a support in the promotion of the cognitive abilities that lead to social inclusion, through its techniques, stimulating the skills of the users and that Social Education plays a fundamental role in Promoting Social Inclusion. Authors[13] defend that:

"(...) the issue of education precedes the reference to aging and to aging subjects, since (...) science (...) is more concerned with teaching and learning than with the fact that the students are elderly. It should allow the combination of distinct specialties, such as psychology, philosophy, anthropology, history, sociology and economics, (...) and help when it is necessary to decide on how, what and why the education for the elderly".

The elder is a person who has a unique personal history, with all the knowledge gained throughout life. This personal history has to be harnessed and inserted in group dynamics, so that the elderly person can speak/have an active voice and re-examine his potentialities. This is the only way to gradually change the social representations about old age and promote the social inclusion of the elderly.

FINAL CONSIDERATIONS

The study made it possible to understand the importance of employees of the ULDM to have competence in promoting Social Inclusion and Mental Health, at a time when physical and mental health problems influence so much the well-being and quality of life of the elders of these institutions.

In order to be able to respond to the real needs of users, it is important that the multidisciplinary team articulate, create and operate adequate, effective and interdisciplinary responses that meet the needs of each user, according to the plan established in the "Guia Prático da Rede Nacional de Cuidados Continuados" (Practical Guide to the National Network of Continuous Care).

It is important to remember that one of the main objectives of Integrated Long-term Care is to carry out: "a set of health interventions and social support, resulting from interdisciplinary assessment, with the objective of helping the person recover and/or maintain his autonomy and improve the functionality , through rehabilitation, readjustment and family and social reintegration"[14].

It is also necessary, in these institutions, professionals who possess knowledge and skills not only at the level of the necessary conditions to promote reintegration and social inclusion. The Social Educators are professionals who have this knowledge and skills and who should form part of all the ULDM teams.

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