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TYPES OF SPECIFIC ACTIVITIES CONDUCTED WITH INSTITUTIONALIZED ADULTS WITH DISABILITIES IN A CARE AND ASSISTANCE CENTER

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ABSTRA CT: *in this article we aim to analyze the activities that an adult with disabilities benefits in a residential center. The sample comprises 50 adults with intellectual disabilities, institutionalized in a care and assistance center. The severity of disabilities among the beneficiaries is mostly severe with personal assistants, with only a few having accentuated disabilities. The activities carried out with them are planned individually according to their needs and are divided into six branches that relate mainly to: social work activities, psychological activities, recovery and rehabilitation activities, care and assistance activities, activities for independent living and social integration activities. To achieve this goal, we use the document analysis method and the observation method. Thus, we reviewed the files of the 50 beneficiaries of the center, identifying similarities and differences, and we applied observation sheets to all members of the sample.*

Key words: *disabilities; activities; care and assistance; institutionalization;*

1. Introduction

The percentage of people with disabilities is estimated at approximately 10% of the total population in any society [Mactaggart, et al., 2016] which highlights the need and importance of both residential and non-residential services aimed at the recovery and rehabilitation of people with disabilities.

The services offered to these people represent one of the most important social variables directly or indirectly determining the development and integration of people with disabilities in society [Fleming, et al., 2017].

No society is without people with different disabilities regardless of its level of development and the protection and prevention measures taken [Kassebaum, et al., 2017].

2. Description of the social service

The Centre for Care and Assistance for Adult Persons with Disabilities from which data were collected for this study, is a residential centre offering social assistance services for beneficiaries with profound disabilities. The purpose of the residential service is to provide multidisciplinary services to beneficiaries who meet the eligibility criteria, as follows: hosting and care, social assistance focused on respecting the rights of persons with disabilities, psychological counseling, psychological counseling, healthcare, rehabilitation and rehabilitation activities, socialization, social and civic integration and activities for independent living skills.

3. Research methodology

The paper presents an inventory of the activities of institutionalized disabled people but is part of a larger study that aims to capture the type of disability, the context of institutionalization, personal and family history, the services offered within the center and the involvement of institutionalized disabled people in the activities carried out within the residential center. Document analysis and observation are the methods used in data collection and the presented results were obtained from qualitative data analysis: the inventory of specific situations, their classification by categories, the coding of answers, and their interpretation.

The sample of this study is represented by 50 adult beneficiaries with disabilities, of which 20 are male and 30 females, aged between 19 and 79 years. Regarding the degree of disability, 10 beneficiaries fall, according to the disability certificate, in the accentuated degree and 40 in the severe degree with a personal assistant. The types of disability of these beneficiaries are mental, psychic, and associated, as follows (Fig. 1):

Number of beneficiaries	13	4	33
Type of disability	Mental	Psychic	Associate

Fig. 1. Distribution by type of disability

5. Results of the analysis

To achieve this stage, we analyzed the psychological, social and medical profile, respectively that of the beneficiaries' autonomy,

Principal Diagnosis	Mild Mental Retardation	Moderate Mental Retardation	Severe Mental Retardation	Profound Mental Retardation	Behavioral Disorders	Cerebral Palsy
Number of beneficiaries	1	11	18	17	1	2

Fig. 2. Distribution according to the main diagnosis of the beneficiaries

The main diagnosis of the beneficiaries, according to the disability classification certificate, refers to mental retardation, behavioral disorder, and infantile cerebral palsy (Fig. 2).

4. Collection and qualitative analysis of documents

To collect the data needed for the study, two qualitative methods were used: document analysis and observation.

The document analysis was carried out on each beneficiary file, focusing on the documents that contained information about the beneficiaries (for example, the disability classification certificates), the assessment sheet, the personalized plan and the beneficiary sheet, documents used by all the specialists of the center.

Thus, from the personal documents, information was collected regarding the beneficiaries [gender, age, degree and type of disability, as well as their main diagnosis], from the evaluation form, socially relevant information was collected, psychological, medical and autonomy, information was collected from the personalized plan regarding the activities planned for the beneficiaries for a period of 6 months, divided into 6 areas: social assistance services, psychological services, habilitation and rehabilitation services, services for the acquisition of independent living skills, medical assistance services and social and civic integration and participation services, and the activities carried out with the beneficiaries in the respective month were recorded from the beneficiary's file.

In the observation stage, I followed aspects such as: the activity carried out at that moment, physical appearance, communication, mimicry, behavior, attitude and attachment.

and thus followed the predominant typology of the activities carried out according to 3 important factors: major mental deficiencies, major health problems and the social contacts of the beneficiaries, on which I correlated with each other. Thus, we obtained several groupings of factors: major mental impairments – social contacts, major mental impairments – major health problems, major health problems – social contacts. Cases in these categories are unique (one case is not found in two categories).

5.1. Major mental impairments/ Social contacts

In the category of people with major mental deficiencies, correlated with social contacts, we have 29 unique cases. Their social profile obliges us to divide them into two categories: without social contacts [where we have 5 beneficiaries who do not have families and have not built significant relationships with those around them, especially with other beneficiaries], and with social contacts (24 people, two of whom maintain contact with the family, and in the case of the other 22, the social contacts are represented by other beneficiaries from the center). Major mental impairments indicate moderate, severe and profound mental retardation and behavioral disturbances (one case). Their autonomy indicates that they can mobilize themselves, but they need help with instrumental and basic activities. These needs are indicated more by the mental state than by other medical conditions. Psychologically, we find that 9 people do not have verbal language (4 cases in the first category and 5 cases in the second category).

a) No social contacts. The predominant activities we found for the 5 people in this

subcategory are healthcare activities, followed by socializing and leisure activities, and social work and psychology activities. More specifically, medical activities refer predominantly to care and supervision, followed by help in choosing the correct clothing, administering medication and monitoring health status. Social assistance activities focus, but are not limited to legal proceedings to obtain special guardianship, for two beneficiaries susceptible to lack of discernment and the involvement of the guardian in the provision of services, in two other cases (for example, information on the rights of the beneficiaries and other related issues of the beneficiary status, as well as information on the evolution of the beneficiary). The psychological part is predominantly carried out through emotional support, specific interventions to avoid situations of depression or isolation (Fig. 3).

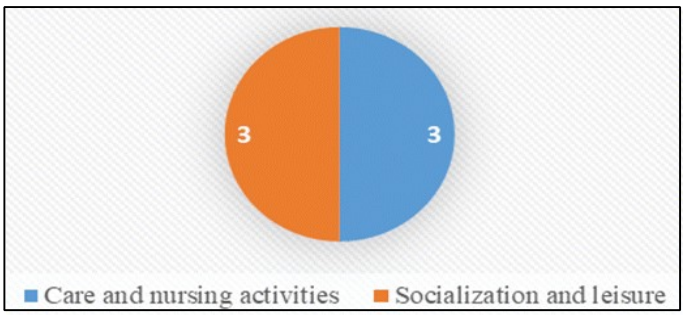

Fig. 3. Predominant activities in the "Major mental disabilities - No social contacts" category

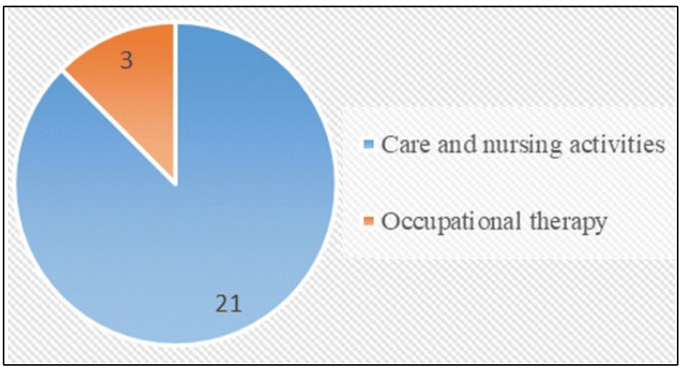

Fig 4. Predominant activities in the category of „Major mental deficiencies - With social contacts"

b) With social contacts. In this subcategory we find 24 cases, of which medical activities predominate in 3. In the other 21 cases, occupational therapy activities and independent living skills predominate, as a result of social and psychological activities.

Medical activities in this category are similar to the previous subcategory. Ergotherapeutic activities (branch of recovery and rehabilitation services) predominate through occupational (household) activities and art therapy. The predominant social activities refer to the facilitation of maintaining the connection with the family, in the two cases where there is family, support for maintaining social connections, maintaining the connection with the guardians, where they exist, information and counseling.

Psychological activities, similarly to the previous subcategory, are based on emotional support, stimulation of verbal and non-verbal language, avoiding situations of isolation and depression, as well as intervention in crisis situations (Fig. 4).

5.2. Major mental impairments/ Major health problems

In this category we find 18 unique cases. Major mental disabilities refer to severe and profound mental retardation, and among the major

health problems we can list infantile encephalopathy, epilepsy, spastic tetraparesis. Their psychological profile indicates that 11 people have verbal language present, while the other 7 communicate predominantly non-verbally. The assessment of the autonomy of the beneficiaries indicates that they need constant help and supervision in all branches of instrumental and basic activities.

In this category, the predominant activities are medical, found in 16 cases, represented by mobilization and transfer where we have people in wheelchairs, care and supervision activities in all segments [feeding, hydration, dressing/ undressing].

The next predominant activities are social and psychological. Where there is no guardian, the procedures for obtaining special guardianship have begun, and where it already exists, the guardian is involved in providing services by informing and maintaining contact with him, constantly.

We also have cases where there is a family, and the social worker facilitates maintaining the connection between the family and the beneficiary (Fig. 5).

In this category we identified only cases with social contacts, a distinct classification is no longer necessary in this regard. So we have 3 beneficiaries, whose social profile indicates that they have other beneficiaries from the center as social contacts, they also have (moderate) mental deficiencies, but the health problems indicated by spastic tetraparesis predominate. Verbal language is present in all 3 beneficiaries, and in autonomy we can talk about the need for help in all plans in one case, and in the other 2 cases, they need full help in terms of instrumental and partial activities in daily life day. The predominant activities in this category are medical in one case (support for transfer and mobilization, care and supervision, providing drug treatment), and in the other two cases occupational (household) activities predominate, as well as activities for learning independent living skills (for example, learning actions to take care of oneself - washing the body, dressing, organizing and cleaning one's living space), (Fig. 6).

Fig 5. Predominant activities in the category of „Major mental deficiencies - Major health problems"

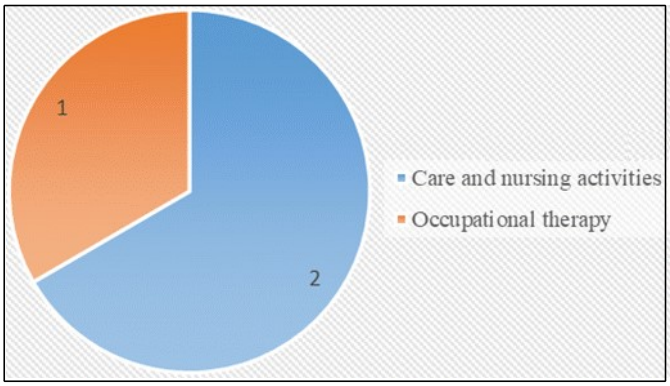

Fig 6. Predominant activities in the category of „Major health problems - With social contacts"

6. Conclusions

Rehabilitation activities are influenced on the one hand, by the personal characteristics of the disabled but also by the characteristics of the recovery and care staff, for example education and experience [Esteban et al 2023].

Training and continuous improvement of social service providers on the nature of disability and how to deal with it is recommended [Esteban et al 2023].

Although there have been deinstitutionalization policies, despite the benefits of community living, there has not been a substantial decrease/reduction in the number of disabled people remaining institutionalized across Europe [Šiška & Beadle-Brown, 2020, 2022].

Institutionalized people require more intensive support, either because of additional physical or sensory disabilities, or because of the presence of other behavioral or mental health disorders [Verdugo & Navas, 2017].

Participating in activities at the center shows a positive change in physical and emotional well-being.

References

1. Mactaggart I., Kuper H., Murthy G.V., Sagar J., Oye J., Polack S. (2016). *Assessing health and rehabilitation needs of people with disabilities in Cameroon and India*. Disability Redabil. 38:1757-64.
2. Fleming, A. R., Oertle, K. M., Plotner, A. J., & Hakun, J. G. (2017). *Influence of social factors on student satisfaction among college students with disabilities*. Journal of College Student Development, 58(2), 215–228.
3. Kassebaum N.J., Smith A.G., Bernabé E., Fleming T.D., Reynolds A.E., Vos T., et al.(2017) *Global, regional, and national prevalence, incidence, and disability-adjusted life years for oral conditions for 195 countries, 1990–2015*: A systematic analysis for the global burden of diseases, injuries, and risk factors. J Dent Res 96:380-7.
4. Esteban L., Navas, P., Verdugo M. A., Iriarte, E. G. Arias. V. B. (2023). *A community living experience: Views of people with intellectual disability with extensive support needs, families, and professionals*. Research in Developmental Disabilities. Jun;137:104503.
5. Šiška J. & Beadle-Brown, J. (2020). *Transition from institutional care to community-based services in 27 EU Member States: Final report*. Research report for the European Expert Group on Transition from Institutional to Community-based Care. https://deinstitutionalisationdotcom.files. wordpress.com/2020/05/eeg-di-report-2020-1. pdf
6. Šiška J., & Beadle-Brown, J. (2022). *Progress on deinstitutionalisation and the development of community living for persons with disabilities in Europe: Are we nearly there*. Disability & Society Advance Online Publication. https://doi.org/10.1080/09687599.2022.2071676.
7. Verdugo, M. A., & Navas, P. (2017). *Todos somos todos: Derechos y calidad de vida de las personas con discapacidad intelectual y mayores necesidades de apoyo*. Real Patronado sobre Discapacidad. http://riberdis.cedd.net/bitstream/handle/11181/5267/Todos_somos_todos_ discapacidad_intelectual.pdf?sequence=1&rd=0031275596861030.