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SPECIAL PEDAGOGICAL AND SOCIAL SUPPORT IN THE LIFE OF AN AGEING PERSON WITH A MENTAL DISABILITY

APOIO PEDAGÓGICO E SOCIAL ESPECIAL NA VIDA DE UMA PESSOA IDOSA COM UMA DEFICIÊNCIA MENTAL

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Abstract: The professional text brings reflection and small reflection from practice on the topic of ageing in people with mental disabilities in the context of the importance of professional cooperation, especially special pedagogy and social work. The phenomenon of ageing, not only in the context of mental disabilities, is a topic that resonates in a professional society but also points to the aspect of quality of life and social setting in the perception of ageing of people with disabilities - in our case, people with mental disabilities. Providing care for ageing people with mental disabilities should aim to improve their existence. These are people who have a mental disability that has a significant impact on their stages throughout life.

Keywords: Individuality. Quality of life. Mental disability. Support. Cooperation. Ageing.

Resumo: O texto profissional traz reflexão e pequena reflexão da prática sobre o tema do envelhecimento das pessoas com deficiência mental no contexto da importância da cooperação profissional, especialmente da pedagogia especial e do trabalho social. O fenómeno do envelhecimento, não só no contexto das deficiências mentais, é um tema que ressoa numa sociedade profissional mas também aponta para o aspecto da qualidade de vida e do contexto social na percepção do envelhecimento das pessoas com deficiência - no nosso caso, as pessoas com deficiência mental. A prestação de cuidados às pessoas idosas com deficiências mentais deve ter como objectivo melhorar a sua existência. Estas são pessoas que têm uma deficiência mental que tem um impacto significativo nas suas fases ao longo da vida.

Palavras-chave: Individualidade. Qualidade de vida. Deficiência mental. Apoio. Cooperação. Envelhecimento.

Introduction

Extending life's length brings higher expectations related to preserving life quality. This topic is and will be more accurate due to the ageing population. The extent of demographic changes in the 21st century offers Europe a chance and a challenge at one time. There is a need for a shift in relation towards the ageing population, and that includes various handicaps as well. These changes can be understood as reinsurance for adequate social care and health care but as a test not only for aforementioned care (Starek, 2021a). The current generation of older people is healthier than the previous one. However, older adults require a significant amount of specific health care and social care. Let us think about the ageing of people with various handicaps – in the context of our text, we focus on ageing people with mental handicap.

Seniors are one of the largest groups in our society, which has specifics that must be reflected in their attitude towards and care for them. "Even though we can assume that the functional age will be longer within future seniors than it is now. The growth of the elderly population will significantly influence our whole society." (Ondrusova, Krahulcova et al., 2019, p.10). As statistical prognosis and data assume, "… the year 2040 for the Czech Republic will be the era when a generation of baby boomers from 1970s will reach the border of elderly age ... the change of inhabitants number will not be crucial, the assumed number of inhabitants older than 65 years is more than 2,75 million which will be 25% of Czech's population." (Ondrusova, Krahulcova et al., 2019, p. 9).

Ageing of people with mental handicaps

Therefore, the general information influences the ageing of people with mental handicap. The average length of people's lives with a mental handicap has grown in the last decade. Females and males with mental handicap have more years which can help their helpful existence in society. Most of them achieve the elderly age and have the right to retire. They deserve calm and dignified elderly age as most of the community.

People with mental handicap start to age sooner than people without mental handicaps. Within the group of people with a mental handicap, ageing is linked to the age of 45, whereas within the rest of the population, the ageing is assumed at least 15 years later (Cerna et al., 2015). It is essential to respect that people age differently at various paces or with multiple methods. Ageing is different for people with any handicap or without it.

Thus, we cannot provide any list of signs or procedures because the differences between older adults are enormous. For example, everyone will have a different experienced life picture – understanding the world and their environment, whether in their family or retirement home. "No one doubts the generosity of the thought of ageing in the community. The academia mainly agrees that young people with a handicap can be prepared for ageing in the community. Thus, they have no reason to spend their lives dependent on service they do not need" (Cimrmannova et al., 2020, p.22). Even though people with a similar handicap are born in the same year, they will experience the changes and process ageing differently. Plus, during ageing, the handicap can be changed. Thus, this brings along different needs.

Special pedagogy in social work is also essential to support the idea of multidisciplinary cooperation. Support plays a significant role for a client and relies mainly on specialists' cooperation. They can connect and overlap their experience and knowledge and provide complex help that a client requires. The concept of multidisciplinary team cooperation was founded in the 70s-80s of the 20th century by specialists who specialized in social services for people with mental handicaps and workers providing care for diabetic patients (Madge and Khair, 2000).

Respect and an optimistic view of the role of workers from diverse organizations are critical components of a functional cooperating relationship. For the foundation of teamwork, members must accept individual differences, learn from each other, respect others, and build personal relations with other team members. Every unique team member is uniquely important (Starek et al., 2021).

The life quality of people with mental handicaps

The individual's life is biological, but we adopt a holistic approach, which includes family, social, work, and emotional energy. However, we can focus on existence only. This leads us to question how we should live, so our life reaches its quality. The answer is based on our values, upbringing, diverse life experiences, and religion. Therefore, everyone must find this question solution for themselves. There are as many definitions of life quality as there are people worldwide, and their life quality changes over time (Hudakova and Majernikova, 2013).

Current era advocates for interest in Quality-of-Life QOL. The World Health Organization (WHO) divided diverse aspects of life and defined them in their definition of

QOL. The WHO recognize four main areas which define dimensions of human life without differences in age, gender, ethnicity, or handicap: physical health and level of independence (i.e., energy and tiredness, pain, rest, mobility, everyday life, dependence on medical help, ability to work etc.), psychological health and spirit (i.e., self-understanding, negative and positive feelings, self-evaluation, thinking, learning, memory, concentration, religion, spirituality etc.), social relationship (personal relationships, social support, sexual activity etc.), environment (financial sources, freedom, safety, accessibility of health and social care, home environment, opportunities for gaining new knowledge and skills), physics environment (pollution, noise, traffic, clime etc.) (Dragomirecka, Bartonova, 2006).

Interestingly, research in the field of QOL has begun in the medical field in the 1970s. Its primary purposes were economic and clinical analysis. Overall, the study was informed by two main factors. The first factor was pharma-economical, where it was needed to evaluate financial costs and effectiveness of treatment and define priorities during diving the resources. The second factor should declare the clinical success of treatment. So, the effectivity and impact of medical surgeries on a patient's health condition (Mares, 2006; Gurkova, 2011; Hermanova, 2012; Perrotti, 2019).

The extended WHO's classification highlights the term quality of life with a reflection on the improvement of quality of life in most of society. However, it can point out the client and their needs as well. Therefore, the client should be the starting point of providing care.

Several factors play a role:

1. For a long time, the care providers dictated the offer of providing care for clients with mental handicaps. By extending the provided care, we are slowly shifting thinking in the field.
2. Thus, the providers must eliminate their power and ask for permission or provide more information about the problems.
3. By providing a more comprehensive range of care, there can be a deeper dependency on the providers, which might be harder to moderate.
4. There is a tremendous difference between when clients cannot vote and when they learn how to vote.

(Bleeksma, 2001).

Care for people with mental handicap lead towards improvement in their life. During research in QOL within this specific group, ageing people with a mental handicap, there is an agreement in four areas, according to van Houten-van den Bosch (1999):

1. The QOL should be similar for people with a handicap and those without a handicap. This means that the areas mentioned here are identical for all people.
2. The QOL is measured as the effect of equality in which we include basic wishes, needs, and methods of their fulfilment. Enough food, drinks, and a roof above the head (under which they feel safe). These are considered basic human needs. Further, there should be realized general human development and level of responsibility.
3. The QOL is determined by the extent and type of interaction with other people. For people is very important to interact and maintain relationships with others. We develop throughout the interaction. We wonder about the frequency of contacts, their pleasure, and mutual respect (connections can occur in an uncomfortable atmosphere and thus lead to conflicts).
4. The QOL is considered from personal understanding and evaluation. Everyone prefers something different, and everyone prioritizes other things. Individual interpretation is subjective and, similarly, the assessment of a situation. The specific situation can be seen as positive from one perspective, but others can interpret it differently. Uncountable conditions and surroundings form the QOL.

The QOL is a personal question. Its evaluation can be approached from the subjective perspective of a person on the eras of their life. Several questionnaires focus on the quality of life for people with various handicaps (Dragomirecka, Bartonova, 2006). These questionnaires target questions on several aspects of life, such as independence in daily activities, evaluation of memory abilities, and other results of personal or life-challenging situations. Assessment of the QOL has its importance for an individual as well as for care providers. However, it is essential to reflect and respect how an individual feels psychologically and physically as, from these points, the subjective experience origins. Therefore, realizing how an individual reflects on their life is crucial. In general, we can speak about nowadays' influences, such as:

Self-definitions – this sphere is influenced by a personal force, and one can investigate their self-control and what is happening in their life. No one has control of their

whole life for this. We are to depend on our environment. However, if we would experience our freedom of choice through questions like "What will I eat today?" it would not enrich our life much.

Personal development and adjudication of sense – identity creation, self-esteem, and self-respect. They are gaining knowledge and abilities essential for one, but also competencies and responsibility in critical situations.

Emotional satisfaction – in this area and its relation to the QOL, we mean safety and challenge. Too many challenges can lead to stress, but too few challenges can lead to clients' boredom. Therefore, clarifying terms when emotional satisfaction can be exchanged for good quality of life is crucial. Only emotionality influences the quality of life.

Relationships – mainly, we talk about relationships with family, friends, other clients, or care providers. The frequency and diversity of these relationships are significant providers of belonging, warmth, love, and friendships.

Life climate – what can provide housing and the environment we are living in. Whether it is safe or not, whether we have enough privacy, or whether we are surrounded by noise, the condition of a flat or a house, its environment, and where it is situated are also essential.

Material satisfaction is related to possessions and financial stability, which should be the base for good quality of life.

Social position – a crucial position a person takes in society and, at the same time, their ability to participate in society's values and other society's possessions.

The aforementioned areas provide us with a more in-depth picture of the meaning of the QOL. However, whether an individual considers their life adequate depends on their judgment. Many people with mental handicap apply that with a relatively good quality of life. Their opinions rely on the views of their care providers. However, the care providers highlight some life qualities above others. Also, some differences in interests in diverse areas are noticeable.

With regards to the focus of this text is essential to mention the legal problems "… nowadays tendencies in the history of democratic and legal states presents requirements for active participation of citizens on creating an environment of legal stability and legal certainty, mainly with relation to human rights and freedom. There are complicated legal rules that should guarantee full and uninterrupted execution of human rights and freedom, and on the other side fulfil legal responsibilities" (Visek, Kroupa, 2020, p. 174).

Changes related to the ageing of people with mental handicaps concerning chosen specifics

During ageing, we notice several changes that do not occur among seniors. The most affected area is health which is significant for ageing and related changes. However, it does not mean that these changes must be accepted and that we cannot challenge them. On the other hand, it is essential to be aware that tiredness, skin issues and issues with senses, mainly sight and hearing, are part of our life. Most of these changes progress over time. Mood swings and changes in behaviour can cover the lower abilities of sight, hearing, and tiredness. Other ageing people with mental handicap reflect their tiredness differently; for example, they leave their house less and adapt to their situation.

In many cases, the changes are milder and can be problematic at the begging. However, the issues can worsen over time, and ageing becomes problematic. For example, problems with organ functions can occur, the cooperation of organs becomes more challenging or other and more complicated illnesses occur and influences one's life.

One of the most often issues is obesity. This physical change is related to lower energy outcomes. If an individual consumes the same amount of food, they become obese. People with a mental handicap are more likely to become obese as their energy outcome lowers due to reduced activity, which applies mainly to ageing individuals. There is agreement that obesity is unhealthy as it negatively influences the heart and veins (Malkova, Krch, 2001).

Further, obesity is not suitable for back muscles either. Also, the assistants and caregivers do not profit from a client's obesity as they need to lift them. The National Institute of Public Health in Prague highlights obesity in older people. They state we should not forget about these areas: food should be diverse, is adequate to adapt the food – with regards to teeth loss; the appropriate consummation of meat and fish; provision of fruit and vegetable frequently in a day; in case of inability to provide diverse and nutritional food is crucial to provide adequate food supplements (vitamins and minerals); and sufficient water provision.

For the obese individual is essential to use diverse reduction diets. It is crucial to realize that diet does not mean hunger but the consummation of light and nutritionally diverse food.

However, obesity is not the only disease which can occur among older people; the other end of the spectrum is frequent, insufficient nutrition or malnutrition. This issue can be caused by worsened taste or medication usage that might have a side effect of distaste.

The digestive system can be weakened, and a client might experience issues while digesting food. A crucial part is if a client does not want to eat in a standard dining room, which can happen in diverse institutions and for various reasons. For example, when a client is seated with someone, they do not like it or are ashamed of their etiquette (it might be trembling of their hands, which might look like they cannot use cutlery). It is good to use various helping tools, or a client can sit alone if they wish, and it is possible. The food regime is essential where standard rules apply, such as eating frequently and in smaller portions. In the context of eating is necessary to not forget about drinking.

However, we cannot forget the importance of movement, which is known for its positive influence on body improvement and overall, they improve the physical condition of clients. Suitable activities are tourism or musical movement. The negative side of ageing is falls and injuries. These can limit walking abilities whether a client uses any supportive tools. An individual does not have much strength, and maybe they cannot walk, but at least they can stand up and lean on their hands. The unpleasant part of any fall is pain which echoes during any more tiring movement.

It is crucial to be prepared for mobility change which might lead to clients' immobility in their housing or provide housing by care providers. The regulation of mobility has many results. One of the results is already mentioned obesity. Further, it can be worsened blood circulation and digestion also. Decubitus can occur during long-term lying or sitting, so it is vital to set the client into diverse positions more often. Even the need for care can result in longer waiting for nursing personnel, doctors, family, or friends. Immobility causes loss of movement, a significant interruption of a client's life. The client's surroundings should adapt and encourage the client to move. One form of encouragement can be mutual training. During joint training, we should focus on the client's self. We can use various training tools and stimulate the atmosphere with music. So that client would find it relaxing and comfortable. This relates to daily harmonographs creation for training which a specialist should complete. Hence the body of an ageing client is not as mobile as before, and its functionality cannot be interrupted.

Nevertheless, clients should be disposed of with enough impulses, so they can walk and not be interrupted. This leads us to bathroom use, where should be grips, adjustable and quality chairs, beds with correct high adjustment and other necessary tools which make residency, recovery, and everyday life easier. Some clients do not like to attend some centres requiring walking in them as they might be worried about their walking and

possible clashes with cars or bikes. Simply, they worry or stress about their mobility. For some clients, it is helpful to use a stick or other support to lean on something and establish their walking pace and when they will rest. Therefore, we cannot forget to teach them how to operate these tools. It is for clients' safety and appreciation of the devices (Bleeksma, 2001).

"Personal hygiene is the easier factor which can be influenced. We include overall care for the body, nutrition style, nutrition regime, food preparation and other hygiene issues, and appropriate food and drink consumption. Also, the activities regime and rest regime are crucial. We cannot forget about mental and sexual health so everyone can live harmonically." (Kvapilik, Cerna, 1990, p. 63).

Withing ageing clients with mental handicaps, we notice their habits and routines – mainly in personal hygiene. It is better to prefer showering, and clients choose whether they desire a tub or shower. The platitude is frequent hand washing due to the danger of disease transmission, which might worsen clients' condition. It is hard to change hygiene among older adults, mainly their skin, hair, and teeth care. Still important is to remember the first impression, so appreciating the choice of clothes and shoes is also essential. Clothes and shoes should be made from materials that feel comfortable and nice. Nowadays, there is a significant market for fabric, so it is much easier to provide comfortable materials. The author would like to mention teeth care when the critical issue is when a client has a few teeth left or none. It is no difference among ageing clients; some have teeth prostheses, allowing them to consume food. Often teeth are in bad condition, or there are a few of them. A considerable influence on teeth condition has drugs that clients consume, as some medications might damage teeth. However, this can be prevented by regular dentist visits.

Another problem can be incontinence which can be linked to mental handicaps and older age. Incontinence can confuse clients; they might react this way because they think incontinence is linked with little children. The client can try to solve the issue and appropriate reaction. However, we might recognize emotional disbalance and physical instability as well. The time for personal hygiene is longer. Not only the smell and damage on underwear can awaken as opposed to leaving their room or meeting their friends. The help is easy. We can use modern anti-incontinence material. However, we still need to be aware of clients' feelings, and the client will be shy or angry at the beginning of solving this issue.

Ageing influences sense organs as well. The impulse needs more time to get to the brain, and thus the experience of the world is worsened. Overall, the nervous system slows down. As a result, older adults are disadvantaged in situations requiring more easy procedures simultaneously. "The older adults preserve their wisdom (crystallin intelligence); however, they lose their agility and perspicacity (fluid intelligence). This opinion is supported by research, but we must highlight that some older adults preserve their fluid intelligence" (Stuart-Hamilton, 1999, p. 87).

Older adults often experience worsened sight due to the interruption of sight organs. The eyes of older adults need more light to function correctly. There are mixed signals and situations which give us hints about sight conditions. For example, the client wants to touch something, misses, is tired, or does not do some activities, such as making the table for dinner. There are many hints on how to notice sight issues in older adults. For example, they make more mistakes while doing some activities using their hands. If the client is seeking other activities, it can be a sign of worsening sight condition. On the other hand, we should remember that it can simply mean a loss of interest in the activity. Glasses can fix the worsening sight condition so that the issue can be solved quickly.

However, another can occur – some clients do not want to wear glasses or keep taking them off. It is good to focus on whether the glasses push them and remain calm when a client is getting used to wearing new glasses. For example, the client can wear glasses for a part of the day. If this procedure causes it, problems are good to ask a client how they feel about their worsened sight. This applies if the client has sight problems with new glasses as well. What can we do to preserve the quality of life in this area? Client must learn to adjust to this handicap so the handicap will not limit them. So, their quality of life remains preserved.

The assistant and the client should cooperate and find the best way to function most effectively and what impulses and information are also essential for them. The situation when a client loses sight completely. This is a challenging situation, and it is vital that another sense, for example, touch, is used instead. It depends on the client and their attitude towards life, but it is assumed that the client is interested in their surroundings and can imagine diverse terms and react to impulses. Some older clients are shy to share their sight and hearing problems.

Another interrupted sense is hearing. Sight is crucial to investigate whether a client can listen adequately daily. The worsened hearing can be recognized by passivity or lower

interests. A client may have grease or any subjects in their ears. A sign of heightened hearing can be the ageing of hearing organs. Worsen hearing can lead to lower social interaction. Loss of hearing can make some clients feel vulnerable. To preserve hearing sense, we can use various tools such as earpieces.

Similarly, as with walking with an earpiece, we must help a client get used to it. It is essential to teach a client how to use the earpiece and how to check whether it is working or not. The transition to earpiece is challenging as before, the client did not hear, and now, they hear too much. This can lead to tiredness from too much noise. Whether a client has an earpiece, it is essential to speak. The client needs to see the mouth, so there is no reason for a higher speech volume.

During communication with people with mental handicaps, generally applies that is good to use gestures and mimics. A client with a hearing issue must still be part of a group or community. The slower pace of communication is more comfortable as they need to put too much energy into keeping with the topic. Sometimes the client can feel isolated. The repetitive attention is provided to another aspect of an ageing client: it does not always apply that a client with hearing issues needs to know everything and be part of a group. It depends on the client's needs and personality. Some clients prefer to be in their quiet room and not to be in a noisy standard room.

Taste and smell are other senses which are worsening over time. The cause is the deterioration of these organs. We cannot agree that due to the worsening of these senses, the client will not eat. Therefore, it is suitable to use diverse games during which the taste and smell are trained.

Also, we cannot forget about worsening fine motorial skills, which are affected by people with mental handicaps already. For example, fine motorial skills can decline due to rheumatoid illnesses or Parkinson's illnesses but even without these illnesses, for some older people is hard to perform fine motorial skills. For many people, these changes mean loss of activities and the ability to care for themselves. However, due to modern tools, we can replace activities during which fine motorial skills are used.

Conclusion

This paper was focused on people with a mental handicap who are ageing. The order of the words has meaning – they are people with a mental handicap which influences their life, and these people live longer, have experienced a lot, and are ageing. Ageing brings a

significant chance that some changes will appear, which might influence their quality of life. If we want to help, as a person or as a care provider, it is vital to focus on how clients experience their life. It applies to all people, not only those with mental handicaps. The care after people should be focused on a specific goal. Support and care must allow a client to live a quality life. Further, it is essential to discuss an aspect of this life stage, for example, palliative care for people with mental handicaps and their spirituality. Finally, we need to focus more on their relatives' needs, which might change over time and might not be recognized by their relatives.

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