THE ROLE OF SOCIAL ASSISTANCE IN THERAPEUTIC EDUCATION

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ABSTRACT — Therapeutic education is a decisive factor in the management of self-care for people with chronic diseases. The theoretical perspective is based on the model of chronic care, focusing on therapeutic education as part of the general system of care for cronic patients.
In the context of this article, we will interpret the results of a questionnaire applied to patients with various chronic diseases, who due to their status of vulnerability, are beneficiaries of social services. The questionnaire was applied to 60 patients with chronic disease: diabetes mellitus, hypertension, chronic renal failure, chronic hepatitis and HIV infection, patients living in the northeastern region of Romania, beneficiaries of social services. We will also highlight the role of social assistance as a form of therapeutic education, aiming at shaping a social assistance profile in the general context of public health.

KEYWORDS — chronic illness; social care; self-care management; chronic care model; therapeutic education.

INTRODUCTION

Therapeutic education is a decisive factor in the management of self-care for people with chronic diseases. The theoretical perspective is based on the model of chronic care, focusing on therapeutic education as part of the general system of care for cronic patients.

In the context of this article, we will interpret the results of a questionnaire applied to patients with various chronic diseases, who due to their status of vulnerability, are beneficiaries of social services. The questionnaire was applied to 60 patients with chronic disease: diabetes mellitus, hypertension, chronic renal failure, chronic hepatitis and HIV infection, patients living in the northeastern region of Romania, beneficiaries of social services. We will also highlight the role of social assistance (Christ & Divan, n.d.; Coleman et al., 2004; Frăţilă, 2017; NASHW, 2005; WHO, 1998) as a form of therapeutic education, aiming at shaping a social assistance profile in the general context of public health..

Difficulties in accessing care services by young people in the conditions of the lack of health education, as well as the increased labor migration, especially of young people, as well as the pressures on the labor market, determine the management of the self-care of chronic conditions outside medical institutions.

Self-care management (Bandol, 2015; Bodenheimer, Lorig, Holman, & Grumbach, 2002; Findley, 2013; Nelson, Meyer, & Bohmer, 2014; Oprea, Cojocaru, Sandu, & Bulgaru-Iliescu, 2013; Verzea & Necula, 2012) most often involves major lifestyle changes involving proper medication, due to a proper diet and increased attention to various risk factors that may lead to the worsening of the chronic condition. Appropriate lifestyles often involve additional costs for both medication, diet and care for complementary pathologies.

RESEARCH METHODOLOGY

The research is based on the sociological survey by questionnaire (Blackstone, 2012; Leahey, 2011), applied to 77 patients with chronic disease: diabetes mellitus, hypertension, chronic renal failure, chronic hepatitis and mental illness in the North-East of Romania, during May-September 2015, who benefited from / benefited from medical and social assistance services through medical and social institutions in North-Eastern Romania.

The questionnaire was completed by a number of 42 female and 35 male respondents. The age structure of the respondents is: 3% people under the age of 18, 3% of people aged between 18 and 25 years, 6% of people between 25 and 35 years of age, 9% of people aged 35 to 50, and 79% of people over 50 years of age.

The large number of respondents over the age of 50 may be due to the particularities of the sample, i.e. those in the health and medical-social system, but may also reflect a possible lack of therapeutic education for young people who "live with the sickness", calling for medical care only at the last minute. Another cause may be the large number of people suffering from chronic illnesses in social services records, amid a rapidly aging population and also due to the migratory phenomenon and negative population growth.

The sample included: 12% non-primary or primary educated respondents, 56% middle-schooled, and 32% university graduates.

The occupational status of the respondents is represented by: 3% students and 10% unemployed and/or who only work in their households, 17% employees, 70% pensioners.

DISCUSSIONS

The exploratory nature of the research (Reiter, 2013, 2017) makes it so that the sample is not necessarily representative for the total population of people with chronic illness in the evidence of medical services. This is due to the particularity that subjects must necessarily belong to a category of vulnerable populations in the sphere of those under the protection of social services. Regarding the two requirements, that of being a person suffering from a chronic disease and that of being a person in the care of social services, we show that there are no cumulative statistics. The sample size was divided by quotas, based on the age and level of education of the respondents who are in the care of social services.

RESEARCH RESULTS

When asked about the type of chronic illness they suffered from, respondents particularly highlighted: chronic cardiovascular disease, diabetes mellitus, chronic liver disease. Diseases reported by respondents in the sample are generally the same as those with the highest incidence at the European level, which may be a confirmation of the correctness and representativeness of the sample chosen (fig. 1).

Respondents mostly declared that they suffer from chronic illness of about 5–10 years, but there are also people who have been suffering from less than 1 year (7%) and others over 10 years (21%) (fig. 2).

The results obtained can be explained by the fact that, in general, the management of self-care for chronic conditions is mainly performed outside the health care institutions during the onset period of the illness, with an emphasized trend for hospitalized care after the first 3 years from the onset of the disease.

It is possible to have hospital care of chronic illness in the first few months after the onset of the disease through daily admissions, given the current conditions for financing health care services (fig. 3).

Most of the respondents benefite d from social services care, at least from the social survey for initial evaluation. Only 11% of respondents say they have not benefited from social services at all (fig. 4, 5).

We note that a relatively high number of respondents are not in the records of social services. Of those who are in the records of social services, a significant proportion of people are classified as disabled. In practice, the other forms of social assistance that chronic patients might be entitled to benefit from (guaranteed minimum income, exceptional benefits) occupy a small percentage of the total target group surveyed for this research. We believe there is a need to increase the involvement of social assistance services in chronic care institutions.

Given the fact that the beneficiaries of the minimum guaranteed income are missing from the sample chosen for this research, although we have tried to ensure the largest possible diversity of respondents, who are chronic patients and beneficiaries of social services, we can conclude that a very small number of people at the limit / below the poverty line — which entitles them to benefit from the minimum guaranteed income — calls for health services, even when suffering of chronic illnesses, which affects even more their quality of life.

As far as the specialized services to which respondents turned to are involved, they mainly indicated the social worker, followed by the physician, and the family doctor/nurse. A large number of respondents indicated multiple responses, including both social and medical assistance. Social assistance has a privileged role, being the first option of the respondents (within the multiple responses given, the role of social assistance was also included).

Specialized services were generally provided by health and medical staff. The role of the priest was not emphasized - spiritual counseling was not considered a specialized service. The role of the psychologist and civil society is particularly low.

Therapeutic education was mentioned by the majority of the respondents among the specialized services they benefited from (fig. 6).

Generally, respondents who stated that they had received specialized services from a certain category of staff, showed that they also received therapeutic education mainly from the same category of specialists. Considerations on specialized services also apply to therapeutic education (the reduced role of the priest, psychologist and civil society, the increased role of the social worker). Although, one mention should be made about the priest, because spiritual counseling, although it contains obvious elements of therapeutic education and supportive intervention (Gavrilovici, Macarie, Damian, Necula, & Tebeanu, 2012), is not placed by respondents in this category (fig. 7).

Although most respondents show that they are aware of the necessary lifestyle changes, these are often unfeasible due to high costs.

The vast majority of respondents said they were satisfied or very satisfied with the involvement of the

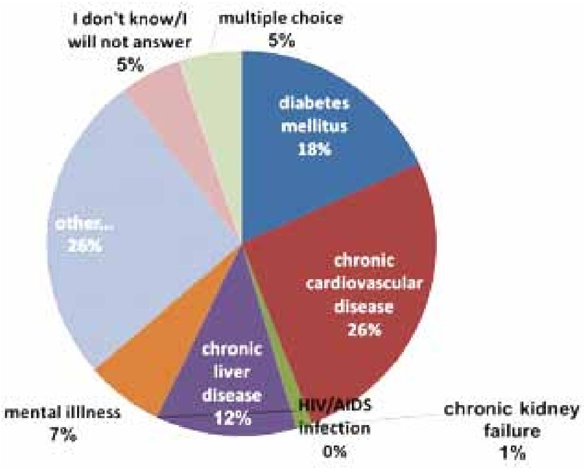

Fig.1. *Type of chronic illness the respondents suffer from*

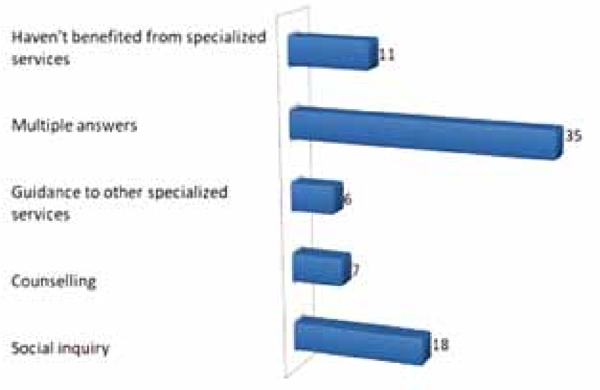

Fig. 3. *Access of respondents to specialized services*

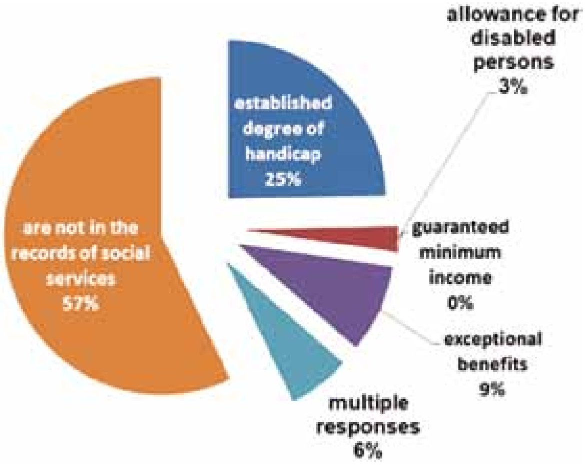

Fig. 5. *Access of Respondents to Types of Social Services*

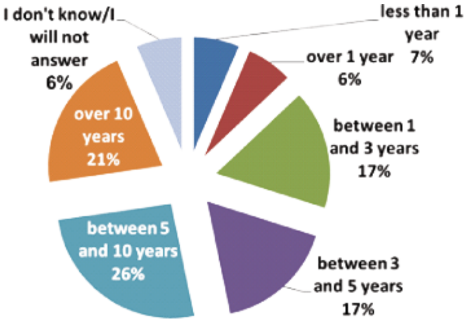

Fig. 2. *How long have you been diagnosed?*

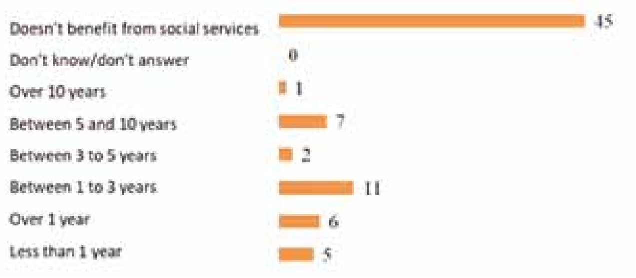

Fig. 4. *Period since respondents have benefited from social services*

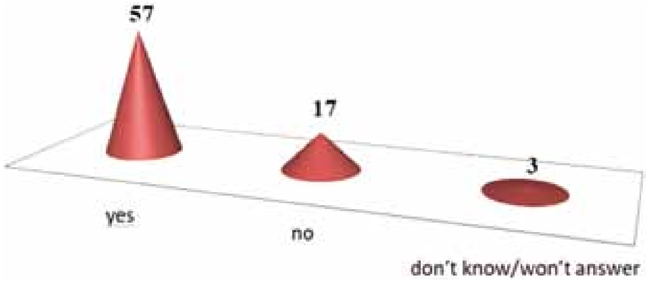

Fig. 6. *Therapeutic education and its place among specialized services*

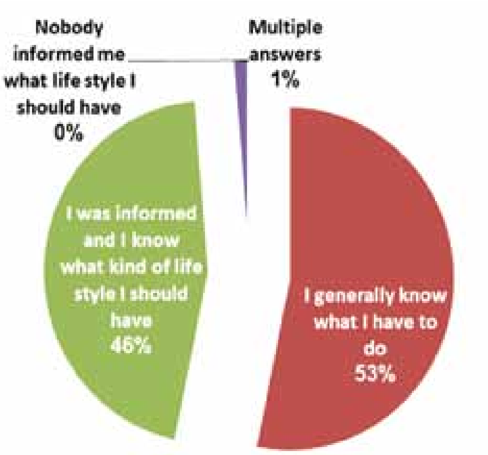

Fig. 7. *Therapeutic education received by respondents*

social workers in their support for chronic disease management (fig. 8).

Only 5% of respondents consider that they have not benefited from the services of the social worker at all.

The social worker's intervention has led to an increase in the quality of life of patients with chronic diseases, both in general terms, as well as regarding its various components: family life, soul contentment, conflict resolution. Some respondents mentioned an improvement in the health status resulting from the intervention of the social worker (fig. 9).

The role of the social worker in the institutional environment is generally polyvalent, and correlates with both the function of chronic care and the general attributions of social assistance practice in public and private institutions. Among these an important place in occupied by community social services (that activate under the jurisdiction of the City Halls), which account for 20% of the respondents' preferences (fig. 10).

Regarding the areas where social services offered to chronic patients can be improved, research results indicate:

- Good patient information on social services offered by the state;
- Patient counseling, supporting them at the time of admission / discharge from a medical institution;
- Establishment of state-funded centers for patients with chronic illnesses, where they should receive treatment and free counseling for a longer period;
- Visiting chronic patients at home and checking their needs;
- Paying more attention to chronic patients by health and social workers;
- Funding of specialized projects / programs for chronic patients;
- Establishment of non-governmental organizations especially for chronic patients (programs, counseling, daily activities);
- Professional development of employees through regular training programs;
- Good collaboration between the social, educational and health sector;
- Increasing the number of experts working in the social field.

A second dimension of this research is represented by the particularities of self-care management for chronic patients in situations of social vulnerability and which would require the intervention of the social worker.

Some respondents show that they are unable or unwilling to assume these costs in part or in full, choosing not to respect the lifestyle specific to their chronic illness, even at the risk of diminishing their quality of life or even their life expectancy (fig. 11).

It is necessary to develop social services for chronic patients, together with the special social benefits necessary to ensure the minimum level of self-care.

Counseling services for health and therapeutic education are significant sources of education regarding the need to adopt a lifestyle suitable for chronic illness. Respondents have shown that information on the particularities of their own chronic conditions has been obtained:

- In the counseling sessions;
- During admission to hospitals;
- Through information obtained from specialists: family doctors, specialist MD, nutritionists, social workers, psychologists, priests;
- Newspapers, flyers, brochures, internet, TV, media, books, relatives;
- Meetings with pensioners within the retirement home;
- At the office of the institutions social worker;
- During the services provided by the social worker;
- Through counseling hours with the school psychologist.

One of the major risks of inadequate self-care management is the diminishing of the patient's social, functional, and decision-making autonomy (Sandu, Necula, Frunză, Unguru, & Damian, 2017). Here we see a significant role of the social worker in building the patient's autonomy, both within the context of institutional care and regarding the integration of the subject within the other social constructs of chronic illness: family, working environment, social and interpersonal relationships etc (fig. 12).

A significant concern in the context of chronic illness care is represented by the overall quality of respondents' lives. Quality of life is a global approach to the subjective status of patients, given by the way they refer to their own lives. In the context of this research, we considered the self-perceived quality of life as a partial indicator of patient satisfaction with care, both medical and social, with a strong impact on self-care management (fig. 13).

33% of respondents said they were completely satisfied with the quality of their own lives, while only 7% were completely dissatisfied.

CONCLUSIONS

Social assistance has a significant role in the care system of chronic patients, especially in self-care management. In our opinion, through the results of this research one can not emphasize the real and functional

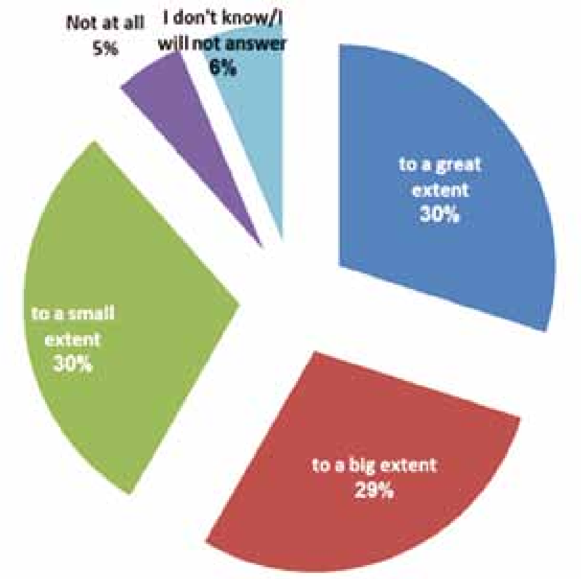

Fig. 8. *Did the social worker help you?*

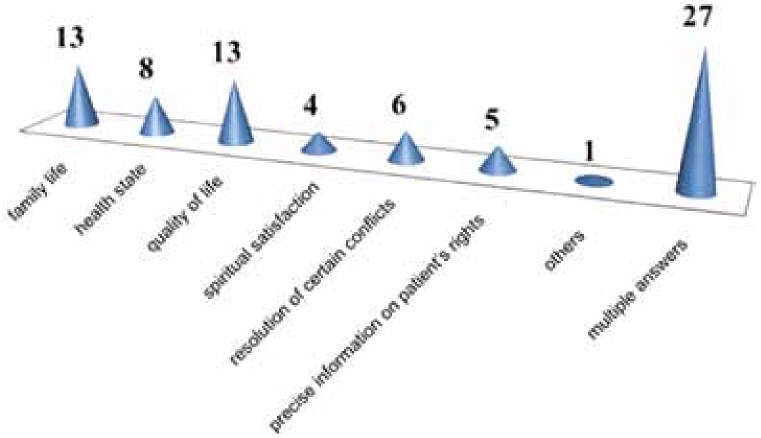

Fig. 9. *Did the intervention of the social worker improve the life of the respondents?*

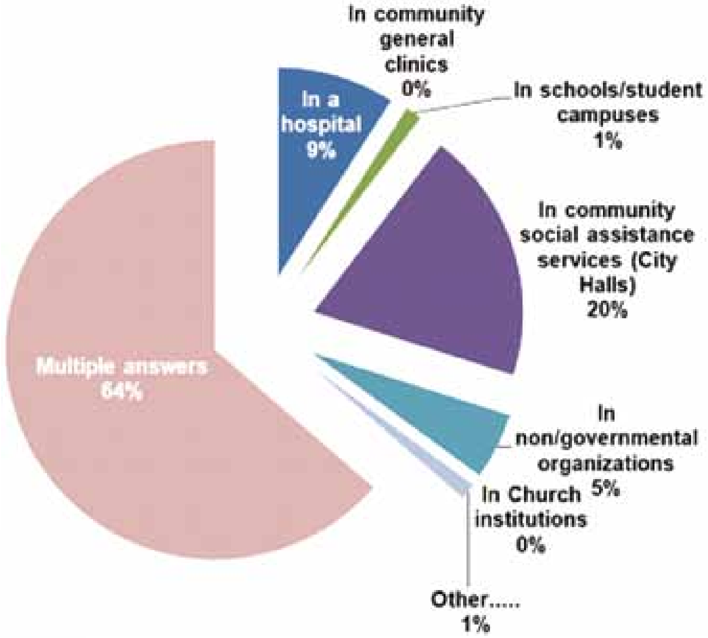

Fig. 10. *The role of the social worker in institutions*

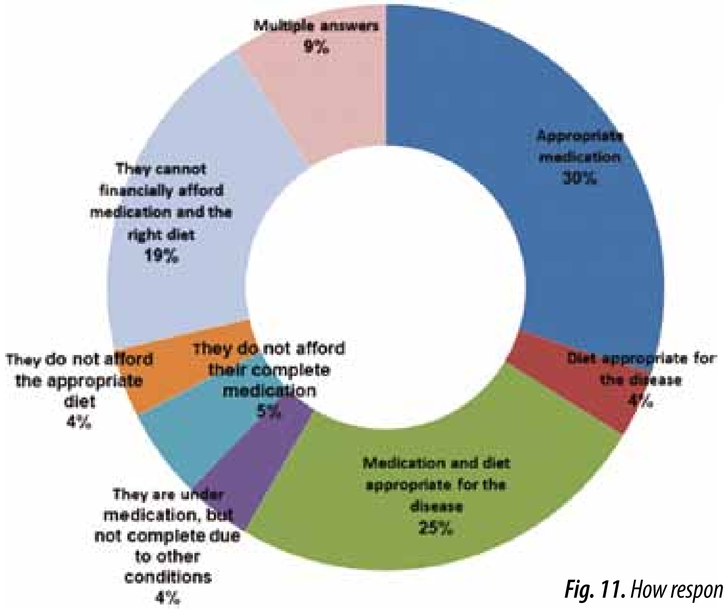

Fig. 11. *How respondents care for themselves*

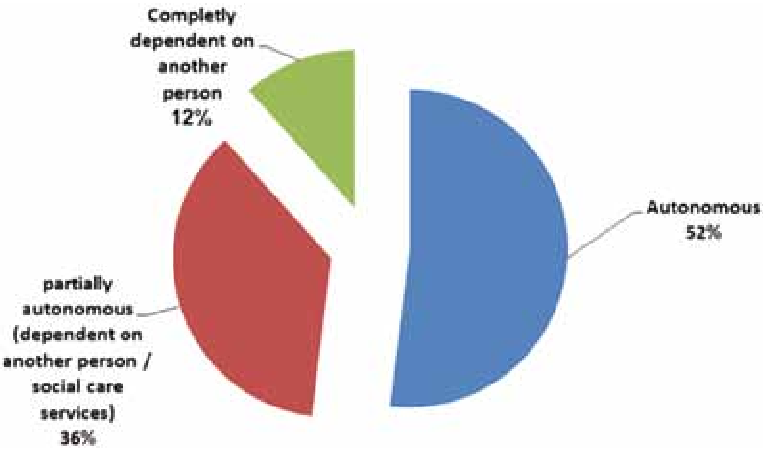

***Fig. 12.** Care and self-care of respondents*

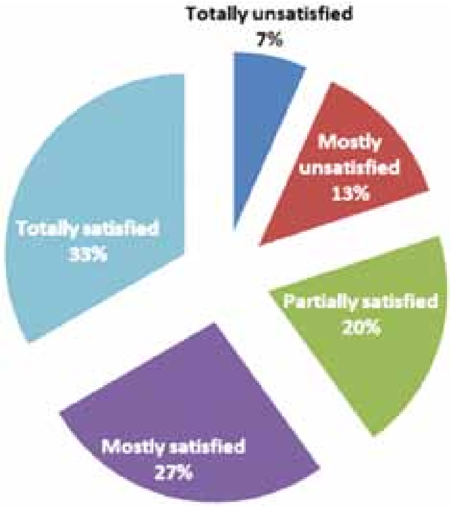

***Fig. 13.** Overall level of quality of respondents' lives*

existence of some transdisciplinary teams involved in the care of chronic patients. It is necessary to increase the involvement of civil society in increasing the quality of patients' lives.

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