REGULATED AND ALTERNATIVE SERVICES ACTING IN MENTAL HEALTH

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DOI: 10.19062/2247-3173.2017.19.2.1

Abstract: *This paper presents how mental health services are organized in Romania, where new rules came into force for the implementation of the specific legislation. The main types of services (specialized, complementary and community) as well as the minimum quality requirements they must meet are presented.*

Since the 60s of the twentieth century, there have been alternative approaches to traditional mental health services. These approaches belong to the community psychology, an approach that is still insufficiently known and applied at the national level.

Keywords: *mental health, services, community psychology.*

1. NATIONAL REGULATION

Within the specific regulation (Law no. 487 of 11 July 2002 on mental health and the protection of persons with mental disorders), the specialized mental health services are defined as those made through the following types of structures: mental health center; psychiatric office, office for evaluation, therapy and psychological counseling, psychotherapy and speech therapy office; crisis intervention center; home care services; psychiatric hospital; inpatient day; psychiatric ward of the general hospital; psychiatric department of general hospital; recovery and social reintegration centers; workshops and protected housing; advisory center on domestic violence.

The same law also defines other two types of services: complementary services ("services that provide psychiatric and mental health care, such as psychological counseling, vocational guidance, psychotherapy and other medical and psychosocial procedures") and community services ("services that allow taking care of the patients in their natural living environment").

Moreover, there are mentioned the conditions of the quality of the care to be provided by all the mental health services:

"a) to be geographically accessible, through the judicious distribution in territory of the public sector units;

b) to ensure the continuity of care and cover the diversity of the needs of assessment, treatment, rehabilitation and reintegration of the persons with mental disorders;

c) to ensure and develop models of community care;

d) to have, where necessary, medical, paramedical and qualified support personnel in sufficient number and subject to ongoing training;

e) to have premises, facilities and equipment in order to permit appropriate and active assessment and therapy procedures to ensure complete care in accordance with international standards;

f) to ensure the use of the therapeutic methods that help restore, maintain and develop the patients' ability to self manage;

g) to permit the exercise of civil rights and those that come with being a patient, with the exception of the situations provided by law;

h) to respect the privacy of the person with mental disorders;

i) to comply with and be adapted to the religious and cultural beliefs of the persons with mental disorders;

j) to ensure the patients' access to the care assessment process."

Although the cited law begins by postulating (article 1) that "Mental health is a fundamental component of the individual health and a major goal of public health policy", four years passed until the implementing rules were issued (2006), and they were recently replaced by the implementing rules of 2016.

Overall, the mental health law and its implementing rules address the mental health services through the inclusion of many activities specific to psychology, recognizing the role of this specialty within the framework of the different types of interventions. Moreover, the two acts emphasize the "therapeutic team", placing the center of gravity of the mental health services within the work groups coordinated by a psychiatrist.

2. THE ALTERNATIV MODEL – COMMUNITY PSYCHOLOGY

The medical approach to mental health services is – incontestably – dominant in the operation of such services in Romania and worldwide. This paradigm reflects both a long tradition and indisputable results in addressing this issue and the way public health budgets are administered in direct connection with the medical act.

For over half a century there is an alternative model for addressing mental health and its services which comes from the recognition of the civil rights of the people with mental health disorders. In the strictest sense of the adverb 'alternative' ("one or the other; one by one"), the model is designed to deliver complementary outcome to the medical one. We would like to emphasize in this context that currently it is not about competing models, a fact that can be also understood from the above presented legislation (regulating, for example, the way in which the representatives of the civil society can access the psychiatric medical facilities in order to monitor the services provided by them).

The application of the alternative model in psychology facilitated the delimitation of a new subdivision, which is detailed in this chapter: community psychology. Currently, community psychology is (still) an almost unexplored field in Romania. Although there have been approaches that can be circumscribed to the area since the 90s and even during the communist period (A. Neculau, S. Chelcea), the articles and the works on this topic are still rare compared to those of other applied branches of psychology. Significantly, only few books were published on this approach; there are only two papers that describe comprehensively this approach (Orford, 1998 and Zani and Palmonari, 2003).

However, in Romania there are many projects and intervention programs based on community psychology, practices that are "imported" from the western practice, where community psychology has existed for decades. For example, within the largest professional association of Psychology, The American Psychological Association abbreviated APA (about 117 500 members, distributed in 54 'divisions' created in correspondence to some sub-areas of psychology), to the community psychology it is devoted Division 27: Society for Community Research and Action: Division of Community Psychology.

The emergence of this field of psychology is considered to be more than a mere extension. Community psychology was conceived as a new paradigm that "... transcends the traditional way of looking, focusing only on individuals or only on the environment. This approach views health problems and the nuisance of life as caused by a poor person-environment fit". (Schileppi, Teed and Tones, p .9) This paradigm shift has been driven by a series of historical events and political developments that led to the definition of community psychology and its affirmation as an indispensable component of psychology in the 60s of the XX-th century.

Around 1700's there were the first attempts to reform the institutions that dealt with the disadvantaged groups (particularly the mentally ill people), i.e. a more "moral" treatment was needed; these attempts have had limited effects, especially for financial reasons.

With the rise of psychoanalysis, the help given to the underprivileged categories of the population was oriented towards the individual, by practicing a paternalistic model of care, a model which is still influential at the present time. The first half of the twentieth century brought an increasing number of the social problems. The two World Wars brought massive redeployment of the population, a lot of unexpected "psychiatric losses" in armed conflicts etc. that is lots of new factors that led to an exponential growth in the number of those who needed qualified help.

The intensification of the efforts to support them materialized in significant changes in the '60s, in terms of the mental illness treatment: there were the antipsychotics and the first scientific standpoints against generalized institutionalization and against the professional practices within the large psychiatric hospitals. Among these studies the most well-known remains that of Hans Eysenck, Sr. (1952): The effects of psychotherapy: An Evaluation, in "Journal of Consulting Psychology", 16, pp. 319 – 324. His main conclusion was that in those days the absence of treatment (i.e. just letting time pass) was a practice as effective as professional care (Duffy şi Wong, p.5).

The movement that led to the rise of community psychology occurred mainly in the USA, where a series of events led to increasing citizen involvement in social life in the '60s – '70s: the civil rights movement, the Vietnam War, the East-West polarity and the specter of a nuclear war and so on.

With President J.F. Kennedy (who had a mentally retarded sister), in the USA, the social change (including the mental health services) passed from the electoral discourse into the sphere of concrete actions. In 1963 it is issued the "Community Mental Health Center Act", a document in which the government recognized the need for local and immediate interventions, and the need for prevention through education. The next administration (Johnson) went further, making the fight against poverty and the "empowerment" national policy priorities.

Under these circumstances it took place in May 1965 the Conference in Swampscott (near Boston) which is considered the "official date" of the birth of community psychology. In this participated clinical psychologists worried about the current professional practices in the field; they were oriented towards social and political changes. At the end of the conference it was agreed to focus their efforts on the actions of prevention, not on the treatment itself and accepted that the inclusion of the ecological perspective (the person-situation match) is an essential element of the professional practice.

A summary of those concerns was made in "The Dohrenwend Model" (1978), which is now a true 'reference system' in community psychology.

The model has the name of the author, Barbara S. Dohrenwend, who first presented it in the article "Social stress and Community Psychology" (published in the *"American Journal of Community Psychology"*, 6, pp.1-14)

In a brief presentation (Schileppi, Teed and Tones, 20), the defining notes of the Dohrenwend model were:

– the opposition to the medical model, paternalistic, practiced mainly at the time;

– the differentiation of psychopathology from the psycho-social stress – "a normal emotional reaction to a traumatic life event which does not imply that an individual is mentally ill";

– emphasizing the importance of the time factor in the intervention (the most successful chances are given by its onset during or at the beginning of the crisis);

– the encouragement of the provision of social services proactively, not reactively. In other words, it is preferred looking for to waiting for the potential beneficiaries for the provision of such services;

– promoting the contacts with the media and the political sphere in order to demonstrate the effectiveness of the social services and the negative consequences (especially on a long term) of a reduction in the funds allocated to them.

3. CONCLUSIONS

Community psychology began its asserting with the identification of several clinical psychologists' common works concerned about the reformation of the mental health services in the conference that took place in Swampscott. Although today it means much more than only the management of the mental health services in the community (which is, however, the most common practice), the new field of psychology retains strong links with clinical psychology.

The current regulatory framework, represented by the Mental Health Act of 2002 and its latest implementing rules allow further diversification of the community services as an alternative to the other two types of regulated services (specialized and complementary).

REFERENCES

[1] Duffy, Karen G.și Wong, F.Y. (2000). *Community Psychology.* Boston: Allyn and Bacon.

[2] Orford, J. (1998). *Psihologia comunității. Teorie și practică.* București: Editura Oscar Print.

[3] Parlamentul României (2012). *Legea nr. 487 din 11 iulie 2002 a sănătății mintale și a protecției persoanelor cu tulburări psihice*, republicată în Monitorul Oficial al României, Partea I, nr. 487 din 17 iulie 2012, în temeiul art. II din Legea nr. 129/2012 pentru modificarea și completarea Legii sănătății mintale și a protecției persoanelor cu tulburări psihice 487/2002.

[4] Zani, Bruna, Palmonari, A. (coord.) (2003). *Manual de psihologia comunității.* Iași: Editura Polirom.