# COMMUNITY-BASED MENTAL HEALTH SERVICES IN ROMANIA

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*Abstract: This paper presents how deinstitutionalization was designed and built in Western countries, as well as the positive and negative effects of this practice.*
*Moreover, the paper presents the main types of community-based mental health services, some of which have also been undertaken at a national level.*

*Keywords: mental health, services, community.*

## 1. DEINSTITUTIONALIZATION AND ITS EFFECTS

Clinical psychology appeared and developed as a psychology of individuality, being concentrated traditionally on the intra-psychic factors as the source of an individual's problems. The latest decades have brought an important change in theory: the wide acceptance of the idea that all behaviors (pathological or not) are the common product of personality and situational factors. In practice, the focus is still on the correction of any deficiencies despite the quasi-unanimous acceptance that "between health and illness there is no border that can be defined objectively, what we call 'disease' may be a departure from the 'norms' established or accepted in a given culture" (Athanasiu, 1998, p.224.). This is idea is also true for the mental health disorders, because the "psychology and psychopathology studies could not establish a separation of the normal from the pathological, between the two being an insidious and imperceptible change" (Ionescu, 1995, p.79).

This approach of the report health / mental illness was one of the factors explaining the major transformations undergone in the past half century by the mental health services in the industrialized Western societies. The meaning of the change was generally that of 'deinstitutionalization' ("usually defined as a sending the mentally troubled patients back into community" – Duffy and Wong, p.114), originally adopted with enthusiasm, from the 'anti-psychiatry' positions (an orientation of the recipients of the mental health services and their families, stated in the broader context of civil rights movements), but relativized then based on some extended studies (Gelder, Gath and Mayou, 583-584).

Despite criticism and detention, deinstitutionalization was spread as a widely accepted practice in the recent decades in all Western countries, and since 1990 it has been 'imported' in the Eastern Europe. Deinstitutionalization requires three intertwined processes:

- *depopulation* of the psychiatric hospitals managed by the state (through the release, transfer or death of patients);
- *diversion* of large groups that previously were automatically subject to hospitalization to community;

- *decentralization* in terms of responsibility for the fate of the patient from only one entity (with a presence as unobtrusive as possible) to a variety of entities, with the expected fragmentation of authority.

Simultaneously with the transformation of the mental health services a change of the image of the group of people they serve was also produced. It is significant in this respect the development of the terms used: from the term 'mentally ill' (a label that would not make differences and would 'guarantee' the public stigma) to names such as 'users' or 'consumers' of such services, or even 'survivors' (for the 'traditional' psychiatric services).

There are currently numerous associations of 'users' and / or their relatives that are very efficient in terms of social support. The most powerful is the American one (the National Alliance for the Mentally Ill People), which is not surprising at all, because "about 1 in 5 adults in the United States – 43.8 million, or 18.5% – have some manifestations of mental illness every year". NAMI has over 130,000 active members, organized in about 1,050 branches, being much more than an association of self-help groups, acting as a powerful political lobby source (Duffy and Wong, p.124).

Of course, not all the people sent 'back to the community' did not find the necessary support. Exemplifying again with the situation in the U.S.A., it is estimated that daily about 150,000 people who are 'homeless' are deinstitutionalized and about as much are arrested or detained. The situation is similar in Europe and for large urban areas is very alarming: for example, a study shows that in Belfast 37% of 'the homeless' had or have mental health problems (McCullough, Long, 1997, p.1).

These figures illustrate the unintended consequences of deinstitutionalization, and rekindle the debate around this practice: its partisans find arguments to support the need to ensure full services, integrated in the community, while the followers of 'traditional' psychiatry view the same figures as an urge to direct the funds towards neurology research, not towards research in psychology.

## 2. TYPES OF COMMUNITY-BASED SERVICES

With the spread of deinstitutionalization, the diversification and growth (quantitative and qualitative) of the community-based mental health services in Western countries were recorded. Some of these services have been developed in Romania, as the following types of community-based services:

*a. Self-help groups* Starting from the idea that people with similar life experience and similar problems can be a powerful agent of change (through meetings and discussion of these issues, mutual support and sharing their experience), the self-help groups have proliferated in recent years, covering a variety of issues ('Alcoholics Anonymous' being probably the best-known example). Without being a new idea, the self-help groups of people with mental health problems or their relatives / friends developed as a 'movement' only during the latest decades, mainly as a reaction to the social stigma of 'anomic minority'. In an attempt to characterize the group of people with mental health disorders, we started from a remark made by G. Mugny (1996, 120), considering this group as a 'minority' not necessarily because they represent only a part of the general population, but especially because the members of this group have very few resources. In addition, these members are the bearers of a social stigma that puts them "outside the society or at its edge" (Enăchescu, 1996, p.166). Jean-Marie Seca (1998, 69) takes an old distinction of Serge Moscovici (1976), according to which the anomic minorities *are defined by the reference to the norm or the responses of the larger social system because the group to whom they belong has no own representations and norms".*

A minority is 'anomic' ('deviant') when it is subjected to the majority rule even in the most intimate choices. The term describes the types of minorities corresponding to the social actors that cannot be described clearly as an 'active minority' ("they have neither a style and a code of conduct, nor publicly identified, recognized objective"). The group of people addressed here, deprived of their psychiatric medical condition, may fall within the anomic minorities, at least in Romania. There are currently networks of such groups, for example the *European Federation of Associations of Families of People with Mental Illness* (EUFAMI).

*b. 'Day care centers' other 'protected' areas* Intended to substitute the heavy atmosphere of the psychiatric hospitals of the last century, these 'protected' premises are placed in the community, providing various services aimed at social reintegration. In Romania such services already have a track record of success, such as the 'Estuar' Foundation network of centers, which has the 'Shield' centre in Brasov.

*c. 'Advocacy'.* It is 'advocacy' "when someone speaks or acts on behalf of the others to present their case as being like their own"; 'advocacy' is of particular interest to people with mental health problems because they are often in a situation where they cannot speak / act effectively to protect their own interests in relation to a group (or a person). In these situations (due to suffering or some more difficult problems – for example, problems related to legal situations or the diminished reliability due to the psychiatric diagnosis) this practice may result in the following strategies (Andronic and Andronic, 2016):

- informational – it is assumed that the target groups and the general public do not have enough information to make decisions about the problem they face. In this situation, media and various promotion actions, round tables and debates, etc. are used;

- collaboration – it involves sending a joint message of several stakeholders in the 'advocacy' campaign and joint actions during its occurrence. The methods used are: coalitions between NGOs, using an expert to support the cause, organization of events (meetings, joint press conferences);

- confrontation – it starts from the assumption that the misunderstandings are so great that negotiation and dialogue would not be successful. It involves the use of demonstrations, boycotts of all kinds and ridiculing the opponent's actions as specific methods.

*d. Mental health prevention and promotion.* The prevention activities in this area are significantly different depending on the targeted age group and the existence or not of some real social support (family, community or support provided by volunteers) for the vulnerable individuals. Regarding the mental health promotion, it is based on several major strategies (Sutton, 1998, 151-152):

- Assistance to the natural systems of social support (family, neighbors) by providing material resources and / or information;

- community networks / building coalitions. This refers to stimulating the approach of some campaigns on mental health issues by the representatives of several social services;

- Support for the take-carers of those in need, provided differently, depending on the type of pain (e.g., senile dementia)

- Influencing the policy makers.

The four categories of community-based mental health services are provided in the community by multidisciplinary teams. In Great Britain, these teams work in already established formulas (Sutton, 1998, 152), depending on the type of care to be given:

i) Preventive care:

- the teams providing basic care include, for example, general practitioners and other specialties doctors, offering help to those who have different disabilities;

- community mental health teams, consisting of people from a wide range of disciplines (including psychiatry, social worker) and provide care in the community. This team effort is taken to avoid hospitalization;

- specialized mental health teams focused on a particular field (area) of difficulties. It offers help to those who must deal with a certain type of mental disorder.

ii) Post-hospitalization care:

- the take-carers for mental health, who may be social workers, community psychiatric nurses, volunteers or those specialized in assisting the severe mental illnesses give continuous support to those who previously received care in hospital;

- teams providing care in the community for people who have been hospitalized for the treatment of an acute disorder. These teams are often multidisciplinary, including psychiatric services, social work, occupational therapy and others;

- teams of the recovery of mental health provide support to those who have been discharged from hospitals after a prolonged stay; also, they are usually multidisciplinary;

- specialized mental care teams, for example, the teams for those suffering from dementia, providing aid for strictly individual needs.

## CONCLUSIONS

The significant developments of the community-based mental health services in the postwar era recorded in the West have a poor correlation in Romania, where the decades of totalitarian ideology 'froze' any attempts to intervene in the community. Important steps required by the reform in this area have been made only since 2000, mainly due to the efforts of the non-governmental organizations.

Currently there are few mental health services operating in local communities, while the current law allows and even encourages the development of such services.

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