THE RECOVERY PARADIGM - FROM MYTH TO REALITY IN ROMANIA

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Keywords: *recovery, social integration, community-based mental health services*

Abstract: *The recovery-oriented mental health services delivery emerged as a shift in attitudes and care for people with lived experiences of mental health problems. This article refers to the main principles and values of recovery approach as reflected by psychiatric practice and describes the Romanian mental health services, within this framework.*

INTRODUCTION

The recovery-oriented approach in mental health disorders has its origins in the social movements driven by human rights organisations in the 1970's; it started as a oppositional statement to the stigma and failure to social integration associated with people suffering from mental disorders.(1) Researchers and people with lived experiences of mental illness contributed to the development of the recovery paradigm, at first in North America, in the 1980's. This concept, although non-linear, often criticised, resistant to a unitary and comprising definition, has led to a shift in mental health policies, especially in US, Western Europe, Denmark, Australia, New Zealand, Canada.(1) As a consequence, more people with mental health problems are nowadays living in the community or in community-based mental health centres, a process termed deinstitutionalisation. The Romanian current status of mental health service delivery begins to reflect this orientation, although not sufficiently understood and implemented at a conceptual level.

The recovery paradigm

To recover from a mental health disorder does not equal to be cured. As noted, many people suffering from mental health disorder manage to improve their condition, even to live symptom-free. Recovery is a dynamic process, different and unique for each person. The focus of this process is not on the outcome, but on the journey itself. Recovering from a mental health disorder relates to gaining hope and individuality, achieving personal goals, having the power of choice, developing significant and supportive personal relationships, social integration, vocational rehabilitation. This term emphasises the personal experience in the process of achieving a meaningful, purposeful and satisfying life within own limitations imposed by the mental health condition, acknowledging, accepting and controlling these limitations. Within this recovery-oriented culture, mental health service users are helped to find a sense of empowerment by addressing their capacities beyond their illness, thus achieving different grades of autonomy in their life, respect and dignity, without stigma and discrimination.(1,2,3,4,5)

Therefore, a simple, unitary and comprising definition is difficult. Patricia Deegan, a mental health consultant, activist and service user, stated:

"Recovery is not the same thing as being cured. Recovery is a process not an end point or a destination. Recovery is an attitude, a way of approaching the day and facing the challenges. Being in recovery means recognising limitations in order to see the limitless possibilities. Recovery means being in control. Recovery is the urge, the wrestle, and the resurrection".(6)

In 1993, William Anthony, a main contributor to the development of this concept, said that recovery is *"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness".* (7)

The term of recovery is not the same with rehabilitation. Recovery, as described, operates within a person-centred philosophy, whereas rehabilitation offers the tools and opportunities to enable service users to achieve recovery. A recovery-oriented psychiatric rehabilitation concentrates on the people, on their needs, goals, hopes and aspirations, rather than the people adapting their expectations to the systems' requirements and rules. Whether they refer to psychosocial rehabilitation, vocational and educational rehabilitation, drug and alcohol rehabilitation, physical or clinical rehabilitation, the best practice includes evidence-based treatments and therapies and continuity, within a recovery-based framework.(3)

Within this philosophy, the classical medical model, focused mainly on symptom-relief and clinical improvement, shifted to a person-oriented, individualised, tailored and holistic approach. Nonetheless, there are challenges in implementing these principles and values, especially in clinical inpatient settings.(1) They are mainly applied in outpatient community-based settings, from ward units in the community with professionally qualified staff, to supported accommodation, where people with mental health problems live either alone or in shared housing, where different levels of support are provided mainly by non-psychiatric staff. There are various types and models for supported accommodation, in the private or public sector (nursing/residential care units with 24h support, supported group homes, cluster flats with flexible support, tenancies supported by floating outreach services, adult placements).(4)

Studies on the efficiency and efficacy of different

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Article received on 15.10.2018 and accepted for publication on 22.11.2018
ACTA MEDICA TRANSILVANICA December 2018;23(4):21-23

models of supported accommodation are heterogeneous, the used terminology varies and the results are inconsistent. There is no evidence sustaining the performance and superiority of a specific model. The available studies demonstrate inconsistent information supporting efficient social integration; as expected, the quality of life is mainly influenced by the severity of symptoms. Nevertheless, there are studies showing that community service users had a lower rate of hospitalisation and reduced duration of hospital admissions. People living in supported accommodation with high-level support are more likely to be hospitalised when compared to participants in low-level support settings.(4) Chilvers and al. (8) stated:

"In the absence of evidence of their relative efficacy, decisions on the provision of alternative forms of accommodation and continued support for people with mental illness can only be based on a combination of professional judgement, patient preference and availability".

The Romanian framework

The main piece of legislation for psychiatric practice in Romania is represented by the "Act on Mental Health and Protection of People with Mental Disorder" (no.487/2002) and the application rules (Government Order no. 488/2016). Article 5/i defines "psychic/psychiatric disability" as the "inability of a person with psychiatric disorder to cope with life in society, the situation arising directly from the presence of the psychiatric disorder".(9) Official statistics data and legislation use terms like "mental and psychic disability", which refer to people with intellectual and developmental disabilities in addition to people with mental health problems and psychosocial disabilities.(10-11,12) In 2015, the Social Welfare Law no. 292/2011 was completed by the Romanian Government with the nomenclature and rules for social welfare services, including housing, health and social care for people with mental health problems. These acts provide the organisational, economic and legal bases for residential centres for social rehabilitation in addictive disorders, therapeutic community residential centres, respite/crisis centres, protected housing, rehabilitation and recovery centres, integration centres through occupational therapy.(10,13) In 2016, the Ministry of Labour and Social Justice started the National Strategy for People with Disabilities, "A barrier-free society for people with disabilities", 2016-2020. The National Authority for Disabled People, a public organisation coordinated by the Ministry of Labour, started the Programme of National Interest - "The Establishment of social services such as day centres, respite centres/crisis centres and protected housing with the purpose of deinstitutionalisation of people with disabilities living in old-age institutions and the prevention of institutionalization of persons with disabilities from the community". The strategy of the programme refers to the social inclusion of people with disabilities in general, including persons with mental health problems.(12)

Deinstitutionalisation in Romania was declared as a national strategy in health policy for many years, yet the mental health and social welfare are mainly institutional systems. General and clinical hospitals have psychiatric wards for inpatient care for people with less severe mental health disorders, whereas mono-speciality psychiatric hospitals offer inpatient care for acute/chronic more severe psychiatric disorders, under the coordination of Ministry of Health or local authorities.(12)

The statistics published in 2018 by the National Authority for Disabled Persons shows that about 1 in 12 people with long-term mental health problems are institutionalised.(11)

The European Mental Health Report, in 2017, "Mapping and Understanding Exclusion in Europe", shows that approximately 8% of people with mental and psychosocial disabilities are living in inpatient settings.(12) The Report of Public Policy Institute Bucharest on the UN CRPD implementation for 2014 states that the majority of institutionalised people (76%) live their whole life in these institutions, only 16% of the total are reintegrated (usually in the family).(14)

The National Authority for Disabled Persons published on their website the following statistic data, available at 31 June 2018, with regards to public social assistance institutions for the adult persons with disabilities:(11)

- 118 care and assistance residential centres, with 6545 service users;
- 19 integration centres through occupational therapy, with 1152 service users;
- 2 pilot centres for recovery and rehabilitation for people with disabilities, with 94 service users;
- 74 neuropsychiatric recovery and rehabilitation centres, with 6334 service users;
- 70 recovery and rehabilitation centres for people with disabilities, with 2956 service users;
- 133 sheltered houses, with 919 service users;
- 3 training centres for an independent life, with 35 service users;
- 4 respite centres;
- 3 crisis centres;
- 63 day care non-residential centres, with 2184 service users;
- 24 day-centres, with 568 service users;
- 2 centres with occupational character, with 64 service users;
- 1 mobile team;
- 2 home social services, with 67 service users;
- 5 psychosocial counselling centres for people with disabilities, with 134 service users.

Frequently, social care settings provide care to heterogeneous groups of vulnerable people (older people, adults with intellectual and neurodevelopmental disabilities, psychiatric disorders, somatic disorders). The above mentioned community-based services are managed by the Ministry of Labour and Social Justice. In the public sector, there are few supported accommodations, with different levels of support ("maximum/moderately/minimum protected"), with 10 to 30 service users.(12)

Often situated and working closely with psychiatric hospitals, there are other community-based services with a main role in continuity of care at a community level and rehabilitation of people with psychiatric disorders. These Mental Health Centres were designed to provide preventive and therapeutic care, psychotherapy, social assistance, occupational and vocational rehabilitation, leisure activities, home visits, crisis intervention. They are often underdeveloped, under-staffed, under-financed and mainly provide outpatient consultations. There are 52 Mental Health Centres, according to official data.(12)

There are few data about the supported accommodation financed by private sector and independent organisations. The European Mental Health Report in 2017, "Mapping and Understanding Exclusion in Europe", shows that, in Romania, as in nearly all European countries, there are peer-support and service-users organisations ("Aripi Association"), a "Hearing Voices network", but their initiatives are often facing failure, as not being sustained by public funding and support from local authorities.

In Romania a cultural association (Estuar Foundation), operates, funded by donations, with interest and initiative in

offering supported accommodation to people with mental health problems.(12)

CONCLUSIONS

A recovery-oriented culture in mental health service delivery implies a holistic and individualised combination of treatment and support services, removing stigma to achieve indiscriminate access to education, work and community life. This is the result of a combined effort of a multidisciplinary team (psychiatrists, nurses, psychologists, psychotherapists, occupational therapists, social workers), working together within a person-centred philosophy. Service users' experiences and advice, family involvement and community education are of major importance. All these aspects should be integrated at a mental health policy level, developed and sustained by appropriate legislation, funding, infrastructure, personnel resources. Therefore, major steps are still necessary to facilitate equity and indiscriminate access to best quality care for people with mental health lived experiences.

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