THE PROVISION OF PSYCHIATRIC CARE IN ROMANIA – NEED FOR CHANGE OR CHANGE OF NEEDS[1]?

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Abstract

The reform of the mental health system in Europe takes place under the umbrella of deinstitutionalization, development of alternative community services, integration of health services and integration with social services (Becker and Vázquez-Barquero, 2001). Current article discusses the reform of the mental health system in Romania by using the results of two studies. The goal was to draw an overview of the reform processes in Romania in the last few years by analysing in parallel the actual status of mental health inpatient and community services. One study was conducted in 2007-2008 where a diagnosis of psychiatric hospitals and psychiatric inpatient units in general hospitals took place. The second study conducted in 2006 addressed the development of community mental health services. The results show that developing a strategic approach for change at system level is most urgently needed. This should be characterised by a clear vision at decision making level, by coupling of responsibilities for reform with the resources needed to conduct change, and by cooperation among the involved institutional stakeholders.

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Background

According to Becker and Vázquez-Barquero (2001) the reform of psychiatric sector in Europe can be characterised by "a) deinstitutionalisation process and closure of the old mental health hospitals, b) the development of alternative community services and programmes, c) integration with health services and d) integration with social and community services". Reform of health care was defined by Saltman and Figueras (1997, p. 3, in De Gooijer 2007, p. 427) as "a process that involves sustained and profound institutional and structural change, led by government and seeking to attain a series of explicit policy objectives". De Gooijer (2007, p. 180) identifies as the most important characteristics of the health reforms in the EU "(1) the improvement of the quality of care and (2) cost containment". These two objectives can be seen as structurally contradictory, pending of the perspective of the political actor involved in the policy process.

One of the primary areas of the reform in the field of mental health focused towards the de-institutionalisation and development of the community care. Experience of other countries, (Priebe *et al.*, 2005; Becker and Vázquez-Barquero, 2001) shows that the transformation from a hospital-based to a community-based system is one that should be based upon a long term strategic approach. In order to make a successful transformation, a strategic perspective is required (Rapp *et al.*, 2005) and the state mental health administration has an important role in establishing this strategy. In addition, the implementation of the strategy should be carried out in cooperation with other responsible institutions. Therefore, the analysis concerning such a large scale process needs to be carried out upfront both at policy level (as strategic component of the policy) as well as in terms of implementation at organisation level.

The pair concepts of "institutionalisation" and "deinstitutionalisation" are often used within the context of the health care reforms aiming to a reverse of the institutional framework where service provision takes place from hospital care to ambulatory and community care. Deinstitutionalisation is often used in the context of mental health reform as "replacement of large residential institutions by a network of community-based services" (Mansell, 2006). In this context, "institutionalisation" remains often implicitly defined as provision of in-patient care within large institutions, usually hospitals or residential care (Banerjee *et al.*, 2003; Priebe and Dielentheis, 2002). Recent years have seen in certain countries a review of the "deinstitutionalisation policy" and a slight return under the umbrella of "reinstitutionalisation" (Priebe *et al.*, 2005). In spite of the large variety in results of the mental health reform processes, the process continues and requires additional attention towards adjustment for conditions of the national specific and coordination in provision of services at regional level (Becker and Vázquez-Barquero, 2001).

As well as for most post-communist countries, the challenges faced by the reform in Romania were not different than in the rest of the region, and the health system reform in Romania had a strong impact upon provision of the mental health services as well. The mental health system was focused, as the whole health system otherwise, on hospital based care (McKee and Healy, 2002, pp. 19-21). A top-heavy health system

combined with low developed system of primary care, together with a poor tradition of cooperation among health, education and social services (Jenkins, Klein and Parker, 2005) contribute neither to developing a strategic approach for reform nor to a coherent implementation of the policy. Changes realised in the first part of the '90s were very often scattered and lacked follow up. The reorganisation of the provision of services in mental health towards primary care is still ongoing in this unstable context in an uneven fashion, with frequent changes and renaming of the organisations and of subunits. A collection of data concerning the provision of psychiatric services was missing at the time of conducting the study and has, therefore, made further analysis difficult to conduct.

The objective of this paper is to pull together the results of two previously conducted studies: one referring to the actual situation of psychiatric hospitals and psychiatric inpatient units in general hospitals (2007-2008) and the second addressing the development of community mental health services (2006), in order to get an overview of the reform processes in Romania in the last few years by analysing in parallel the actual status of mental health inpatient and community services. The main reason for putting together these studies is to sketch a more coherent picture of the existing reform initiatives and of the challenges that had to be faced when addressing the organisational component of implementing a reform strategy. The first study analyses from the institutional perspective the proposed measure of organising catchment areas (also named psychiatric sectors) for the secondary care (first attempted in 2006).

The second part of the paper presents an assessment of the organisation of the hospitals (monitoring done in 2007 and 2008). Units of analysis were the sectorisation committees organised at a county level for the first study, whereas for the second study the unit of analysis was the psychiatric hospital.

1. Community mental health care

The data referring to the mental health centres was collected in the framework of a research conducted by the National Centre for Mental Health and commissioned by the Ministry of Health in 2006. The purpose of this research was to evaluate the existing community mental health services and resources and also the need for additional services and resources - on one hand, and to develop a national sectorization plan starting from the specific needs and resources existing at the county level – on the other hand.

Methods

A questionnaire was sent to members of all Sectorisation commissions (N=42), organised at the county level by the Public Health Authorities (PHA)[2]. The commissions had to offer information concerning the existing Mental Health Centers (MHC) at the

[2] County commissions were established through the Norms of implementation of the Mental Health Law, OM 372/2006, art. 7, and was composed of: a) one representative of the county Public Health Authority (PHA), b) one coordinator: a psychiatrist nominated by PHA and c) a representative of local public administration.

county level (location, number of different trained professionals in the centre, equipment available etc.) and to make proposals for the organization and the needed financial and personnel resources of the future psychiatric sectors, in order to obtain a more accurate bottom up perspective on the resources needed for the organization of these sectors. Answers were received from 37 counties.

Results

The questionnaire was completed by mental health professionals from 37 out of 42 counties. The overall population of altogether 37 counties is 17.918.561 inhabitants (representing 81% of the whole Romanian population). The ambulatory facilities officially existing in the 37 responding counties consists of 63 Mental Health Centers (MHC)[3]. It should be mentioned nevertheless, that more than a half of the MHC's do not function at full capacity, due to inappropriate location or lack of staff. In most of these services, psychiatrists assist ambulatory patients, mainly by prescribing free psychotropic medication and only seldom by offering other services in order to assure the continuity of care.

The respondents suggested a series of reorganization measures discussed further. The County Public Health Authorities have proposed the restructuring of the psychiatric health care system by establishing 122 psychiatric catchments area / sectors[4]. The intention is to establish in each sector a community Mental Health Center (MHC) aimed to assure the easy access to primary mental health care. In order to achieve this objective, a number of 59 new MHC should be established, in addition to the 63 already existing. In addition, up to 30 existing MHC have to receive considerable founding in order to bring them to full capacity functioning.

Table 1: The number of inhabitants/psychiatric sector

Actual number of inhabitants in one psychiatric sectors (63 sectors)	Estimated inhabitants/sectors (122 sectors)
298633.15	155617.86

Table 2: Personnel hired in Mental Health Laboratories

	Number of specialists	Number of inhabitants/specialist
Psychiatrists	91	238576
Psychologists	69	292184.54
Social workers	21	402349.32
Psychiatric nurses	181	138791.61

[3] Out-patient facilities which provide medication and, in some cases, psychosocial services for patients living in certain geographical area.

[4] The catchment area represents a geographic area with a population of 150,000 to 300,000 inhabitants.

Table 3: Personnel proposed to activate in the Community Mental Health Centers

	Number of specialists	Mean inhabitants/specialist
Psychiatrists	201	117033.91
Psychologists	179	119871.03
Social workers	204	83764.86
Psychiatric nurses	609	60821.32

Table 4: Costs for setting up Community Mental Health Centers

Expenditures categories	Euro
Acquisitions of buildings	737.207,94
Maintenance of building, repairs and modification to existing buildings	2.855.396.77
Hiring supplementary personnel	7.779.572,94
Salaries in the first years	10.367.124,41
Personnel training in the firs year	719.559,12
Acquisitions of vehicles	2.263.326,47
Administration	621.743,53
Promotion of the Centers	2.114.532,35
Total	31.183.935,29

The Sectorisation Commissions proposed to double the number of community Mental Health Centers, an important point toward the accessibility of psychiatric services and providing a wider range of access to primary care.

The major hindrances against the reorganizations of the psychiatric care in sectors enumerated by the respondents include: the personnel deficit; lack of budget for investments; weak cooperation with the public local authorities in order to develop mental health services; poor coordination between mental health services and social services; imbalance in geographical distribution of funds; huge problems in hiring adequate personnel in order to assure continuity of care; all profession that should be in the multidisciplinary team are in insufficient numbers; the higher personnel deficit for psychologists and social workers.

2. Hospital care

Methods

In the second study, the National Centre for Mental Health (NCMH) sent to all psychiatric hospitals, subordinated at the moment of data collection to the Health Ministry, a form with the request to be filled up at a six month interval (January and July 2007 and then January 2008) with data concerning patients and services provided. The list of hospitals included in the study and data about actual number of beds of each hospital were extracted from the official website of the Romanian Health Ministry (last updated 2005). Out of the overall 17.074 psychiatry beds reported to exist in 2005 in

Romania[5], approximately 500 beds were not covered by this questionnaire. These 500 beds that were not included in the study belonged to hospitals not subordinated to the Ministry of Health and from which the NCMH had no official authority to request data. These beds were located in military hospitals, prison hospitals, one center for expertise of the capacity to work and a Center for Treatment of Addictions.

The information requested referred to all inpatients and addressed demographic (age, sex, level of education, job status, marital status, living area), and socio-economic data (income, insurance status, housing). Other data requested referred to diagnosis, previous admittances, the length of hospitalization up to the census moment, type of ward (open/closed), legal status (voluntary, committed) and pathways to hospital admission.

Besides data referring to patients, each hospital had to provide some basic data regarding: the number of beds (total number of beds; beds in close/open wards), qualified staff (psychiatrists, psychologists, social workers, and nurses) and the type of services and programs within the hospitals.

Results

The Law for health reform (Law no. 95/2006) provides that the hospital can be public, public with private wards, or private; emergency hospitals should be public hospitals. In Romania, almost all hospitals are public hospitals; there are few private units, and none in the field of psychiatry.

Two additional criteria of classification of hospitals are the territorial one and by specialization (Law no. 95/2006, art. 171 (1), (2)). According to the first criterion, there can be regional hospitals, county hospitals, and local hospitals (municipal, urban, and rural hospitals). The regional hospitals are still in organization (there will be regional hospitals in Timişoara, Cluj-Napoca, Târgu Mureş, Iaşi, Craiova, Constanța, Ploieşti and Bucharest), so we shall not take into account these type of unit in the description of the situation of psychiatric units. Psychiatric units in general hospitals are distributed as follows:

- In county hospitals: 2462 beds in 27 hospitals
- In municipal hospitals: 1672 beds in 22 hospitals
- In urban hospitals: 791 beds in 18 hospitals
- In rural hospitals: 110 beds in 3 hospital.

Hospitals may be organized in relation with the specificities of the pathology. In the formulation of the Law 95/2006, there can be the following categories: general hospitals, emergency hospitals, specialized hospitals, and hospitals for chronic diseases. In the category of specialized hospitals there are 39 psychiatric hospitals (with 9512 beds), with various labels:

1. "Clinical Hospital of Psychiatry" – two hospitals
2. "Clinical Hospital of Neurology and Psychiatry" – one hospital

[5] For more details see http://www.insse.ro/cms/files/pdf/ro/cap7.pdf.

3. "Clinical Hospital of Neuropsychiatry" – one hospital
4. "Hospital of Neurology and Psychiatry" – one hospital
5. "Hospital of Psychiatry" – twenty hospitals
6. "Hospital of psychiatry for chronic patients" – one hospitals
7. "Hospital for chronic psychiatric diseases" – one hospital
8. "Hospital for chronic psychiatric patients" – one hospital
9. "Hospital for psychiatry and safety measures" – four hospitals
10. "Hospital of infectious diseases, dermato-venerology, and psychiatry" – one hospital
11. Neurosis Hospital Predeal – one hospital

The variety of names is interesting. It shows the distribution based on rank (see "clinical hospital" in relationship with "hospital"); specialty ("psychiatry" sometimes combined with neurology", though the combination among "infectious diseases", "dermato-venerology" and "psychiatry" seems a bit bizarre); and on the gravity of the illness ("chronic" versus "acute"). Only one case includes "patients" in the title. The most frequent situations include the name of the specialty, "psychiatry", which suggests that the focus is placed on the function of the organization (curing patients of a particular illness).

In pediatric hospitals there are 105 beds for child psychiatry in 5 hospitals (Cluj-Napoca, Timişoara, Piteşti, Bacău, Bârlad). For children there are in total 753 beds available. Besides those in the five pediatric hospitals, several psychiatry hospitals for adults have also wards for children.

To sum up, out of the total of 17,074 psychiatry beds existent in Romania, 9,170 are destined to acute patients, 5,729 are for chronic patients, 753 are for children, 291 are located in military hospitals and 139 in prison hospitals.

Type of personnel and delivered services

Table 5: Psychiatrists

Type of institution	Number of psychiatrists	Mean number of beds/psychiatrist
Acute hospitals	140	25.97
Chronic	50	59.99
Acute (age>18+children) hospitals	171	
Children hospitals	12	25.87
Acute+chronic	66.5	46.45
Forensic hospitals	19	54.33
Acute (age>18)+ children+chronic	44	19.94
Total	502.5	35.84

Table 6: Psychologists

Type of institution	Number of psychologists	Mean number of beds/psychologist
Acute hospitals	36.5	67.25
Chronic	13.0	118.28
Acute (age>18+children) hospitals	35.5	115.77
Children hospitals	5.0	22.50
Acute+chronic	20.0	148.04
forensic hospitals	8.0	178.16
Acute (age>18)+ children+chronic	44.0	60.08
Total	149.5	100.34

Table 7: Social workers

Type of institution	Number of social workers	Mean number of beds/social worker
Acute hospitals	17.0	101.42
Chronic	7.5	110.83
Acute (age>18+children) hospitals	17.0	182.60
Children hospitals	4.0	29.16
Acute+chronic	11.0	191.56
forensic hospitals	3.0	171.75
Acute (age>18)+ children+chronic	2.0	312.50
Total	61.5	137.79

Table 8: Nurses

Type of institution	Number of psychiatric nurses	Mean number of beds/nurse
Acute hospitals	804.0	4.60
Chronic	404.5	6.40
Acute (age>18+children) hospitals	886.0	4.90
Children hospitals	26.0	4.10
Acute+chronic	553.0	6.17
Forensic hospitals	136.0	6.57
Acute (age>18)+ children+chronic	291.0	3.61
Total	3,100.5	5.22

Table 9: Type of medical and psychosocial services

Service	Percentage of hospitals who offer the service
Psychotropic medication	100.0%
Electroconvulsive Therapy	12.8%
Psychological evaluation	72.1%
Individual psychotherapy	93.0%
Group psychotherapy	70.0%
Occupational therapy	54.7%
Social evaluations	39.5%

The size of the psychiatric hospitals covers a very broad range: from 50 beds (psychiatric hospital „Gorgos", Bucharest) to 1250 beds (psychiatric hospital „Obregia" – Bucharest), as shown in table below.

Table 10: Distribution of psychiatry hospitals per region

Region	More than 400 beds	399-200 beds	Under 200 beds
North–East (Moldova)	"Socola" (Iaşi) – 870	Botoşani – 370 Siret – 210	Murgeni – 120 Câmpulung Moldovenesc – 80
South – East (Dobrogea and Lower Danube)	Săpoca – 730 "Sf. Pantelimon" (Brăila) – 401	"Elisabeta Doamna" (Galati) – 245	
South (Muntenia)	Voila – 565	"Sf. Maria" (Vedea) – 211	Poroschia – 185 Săpunari – 175 Balaci – 110 Vadu-Lat – 70
South – West (Oltenia)	Poiana Mare – 500	Craiova – 205	Schitu-Greci – 160 Drăgoeşti – 130
West (Banat)	Gătaia – 450 Jebel – 405	Zam – 385	Mocrea – 115 Căpâlnaş – 85
North – West (Northern Transylvania)		Stei – 247 Oradea – 228 Nucet – 226 Borşa – 215	Cavnic – 90
Center (Southern Transylvania)	"Gh. Preda" (Sibiu) – 473 Braşov – 639	Tulgheş – 305	
Bucharest	"Obregia" – 1250	Bălăceanca – 341	"Gorgos" – 50

The process of accreditation of the public hospitals, as described in the article 175 of the Law 96/2006, is not started yet. In spite of the fact that in the last two years there have been slight improvements in providing basic living conditions in psychiatric hospitals, some are still below the current legal standards – for example, concerning number of beds per room, or number of toilets.

Table 11: Housing condition in hospitals

Mean	Acute	Long stay	Forensic	Children
Number of beds/room	4.87	5.67	4.27	5.41
Number of beds/ bathroom	8.10	13.28	11.42	10.63
Number of beds/ toilet	13.10	12.88	13.32	6.99

There are also great disparities in terms of regional distribution of psychiatric beds. Calculating the indicator beds/100,000 inhabitants for the 8 regions of Romania, the highest figure (103, for West Region) is almost the double of the lowest figure (59, for South Region). For all the figures see the tables below.

Table 12: Number of psychiatry beds per 100000 inhabitants – including forensic, military and prison hospitals

Region	Population	Beds	Beds/100000
South Est (Brăila, Buzău, Constanța, Galați, Tulcea, Vrancea)	2846379	2102	73.84
Nord Est (Bacău, Botoşani, Iaşi, Neamț, Suceava, Vaslui)	3734546	2421	64.82
South West (Dolj, Gorj, Mehedinți, Olt, Vâlcea)	2306450	1653	71.66
West (Arad, Caraş-Severin, Hunedoara, Timişoara	1930458	1995	103.34
North-West (Bihor, Bistrița, Cluj, Maramureş, Satu Mare, Sălaj	2737400	2644	96.58
Center (Alba, Braşov, Covasna, Harghita, Mureş, Sibiu)	2530486	2408	95.15
Bucuresti Ilfov	2208368	1885	85.35
Muntenia South (Argeş, Călăraşi, Dâmbovița, Giurgiu, Ialomița, Prahova, Teleorman)	3329762	1966	59.04
	21623849	17074	

Table 13: Number of psychiatry beds per 100000 inhabitants – without forensic, military and prison hospitals

Region	Acute	Cronic	Children	Total	Population	Beds/100000
South Est (Brăila, Buzău, Constanța, Galați, Tulcea, Vrancea)	1147	610	118	1875	2846379	65.87
Nord Est (Bacău, Botoşani, Iaşi, Neamț, Suceava, Vaslui)	1274	815	87	2176	3734546	58.26
South West (Dolj, Gorj, Mehedinți, Olt, Vâlcea)	713	885	60	1658	2306450	71.88
West (Arad, Caraş-Severin, Hunedoara, Timişoara)	936	589	65	1590	1930458	82.36
North-West (Bihor, Bistrița, Cluj, Maramureş, Satu Mare, Sălaj)	1334	933	78	2345	2737400	85.66
Center (Alba, Braşov, Covasna, Harghita, Mureş, Sibiu)	1266	1010	105	2381	2530486	94.09
Bucureşti Ilfov	1275	341	70	1686	2208368	76.34
Muntenia (South Argeş, Călăraşi, Dâmbovița, Giurgiu, Ialomița, Prahova, Teleorman)	1225	546	170	1941	3329762	58.29

3. Discussion

The challenges identified in the literature concerning the process of reform (both at policy level and at organization level) became present both in the process of policy design as well as in the implementation phase. They were increased by the fact that the hospitals are subordinated to different ministries. The lack of cooperation among these institutions coupled with a lack of a strategic perspective upon the change, together with frequent changes at ministerial level did lead to a series of fragmented (primarily legislative) efforts that were experienced rather as a hindrance at the implementation level. In this sense, it is illustrative that the feedback received during the sectorisation study focused on the lack of availability of resources at organization level (human, financial, inter-organizational cooperation, implicitly suggesting that through the previous change efforts only responsibilities were transferred at regional and local level, without the necessary decision-making authority).

The institutional reform of the Romanian psychiatry hospital (operationalised in the policy usually through the closing down of psychiatry hospitals) needs to be coupled with increased social welfare measures. Such measures would include provision of protected housing and of vocational rehabilitation programs, as well as the development of hospital based occupational and psychosocial programs, the stress on the assurance of continuity of care and the increase in staff competencies. Consequently, an improved cooperation is needed with organizations acting on the field of social services, both governmental and non-governmental.

The data obtained through the two studies suggest that Romania still struggles with a very low number of qualified psychiatrists, psychologists and psychiatry nurses (tables 1-2 and 8-12) That implies that a reorganization of services through the expansion of primary care should lead to increases in personnel (tables 5-6). What is however less clear, and should be separately investigated is the issue of the budget available for the reform: financial resources are still scarce, and Romania allocates a low percentage from GNP to health (5.7% according to data from WHO[6]). In addition, the overall professional/patient ratio is much lower than the European average[7], especially referring to professions such as clinical psychologists and social workers. The studies did not include other hospital professionals (such as occupational therapists or physical therapists), since these professions are not (yet) listed in the official monitor of the professions in Romania and the few persons acting as such are usually psychologist or self-taught nurses.

Hospital organisations providing mental health services are, at a first glance, quite evenly spread at country level (table 13); however there is a strong regional disparity in terms of availability of beds per 100,000 inhabitants. This pattern of regional disparity is maintained also when including psychiatry beds in forensic, military and prison

[6] For more details see http://www.who.int/countries/rou/en/.

[7] For more details see http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_rou_en.pdf.

hospitals. Housing conditions are also relatively low for current standards, with little concern for the privacy and the environment of the patient.

Analyzing the medical and psychosocial services offered by the hospitals, one could imply that Romanian hospitals offer state of the art care: more than 70% of the institutions suggest that group and individual psychotherapy is a common practice, that psychological evaluation is offered as one of the regular services and that occupational therapy is delivered in more than 60% of the facilities. These data should be considered with much reluctance, since few of the professionals working in hospital wards are trained psychotherapists (official data from 2006 account for around 500 psychotherapists in Romania, the majority of them working in private settings), and since there is no formal training for occupational therapy. One could infer that the real delivery of programs in hospital settings is centered mostly on the administration of psychotropic medication, institutional contention and mostly unspecialized and generic individual and (seldom) group counseling.

Conclusions

The above presented results surmise that the reform of the Romanian metal health sector still has a lot of progress to accomplish. The objectives of the European reform of mental health as identified by De Gooijer (2007, p. 180), objectives which focus on quality of service and cost containment are still far away from being attained, though it can be argued that the steps already done are going towards that direction. The previously hospital-based cure system is on the way to be replaced, according to international trends, with a care-based accessible system of community centres where attention is given to the patient as an individual, according to the least restrictive environment of care principle, pathology specific and with adequate staffing.

That requires not only additional investments into staff training and development, but also an increase of staff competencies, in order to cover all the needs of the hospitalized population. This should be done especially regarding to social and occupational issues that could promote a better quality of life for the patients.

In addition, available services need to be specialized and better links need to be developed to the community and primary components of care. That should be done not only in order to prevent unnecessary hospitalization and to reduce hospital stay, but also to educate the communities about the function and the tasks that are fulfilled by the primary care centers and thus to increase the community support them, reducing the risk of rejection due to stigma.

However, the most important result is focused on the need to develop a strategic approach for change. That would be characterized by a clear vision at decision making level (both national and local), by a coupling of responsibilities with the authority and resources needed to implement the change and by cooperation with all institutional stakeholders involved into reform and ultimately in providing mental health services.

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