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Complex Diagnosis Report on the Situation of Public Social Care Residential Centers for Adult Persons with Disabilities

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Contents

List of Abbreviations

CAbR	habilitation and rehabilitation center for adults with disabilities
CIA	care and assistance center for adults with disabilities
CITO	integration center for occupational therapy
CPRRPH	recovery and rehabilitation pilot center for adults with disabilities
CPVI	independent living center for adults with disabilities
CRPD	United Nations Convention on the Rights of Persons with Disabilities
CRRN	neuropsychiatric recovery and rehabilitation center
CRRPH	recovery and rehabilitation center for adults with disabilities
EU	European Union
GDPR	General Data Protection Regulation
GDSACP	General Directorate for Social Assistance and Child Protection
IRSIP	Individual Program for Rehabilitation and Social Integration
ISP	Individual Service Plan
km	kilometer
MSAU	medical-social assistance units
NARPDCA	National Authority for the Rights of Persons with Disabilities, Children and Adoptions
NGO	nongovernment organization
PA	personal assistant
PNI	Program of National Interest
PPA	professional personal assistant
RC	residential center
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

Introduction

Objective and Context of the Report

This report offers a comprehensive diagnosis of Romania's public residential centers (RC) for adult persons with disabilities. As of September 2020, there were 16,127[2] people with disabilities in 297 such RCs, based on the methodology of the National Authority for the Rights of Persons with Disabilities, Children and Adoption (NARPDCA). In addition, there are those with disabilities who also reside long term in other types of institutions, such as psychiatric and forensic hospitals, as well as MSAUs, under the Ministry of Health. To date, an analysis has yet to be made of the compliance of these institutions with quality and human rights standards regarding persons with disabilities, especially in view of current and future efforts to deinstitutionalize.

Deinstitutionalization is an objective Romania has assumed as a State Party to the United Nations Convention for the Rights of Persons with Disabilities (CRPD). Art. 19 of the CRPD on "Living independently and being included in the community" recognizes the equal right of all persons with disabilities to live in the community with equal choice. By ratifying the CRPD,[3] Romania assumes the obligation to take all measures to ensure community inclusion for all persons with disabilities, including those who live long term in residential institutions, by providing the free selection of residence, as well as access to a range of in-home, residential, and other community support services, including personal assistance if necessary.[4] CRPD provisions, to which Romania abides by, are iterated in other European documents, such as the European Union's Strategy for the Rights of Persons with Disabilities 2021–2030[5] and the Council of Europe's Disability Strategy 2017–2023 (Human Rights: A Reality for All).[6]

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[2] NARPDCA data as of September 30, 2020. The number reflects persons with disabilities who reside in the following types of centers, excluding sheltered homes: (1) care and assistance; (2) integration through occupational therapy; (3) neuropsychiatric recovery and rehabilitation; (4) recovery and rehabilitation of persons with disabilities; (5) recovery and rehabilitation; and (6) independent living training.

[3] Law no. 221/2010, which entered into force on March 2, 2011.

[4] CRPD Art. 19 paras. (a), (b).

[5] Union of Equality: Strategy for the Rights of Persons with Disabilities 2021–2030 (EC, 2021). The Commission calls on Member States to "implement good practices of deinstitutionalization in the area of mental health and in respect of all persons with disabilities, including children, to strengthen the transition from institutional care to services providing support in the community." The new strategy builds on its predecessor, which emphasizes institutionalization as an important barrier to the full participation of persons with disabilities in society on an equal basis with others, as well as the undertaking of the Commission's "community-based care to achieve the transition from institutional to by […] support[ing] the development of community-based services and raising awareness of the situation of people with disabilities living in residential institutions, in particular children and elderly people" (EC, 2010).

[6] Living in the community is one requirement underlined by the Council of Europe to promote the overall goal of Disability Strategy 2017–2023, "to achieve equality, dignity and equal opportunities for persons with disabilities" (Council of Europe, 2016, para. 16).

Even though there is a clear commitment to continue with the deinstitutionalization process, the public residential system reflects little variation over the past years in terms of the numbers of adults with disabilities and residential services. In addition to the obligation assumed as State Party to the CRPD, deinstitutionalization and the prevention of institutionalization in Romania of persons with disabilities, accompanied by the development of alternative support services for independent living and community inclusion, is one of the specific objectives of the 2016–2020 National Strategy of "A Society without barriers for persons with disabilities." Despite strategic commitments and legislative measures, however, the number of persons with disabilities who live in public RCs has decreased only slightly, from 16,906 in 2015 to 16,127 in 2020. During the same period, the number of residential services, in fact, has increased from 260 to 297.[7]

Downsizing and reorganization of RCs for persons with disabilities was prioritized by the government and NARPDCA as a preferred course toward deinstitutionalization, although it is yet unclear the extent to which this process will speed up the deinstitutionalization process to ensure independent living for persons with disabilities. To accelerate the process, the government passed, in 2018, an emergency ordinance[8] limiting the maximum capacity of RCs to 50 places. By December 31, 2018, the General Directorate for Social Assistance and Child Protection (GDSACP), as well as private service providers, were expected to submit restructuring plans for all centers that exceed a capacity of 50 places, accompanied by action plans with scheduled activities for the period 2019–21.[9] In addition, RCs with a capacity of less than 50 places had to be reorganized to provide services tailored to the individual needs of each beneficiary, in accordance with current social service quality standards.[10] There has been no assessment carried out, so far, of neither the efforts to restructure and reorganize, nor of the challenges of implementation or alignment with CRPD principles.

In addition to the public residential system for persons with disabilities under the coordination of NARPDCA, persons with disabilities are also institutionalized in other types of facilities. Persons with disabilities are provided specialized temporary care in psychiatric and forensic hospitals, as well as in medical-social units (MSAU) under the coordination of the Ministry of Health. Often, long-term institutionalization

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[7] According to NARPDCA data.

[8] Government Emergency Ordinance No. 69/2018 for modifying Law No. 448/2006 regarding the protection and promotion of the rights of persons with disabilities.

[9] In addition, the Ordinance sets out a budget cut of 25 percent per annum from January 1, 2019, relating to all RCs above 50 places and their exclusive financing from local budgets from January 1, 2022.

[10] Order of the Minister of Labor and Social Protection no. 82/2019 on the approval of specific mandatory minimum quality standards for social services for adults with disabilities, published in the Official Gazette no. 100 of February 8, 2019.

in these specialized institutions[11] is determined by a lack of disability-specific and community-based services, as well as access to mainstream services within the community. No analysis has been made of the effects that deinstitutionalization may pose on those with disabilities, who reside in these institutions.

The objective of this comprehensive assessment is to provide a thorough analysis of the public residential system for adults with disabilities, as well as of the process that will foment the future policymaking that will be necessary to accomplish every stage of deinstitutionalization. The European Expert Group on the Transition from Institutional to Community-Based Care is a coalition that states that "assessing the situation is central to developing a comprehensive, effective deinstitutionalization strategy and action plan," while "[an] assessment helps to ensure that real needs and challenges are addressed and that resources are used efficiently".[12] Art. 31 of CRPD also mandates State Parties to undertake the collection of "appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the […] Convention." A comprehensive diagnosis of the residential system, therefore, is a necessary endeavor to provide a solid foundation for the future course the government must assume to "[a]dopt clear and targeted strategies for deinstitutionalization with specific timeframes and adequate budgets in order to eliminate all forms of isolation, segregation or institutionalization of persons with disabilities".[13]

Methodology

Elaboration process

To develop the methodology to collect the necessary data for this report, there were two objectives. The first objective was to collect data for a comprehensive assessment of the current position of institutionalized adults with disabilities, as well as of institutional service provision from the perspective of human rights and quality standards. The second objective was to introduce the practice of regular and unitary use of working instruments by professionals in the social protection system for adults with disabilities to carry out similar assessments in the future.

The methodology was developed as a result of a broad collaborative endeavor that involved multi-actor consultations and feedback. Data collection instruments were developed by the World Bank team, with extensive input from NARPDCA, experts in the fields of disability and deinstitutionalization, and GDSACP directors. The extensive

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[11] Of at least six months.

[12] European Expert Group on the Transition from Institutional to Community-based care (2012: 53). The Expert Group recommends the collection of data on residents and institutions, as well as on available resources of the residential system—human, financial, and material aspects covered by the data collection for this assessment.

[13] CRPD Committee (2017a). United Nations Committee on the rights of persons with disabilities is the body of independent experts that monitors implementation of the Convention by Member States.

nature of consultations, especially with professionals and practitioners in the field of protection and the promotion of rights of persons with disabilities, ensured that research instruments and the data collection process covered all aspects relevant to enable assessment of the residential institutions, residents themselves, and local plans to transfer persons with disabilities into the community.

Data collection instruments

Specific data collection instruments were designed to gather data on various aspects of the diagnosis. Data used for the development of this report was collected by using different types of instruments, depending on the type of data needed. These were (1) instruments for collecting data on persons with disabilities living in all RCs, as well as data on public RCs relating to their material, human, and financial resources; (2) data on persons with disabilities temporarily residing in other types of specialized institutions, such as psychiatric hospitals, MSAUs, and forensic hospitals; (3) data on restructuring plans, reorganization processes, and other local deinstitutionalization strategies from the perspective of GDSACP directors and county council representatives (Box 1).

Box 1: Data Collection Instruments

- **A fiche to collect data on each adult person with disabilities from residential centers (RC)**, with information about the age at the moment of admission to the public system of social protection for persons with disabilities; time spent in institutions; legal capacity status; disability and level of support needed/autonomy; services and activities provided; relationship with the family; education level and work experience; among others.
- **An extended fiche to collect data on a sample of adult persons with disabilities from RCs**, with complementary information on the need for specific services and the level of access; health status and needs; social participation and relationships; and complaints, among others.
- **Questionnaire on the material resources of RCs**, with information relating to the size of RCs; localization; state of the buildings and facilities; living conditions; eating arrangements; leisure areas and resources for leisure activities; and facilities for specific habilitation/rehabilitation activities and for learning/maintaining independent living skills; among others.
- **Questionnaire on human resources**, with information about staff working in each RC, or who worked during 2019 but were not any longer at the time of data collection, as well as a fiche about each employee.
- **Questionnaire on financial resources**, with information on RC budget implementation.
- **A fiche to collect data on RC entries and exits of persons with disabilities** in 2019, with information on the distribution of beneficiaries by various

characteristics, such as gender, age, type, and degree of disability; legal capacity; environment of origin; family situation; and length of institutionalization, among others.

- **A fiche to collect data relating to waiting lists of people with disabilities, who require residential care from GDSACPs**, with information about the profile of people requesting residential care, such as socio-demographic characteristics; type and level of disability; and number of children in the child protection system to be transferred in the residential system for adults with disabilities, among others.

Data about the position of adults with disabilities, who temporarily reside in other types of specialized institutions

- **A synthetic fiche to collect data about adults with disabilities, who temporarily reside in other types of specialized institutions**, including sociodemographic information; legal capacity status; type and level of disability (in the case of those with a certificate); medical diagnosis; motives of institutionalization; and services provided, among others.
- **A guide for semi-structured interviews with the heads of other types of specialized institutions**, with information on the position of those with disabilities in specialized institutions, relating to (1) socioeconomic determinants of admission and prolonged institutionalization; (2) previous history of institutionalization; (3) level and type of support required; and (4) difficulties in facilitating transition to other specific services in the community.

Data about the deinstitutionalization process

- **A guide for semi-structured interviews with GDSACP directors** to collect data on the (1) challenges and potential bottlenecks in the process of restructuring and reorganizing RCs; (2) institutional collaborations between GDSACPs and other relevant stakeholders; (3) measures to ensure prioritization of the will and preferences of people with disabilities during the deinstitutionalization process; and (4) current and future measures to prevent re/institutionalization.
- **A guide for semi-structured interviews with the representatives of county councils/local councils of Bucharest Municipality** regarding their contribution to the implementation of restructuring plans, as well as their involvement in the assessment and development of community services for people with disabilities who will transition from institutions to community living.

Data collection process

Administrative data: residential centers

Data for the current report were collected from each GDSACP coordinating RCs and each public RC that fell under the responsibility of the GDSACP—research that while exhaustive, was not sample based. The process covered 45 GDSACPs[14] which, at the time the data was collected, were responsible for a total of 289 functional RCs.[15] Standard instruments that contributed to part of the methodology, for the most part, relate to administrative data drawn from RC documents, beneficiary files, staff files, and budget implementation, among others. Data collection was coordinated by the World Bank team, while the actual process of collecting and inputting data online were carried out exclusively by center staff and GDSACPs, specifically assigned and trained for this. Each RC had one person, delegated by GDSACP management, who was responsible for data collection, while a county coordinator monitored and supervised the activity. All county coordinators and assigned staff from the RCs were provided a two-hour online training session by the World Bank on how to use the data collection application, input data, and validate online questionnaires.

Data collection was carried out in two phases.

Phase 1 (21 September–15 October 2020): The human, material, and financial data relating to each RC, as well as admission waiting lists, was input online by way of resources developed by the World Bank. Throughout this phase, the World Bank team was in constant contact with county coordinators and RC staff to ensure prompt solution to any issues the latter may have encountered during data collection. Table 1 summarizes the results of the data collection during this first phase, including the rates for each type of instrument, all of which exceed 90 percent.

Table 1: Completion Outcome of Instruments during Phase 1

	No.	%
Residential centers (RC) that completed the questionnaire relating to material resources	289	100
RCs that completed in the questionnaire relating to human resources	287	99.3
RCs that completed the questionnaire relating to financial resources	280	96.9
RCs that completed the fiche relating to vacancies	261	90.3
RCs that completed the fiche relating to 2018 and 2019 budget implementation	273	94.5

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[14] From a total of 47 at the national level. GDSACPs from Bucharest Municipality Sector 4 and Sector 5 have closed all RCs and services for adults with disabilities.

[15] The following types of RCs for adults with disabilities were included in the process: Care and Assistance Centers (CIA), Habilitation and Rehabilitation Centers (CAbR), Neuropsychiatric Recovery and Rehabilitation Centers (CRRN), Recovery and Rehabilitation Centers for persons with disabilities (CRRPH), Centers for Integration through Occupational Therapy (CITO) and Centers for independent Living (CPVI).

GDSACPs* that completed the fiche relating to waiting lists of persons requesting admission to RCs	45	100

*GDSACP= General Directorate for Social Assistance and Child Protection.

Phase 2 (October 21–December 3, 2020): Data were collected regarding each RC beneficiary and employee. In the case of large RCs, the number of persons in charge of collecting data was increased. In order to comply with data security requirements imposed by the General Data Protection Regulation (GDPR), beneficiary and employee data were input into a local application, installed on RC computers, subsequently transferred to a centralized database, and then hosted on a nonpublic server by the NARPDCA. This second phase involved intensive workload, particularly in relation to medium- and large-size centers, since it required collecting data on over 16,000 persons with disabilities and 13,500 employees. In addition, data also was needed on those residents and employees who had checked out of RCs between January 1, 2019 and September 20, 2020.

In the context of the COVID-19 pandemic, the data collection process was affected by the measures taken by most centers to reorganize staff activity. As indicated in Table 2, however, over 90 percent of RCs had managed, by December 3, 2020, to fill in the two types of instruments. Overall, information was collected by October 1, 2020, on 81.2 percent of RC beneficiaries and 87.2 percent of employees, relative to the information provided by RCs during the first phase.

Table 2: Completion Outcome of Instruments during Phase 2

	Number	Percent
Residential centers (RC) that completed the beneficiary fiches	261	90.3
Beneficiaries reported by RCs/present on October 1, 2020	16,095	-
Completed fiches	15,049	-
Beneficiaries in RCs on October 1, 2020, for whom fiches were completed	13,076	81.2
Beneficiaries who had left RCs between January 1, 2019 and September 30, 2020, for whom fiches were completed	1,973	-
RCs that completed employee fiches	267	92.4
Employees reported by RCs on October 1, 2020	13,439	-
Individual employee fiches completed	12,698	-
Employees working in RCs on October 1, 2020, for whom fiches were completed	11,718	87.2
Employees who left RCs between January 1, 2019 and September 30, 2020, for whom fiches were completed	980	-

Data collection methodology, relating to beneficiary information that required considerable collection effort, was compiled with only a relevant sample. The sample size included 1,060 beneficiaries, randomly selected and proportionately distributed by the total number of beneficiaries within each RC. By December 3, 2020, fiches had been completed for 820 beneficiaries (77.4 percent of the sample volume).

Considering the distribution of total beneficiaries for which information was collected, according to certain characteristics (i.e., gender, age, degree, and type of disability; period of institutionalization; and degree of autonomy, among others), the maximum error recorded for the sample is +/- 4 percentage points.

Administrative data: specialized institutions

Analysis of the position of adults with disabilities, temporarily residing in other types of specialized institutions, required a data sample of long-term chronic patients; that is, people who, at the time of the research (November 2020), had been hospitalized for at least six months, or whose hospitalization was estimated to last at least six months. Examples were selected from a nonprobability sample of psychiatric hospitals (including forensic) and MSAUs.

In the absence of a sampling framework to allow for a probability selection, a convenience sample was selected, with an initial number of 20 institutions to ensure the widest possible regional dispersion, as well as sufficiently large subsamples from not only psychiatric hospitals, but also from MSAUs. Ten patients were selected from each institution, using a statistical interval method from a list of patients meeting the eligibility criterion relating to the length of hospitalization. Patients were selected by an employee, based on instructions from the research coordinator. The final sample in the analysis comprised 180 long-term chronic patients from 18 psychiatric hospitals and MSAUs, of which 104 were those with disabilities. Instruments were filled in on paper by employees of these institutions, based on information from the personal files of patients or from other available sources. Given that the sample of adults with disabilities from other specialized institutions does not qualify as a probability sample, results cannot be extrapolated from the entire reference population and, therefore, they should be interpreted with caution.

Qualitative data

In addition to administrative data, qualitative data was collected via interviews with staff of specialized institutions. World Bank experts interviewed 20 employees, of which 8 were representatives of MSAUs (5 social workers and 3 heads of unit); 3 social workers from psychiatric wards; 2 social workers from forensic hospitals; and 7 employees of psychiatric hospitals (1 nurse, 1 manager, 4 psychiatrists, and 1 psychologist).

Analyses of local deinstitutionalization strategies required that interviews be carried out regarding restructuring plans, reorganization processes, and other local deinstitutionalization strategies. Interviews were facilitated by World Bank experts, including 45 with GDSACP directors and 42 with representatives of county councils/local councils of the various sectors of Bucharest.

Structure of the report

The report is structured in three sections, in addition to this Introduction and a set of concluding remarks and recommendations.

The first section is a comprehensive analysis of the status of public RCs for adults with disabilities, as well as their residents. The section comprises two parts.

- **The first part** provides a general overview of (1) RCs in terms of specific profiles, geographic distribution, capacity and occupancy level, and waiting lists; (2) the profile of persons with disabilities living in RCs with respect to sociodemographic aspects (i.e., age, gender, family and marital situation, education, income and assets, occupation, type and level of disability) and their trajectories in institutionalized centers; (3) the profile of staff in residential institutions with respect to employment type, age, gender, education, type, and distribution of specialized staff; and vacancies and motives for terminating employment; and (4) the financial resources of RCs relating to the medium annual expenditure of each resident, revenues, and budget implementation.
- **The second part** is an assessment of the material and human resources of RCs, as well as other aspects of beneficiary profile, in line with five dimensions of RC care and support:[16] (1) an "adequate standard of living;" that is, living conditions (buildings and infrastructure; accessibility; sleeping quarters; hygiene and sanitation; provision of food, water, and clothing; communication and privacy; indoor and outdoor activities; personal and social life; community life and activities; and respect for personal and family life); (2) "enjoyment of the highest attainable standard of physical and mental health" (assessment and case management; health profile and health service; specific activities in RCs; availability of specialized staff; staff training level; volunteers and other collaborations); (3) "legal capacity and the right to personal liberty and the security of person" (situation of persons with disabilities placed under guardianship; decision-making support activities; informed consent and psychotropic medication; (4) "freedom from torture or cruel, inhuman, or degrading treatment or punishment and from exploitation, violence, and abuse" (number of cases and complaints; access to justice for persons with disabilities in residential institutions; and measures for preventing violence and abuse); and (5) "living independently and being included in the community" (segregation of RCs from mainstream services in the community and community life; access to transportation; participation in social, cultural, religious, and leisure activities; and access to educational and employment opportunities).

The second section is an analysis of past and present efforts to ensure the transition of those with disability to community living, while focusing on the difficulties of the ongoing process of restructuring and reorganizing RCs at the local level. The analysis covers specific aspects pertaining to the development and implementation of plans to

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[16] The aspects covered by the RC analysis in this section are similar to those of the *WHO QualityRights Toolkit: Assessing and Improving Quality and Human Rights in Mental Health and Social Care Facilities* (WHO, 2012), detailed in Chapter 2 of the diagnosis.

restructure and reorganize residential institutions, including (1) consultations and collaboration with relevant stakeholders to develop plans; (2) assessment of the needs of residents and the prioritization of their transfer options into the community; (3) access to material, human, and financial resources for the implementation of plans; (4) assurance of access to community-based services; (5) assessment of family needs and the measures required to support the families of beneficiaries moving into the community; (6) measures for preventing reinstitutionalization.

The third section presents the position of persons with disabilities in other types of institutions, such as psychiatric hospitals, forensic hospitals, and MSAUs. Unlike those RCs for persons with disabilities that are able to offer services only to those with a disability certificate, specialized institutions can admit those with disabilities who, in fact, may not have a certificate. This part of the report offers an overview of the (1) reasons for admission to these types of institution, as well as long-term institutionalization and reinstitutionalization; (2) type of services offered to beneficiaries; (3) challenges of referring them to other services in the community; and (4) barriers preventing an independent life within the community.

1

OVERVIEW OF PUBLIC RESIDENTIAL CENTERS FOR ADULTS WITH DISABILITIES

1. Overview of Public Residential Centers for Adults with Disabilities

1.1. Profile of the System

The overall picture of Romania's public system of RCs for adults with disabilities is a geographically and unevenly distributed system, with a large number of medium- and large-size institutions, some overcrowded and, on average, functioning close to full capacity. The system has grown significantly since 2000, in order to accommodate a large number of adults with disabilities needing social services. Since admissions to RCs are approved only under the condition that no other services can be provided, at home or in the community,[17] this growth points primarily to a lack of community-based services that could support independent living.

The residential system for persons with disabilities includes different types of RCs, each designed to offer specific activities according to the needs of their residents. Currently, adults with disabilities live in several types of RCs throughout Romania. These are: (1) habilitation and rehabilitation center for adults with disabilities (CAbR); (2) independent living center for adults with disabilities (CPVI); (3) care and assistance center for adults with disabilities (CIA); (4) recovery and rehabilitation center for adults with disabilities (CRRPH); (5) neuropsychiatric recovery and rehabilitation center (CRRN); and (6) integration center for occupational therapy (CITO). While currently only CAbRs, CIAs, and CPVIs can be licensed as residential services that offer specific types of services for their residents (Box 2),[18] there are still a number of CRRPHs, CRRNs, and CITOs that house adults with disabilities all over the country (Annex-Table 1), even though these RCs are currently unregulated by specific legislation.[19] The system is dominated in terms of number of institutions as well as in capacity by two types of centers (from six existing types): CIAs and CRRNs.

Box 2: Types of Residential Center

- **Center for habilitation and rehabilitation for adults with disabilities (CAbR)** is the residential social service that offers a set of activities—predominantly habilitation and rehabilitation activities—to meet the individual specific needs of adults with disabilities to develop their personal potential.
- **Center for independent living for adults with disabilities (CPVI)** is the residential social service that offers a set of activities—predominantly

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[17] Law No. 292/2011, Art. 89 para. (1) and Law No. 448/2006, Art. 51 para. (5).

[18] Order No. 82/2019 on the approval of mandatory minimum specific quality standards for social services for adults with disabilities.

[19] While CAbRs, CIAs, and CPVIs are also established as residential services by Law no. 448/2006 regarding the protection and promotion of the rights of persons with disabilities (Art. 51 para. 3 (b), (c), and (d), the latest amended version of Law no. 292/2011 of social assistance still refers to CRRNs and CITOs as types of RCs that can provide accommodation to adults with disabilities – Art. 89 para. 2(b), (c). Although Order No. 82/2009 defines the specific activities and purpose of CAbRs, CIAs, and CPVIs, there are no similar legal provisions regarding CRRNs and CITOs.

activities to develop independent life skills—to meet the individual specific needs of adults with disabilities to develop their personal potential.

- **Center for care and assistance for adults with disabilities (CIA)** is the residential social service that offers a set of activities to meet the individual specific needs of adults with disabilities to maintain/develop their personal potential.

Source: Annex 1 of Order No. 82/2019 from January 16, 2019 regarding the approval of mandatory specific minimum quality standards for social services for adults with disabilities.

The public residential system registered little variation over the past years in terms of the number of adults with disabilities and the type of residential services. The number of persons with disabilities, living in public RCs, decreased from 16,906[20] in 2015 to 16,127 in 2020, particularly in certain types of centers. For instance, a decrease in the number of persons is noticeable in centers that cannot be licensed any longer, such as CRRPHs.[21] At the same time, there currently are no data on the trajectories and whereabouts of persons who have exited RCs each and every year, and intra-institutional transfers are highly probable in many cases. During the same period, the number of residential services, in fact, did increase from 260 to 297, most probably due to the legal requirements to downsize large RCs, resulting in the creation of additional residential services. For instance, CAbRs were only licensed as residential services after 2019 (Annex-Table 2).

CIAs and CRRNs are the two types of RCs dominating the system in terms of the number of centers and the number of total approved places, and this can have important implications for deinstitutionalization. Of the 289 RCs evaluated for this report, almost half are CIAs and almost one-fifth are CRRNs, together accounting for 77 percent of the total approved 18,075 places in the system (Figure 1). CIAs are centers that reflect the national residential population structure in terms of types of disability[22]—with a high proportion of intellectual and psychosocial disabilities—and are atypical in terms of age structure. They concentrate the older population (Figure 2) and therefore are more resistant to change and restructuring, as the older resident population is neither the preferred target for transfer nor an investment through increased or improved services.[23] CIAs are large-size institutions, with an average capacity of 59 places and accounting for 44 percent of the national capacity. Most admissions to RCs in 2019 were to CIAs (70 percent). The large proportion of residents housed in CRRNs also can offer an explanatory basis for the system's inertia: the CRRNs are very large institutions (average approved capacity of 105 places per center) with

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[20] Reference will be made separately to the number of people (residents) in the system and to the number of places (the maximum approved number of people who could be admitted to the centers).

[21] According to NARPDCA data.

[22] According to NARPDCA statistical data, 2020, 3rd trimester.

[23] According to interviews conducted with GDSACP directors and county council representatives.

long histories. The challenge is compounded by further concentration and unevenness: seven counties concentrate most of their capacity in CIAs (over 80 percent) and seven counties in CRRNs,[24] making those counties a challenge in terms of restructuring and reorganization.

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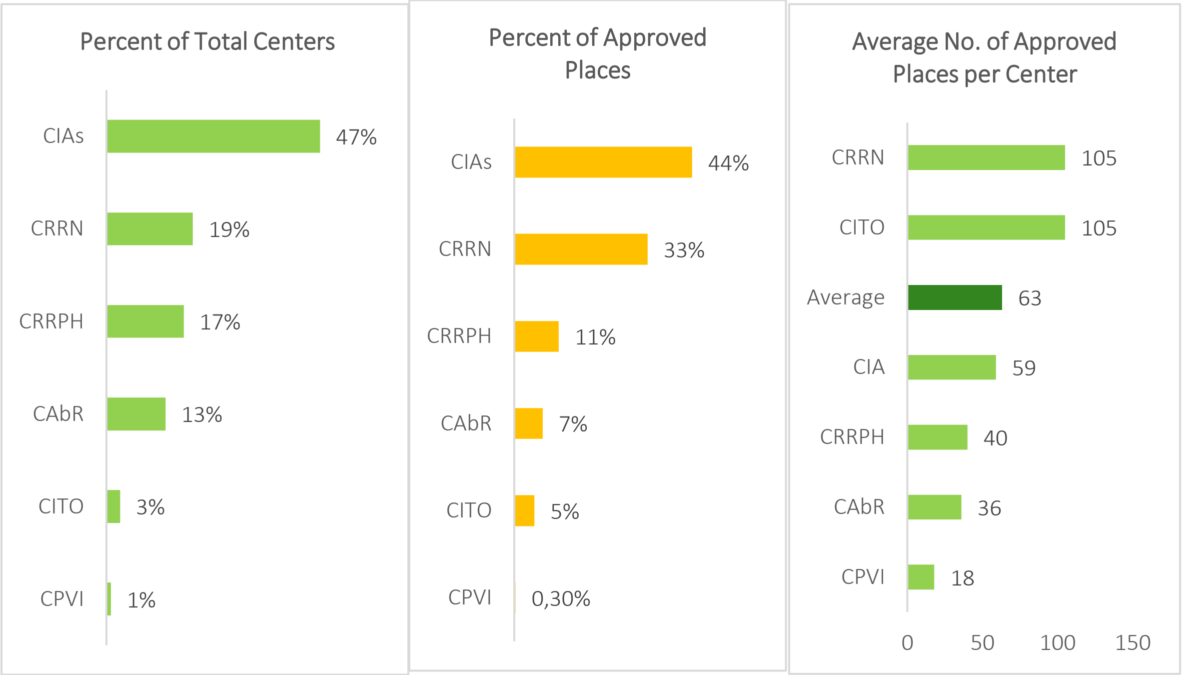
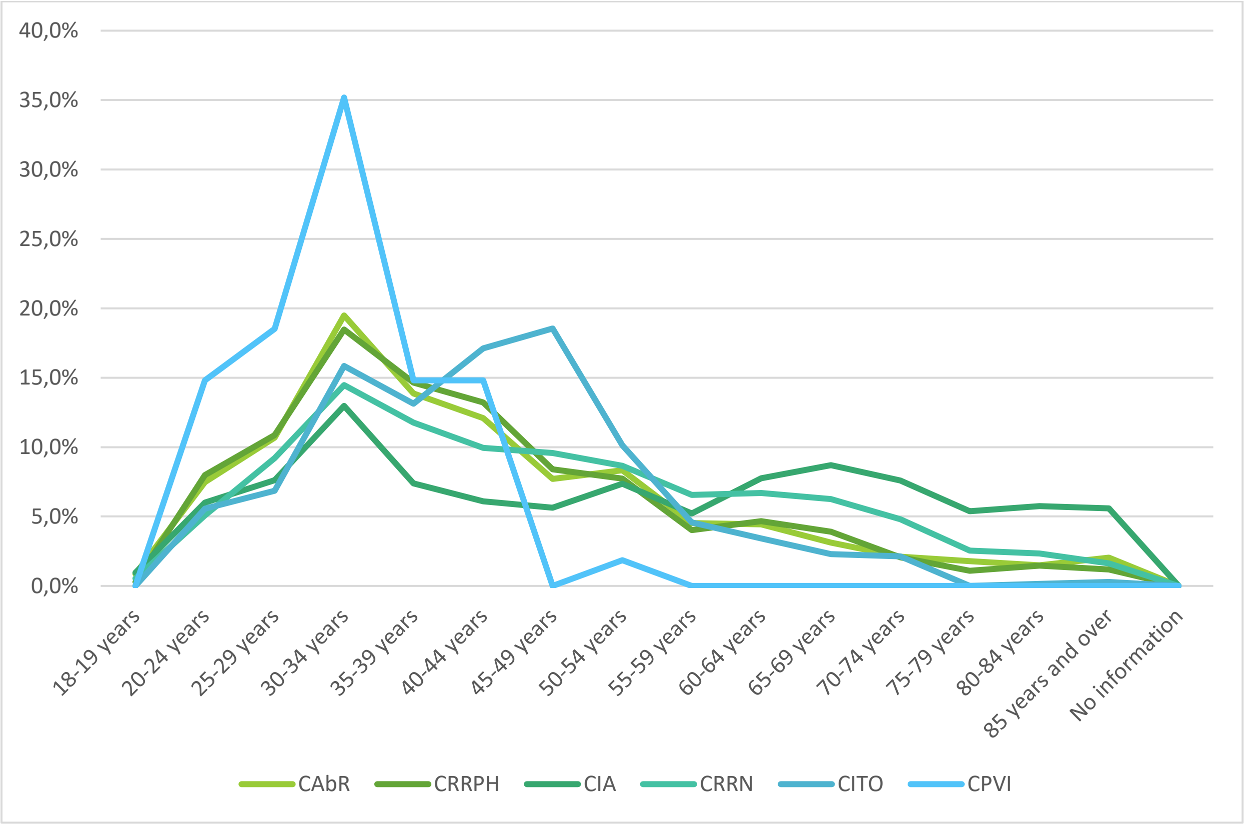
[24] Seven counties concentrate all or most of their capacity in CIAs (over 80 percent): Caraș-Severin, Dolj, Galați, Hunedoara, Mehedinți, Satu-Mare, Teleorman. Only one county (Suceava) concentrates more than 80 percent of its capacity in CRRNs, but there are several counties that have over two-thirds of their capacity based on CRRNs: Bistrița Năsăud, Călărași, Mureș, Neamț, and Timiș.

Figure 1: Structure of the Public System of Residential Centers



Source: World Bank survey of residential centers (2020).

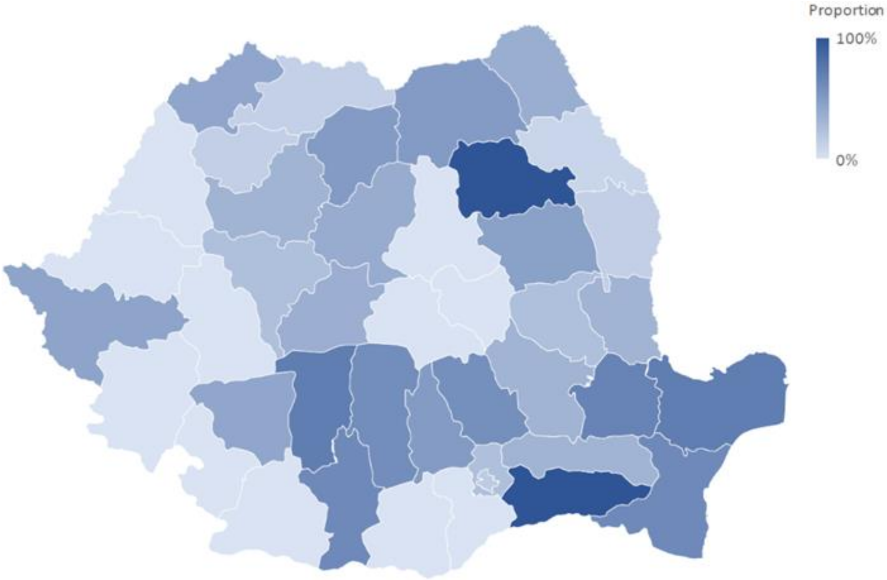
Figure 2: Comparative Structure of Residential Centers, by Age of Resident and Type of Center



Source: World Bank survey of residential centers (2020).

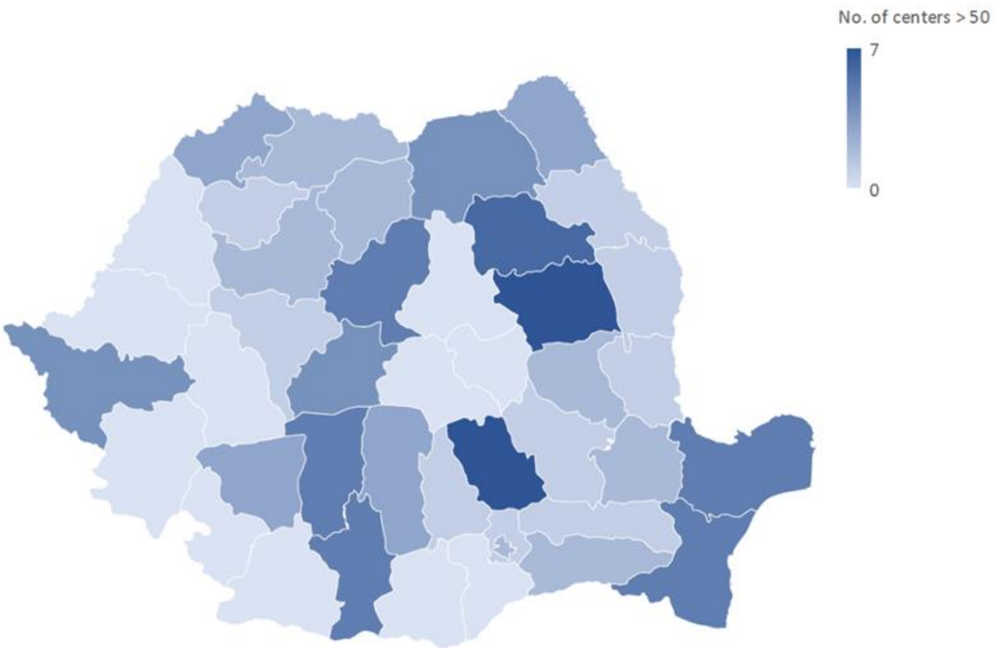
The residential system still has a considerable number of large and very large institutions. In 2020, one-third of the institutions (92 out of 289 centers) had approved capacities of over 50 places. It is worth noting that large and significantly large centers, alike (over 50 places), as well as small centers (below 20 places), are distributed unevenly and concentrated in a handful of counties, while average-size centers (21 to 50 places), accounting for about half of the number of centers, have a more even distribution (Figure 3, Figure 4, and Figure 5).

Figure 3: Distribution of Large and Significantly Large Centers with a Capacity of over 50 Residents, by County and by Proportion of Centers within the County



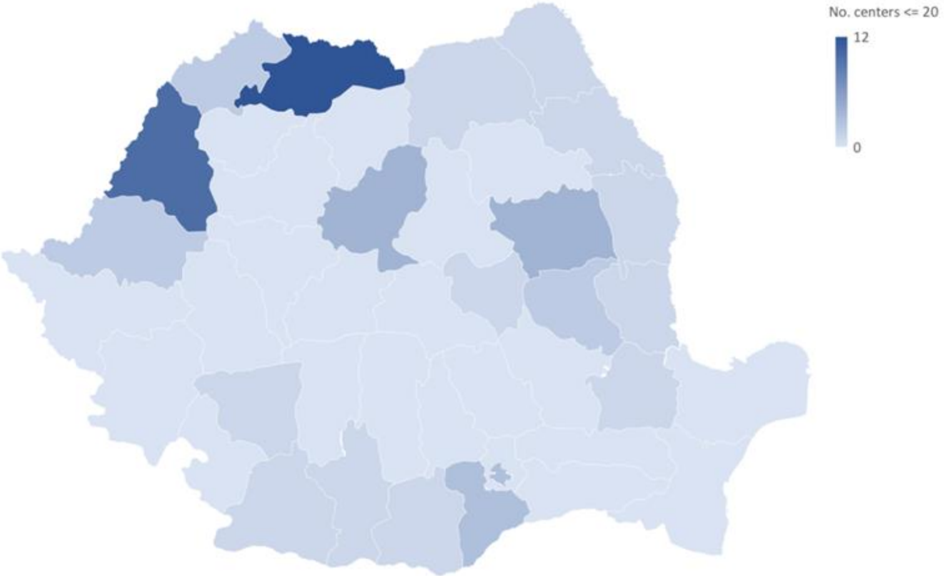
Source: World Bank survey of residential centers (2020).

Figure 4: Distribution of Large and Significantly Large Centers with a Capacity of over 50 Residents, by County and in Absolute Numbers



Source: World Bank survey of residential centers (2020).

Figure 5: Distribution of Small Centers with a Capacity of Less than 20 Residents, by County



Source: World Bank survey of residential centers (2020).

The distribution of centers across counties is uneven, with higher concentrations of centers and residents in a few counties. Most counties have less than the national average of seven centers. Six counties, however, have a disproportionate number of centers (over 12)[25]—which not always is correlated with a high number of residents, as

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[25] Eighteen centers are located in Bihor, 15 in Bacău and Maramureș, 13 in Mureș, and 12 Bucharest and Prahova. Bihor, Bacău, and Maramureș are particular in that their higher numbers are due to the unusual amount of CRRPHs, compared to the rest of the counties (15 and 14, respectively), and not to the number of CIAs, as one would expect.

the distribution of the centers in terms of capacity also is uneven. While an explanation for the unevenness of this distribution cannot be drawn from available data or the admission procedure,[26] in some counties there is a correlation between the total capacity of RCs and the number of older institutions (pre-1990) (Figure 6); that is, counties that have inherited more institutions from the socialist system have a greater proportion of higher total capacity. This uneven distribution may further translate into differing pressures and challenges for each GDSACP in terms of not only ensuring quality residential services, but also in terms of planning the transition of persons with disabilities from RCs to community living.

Figure 6: Top Counties by Number of Centers/County, Number of Approved Places/County, and Number of Old (Pre-1990) Institutions

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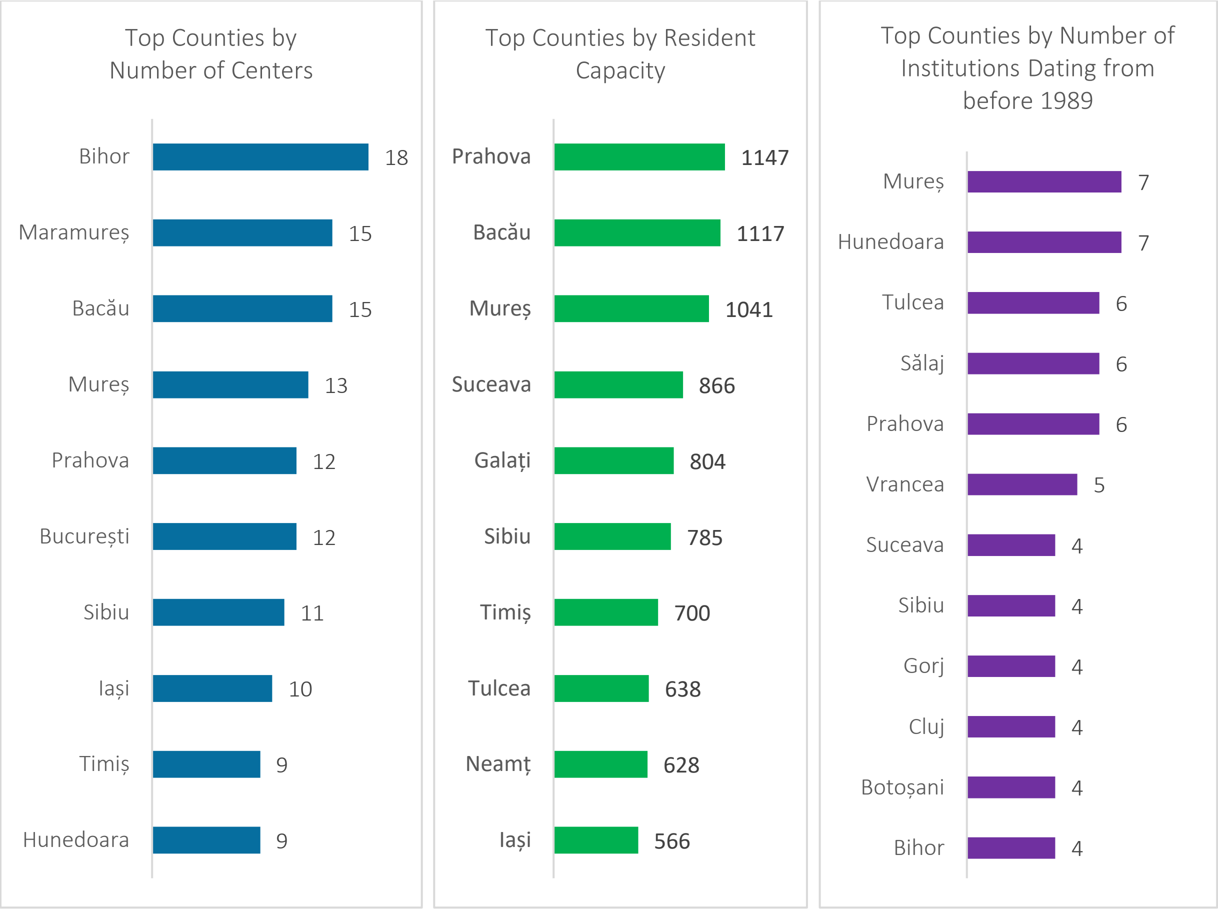
[26] According to current admission procedures, a person only can be admitted to an RC from the same county where the person resides.



Source: World Bank survey of residential centers (2020).

The residential system also is uneven in terms of the capacity and size of centers. The average capacity for a center in Romania is 63 places per center, well above the maximum allowed by the law.[27] However, several counties have very large average capacities, of over 100, and even up to 268,[28] while there are counties with average capacities per center under 30, and as low as 19 (e.g., Covasna) (Figure 7). For more data, see Annex-Table 3. This may have implications for the practical specifics of the deinstitutionalization process, which will have to take into account these differences. The challenge is safeguarding against the restructuring and reorganizing process perhaps falling into that of transfers of residents, simply to optimize capacity and not necessarily to focus on the needs of the beneficiaries and on the ultimate goal of providing them with a life outside the institution and within the community.

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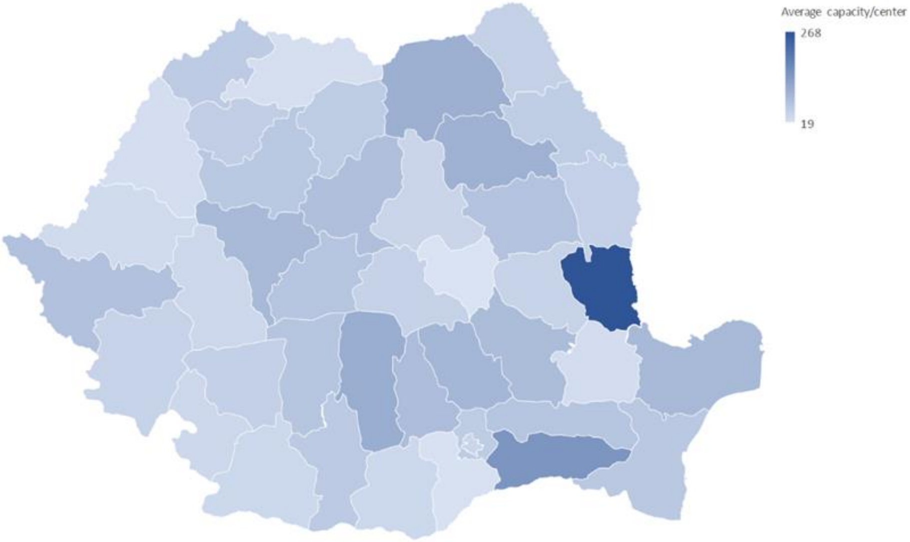
[27] Law No. 488/2006, Art. 51, modified by Government Emergency Ordinance No. 69/2018.

[28] Galați has an average of 268 approved places per center; Călărași, 155: Argeș, 112: Suceava, 108; and Neamț, 105.

Figure 7: Distribution of Counties, by Average Capacity per Center



Source: World Bank survey of residential centers (2020).

The system is unevenly occupied, overcrowded, and more than half the centers function at full or above maximum capacity. Of the total of 18,075 places approved in the system, about 88 percent are occupied, although the occupancy level is not evenly distributed among counties and type of institution. More than one-third of centers are fully occupied, and a further 12 percent function at over maximum capacity. There is no singular explanation for the unevenness of the overcrowding. In some cases, overcrowding might be a function of a demand for residential services that exceeds the local offer: the smaller centers—particularly the CPVIs—are overcrowded in a higher proportion, as well as counties that may have fewer centers and a low number of approved places.[29] There are also counties with some of the highest number of centers and total capacities that have occupancy rates well above the average, close to 100 percent.[30] For a more detailed overview, see Annex-Table 4.

A large number of admissions to RCs are still being processed, despite creating additional obstacles to the process of deinstitutionalization. Moratoria on new admissions to institutions have been emphasized as an essential phase of deinstitutionalization by the CRPD Committee[31] and the previous Council of Europe Commissioner for Human Rights.[32] In 2019, however, 2,112 requests for admission to RCs were submitted, with only 25 percent having been submitted for transfer to other RCs by persons already in the system. More than half (1,197) were approved, accounting for approximately 7 percent of the total number of places in the residential system.

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[29] Brăila, Covasna, and Teleorman.

[30] Bihor, Maramureș, and Mureș.

[31] CRPD Committee (2017b, para. 37).

[32] The Council of Europe Commissioner for Human Rights considers moratoria crucial, given that any placement to institutions, even temporary may cause irreparable harm and constitute a violation of human rights (Council of Europe Commissioner for Human Rights, 2014).

Existing new admissions will create further difficulties for the deinstitutionalization process.

Some GDSACPs are compiling waiting lists of admission requests to RCs, but not all files contain an Individual Service Plan (ISP). The ISP is approved by the Committee for the Complex Assessment of Adults with Disabilities and includes specific needs and activities.[33] In 2020, there were 1,388 admission requests on GDSACP waiting lists, even though this practice is not unitary across counties. Only approximately 40 percent of persons requesting admission had an ISP. CIA is the type of RC that is most often recommended in the ISP, in approximately 57 percent of cases.

The procedure for registering requests for admission to residential centers is not regulated. Many counties do not have waiting lists, for example, Alba, Argeș, Brăila, Brașov, Dâmbovița, Galați, Ilfov, Olt and Satu Mare. Although the waiting list is a method of registering the demand for residential services at the local level, not all counties use it, not to create even more pressure to respond to requests. This can represent a challenge in places where there are no places available at county level.

Many institutionalized young persons with disabilities continue to be admitted to RCs for adults with disabilities once their placement measure ends. The transfer of youth with disabilities from the child protection system RCs to those RCs for adults with disabilities is a long-standing phenomenon in Romania and in the wider region,[34] affecting particularly children who enter the child protection system at a very young age. A World Bank report shows that among youth aged 18 to 26 in Romania, 4–10 percent of those who entered the residential system before the age of three were later transferred to RCs for adults with disabilities.[35] At present, 31 percent of the 13,076 adults with disabilities in RCs the 13,076 come from the child protection system. Of 696 young persons with disabilities between the ages of 18 and 26, whose placement measure ended in 2020, 65 percent had their admission to a RC for adults with disabilities already approved or pending in October 2020. Approximately 47 percent have an intellectual disability (455 persons), while around 70 percent have a certificate ascertaining a severe disability—a profile that may reduce their chance of being included in current and future deinstitutionalization efforts which, in some instances, and based on interviews with GDASPC directors included in this diagnosis, may result in the prioritization of persons with disabilities with lower needs for support.

The form of administrative organization is also geographically uneven and most likely depends on the specific histories and strategies of counties. A very small percentage of centers (only 15 percent) are independent legal entities, almost all concentrated in four counties. Moreover, the centers in three of these counties (Sibiu,

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[33] GD no. 268/2007, Art.23 and Art. 50 para. (d). The obligation of including the ISP in an admission file to a residential center is regulated as of 2019, according to Order no. 82/2019.

[34] For instance, in Bulgaria (EUAFR, 2018, 49).

[35] Stănculescu et al. (2017, 285-286).

Neamț, Prahova), and a good part in the other (Mureș, with 7 out of 13), are independent legal entities. In contrast, most of the rest of the counties have no independent centers and only four counties have one or, at most, three[36] (Table 3). Being a legal entity facilitates the decentralization and streamlining of services and activities in RCs, due to (1) a possible increase in the efficiency of management and administrative operations no longer requiring GDSACP approval; and/or (2) the direct procurement of goods and services. This may further lead to an improvement in the quality of service provision and in greater responsiveness to the needs of residents and staff.

Table 3: Distribution of Counties by the Number of Centers that are Legal and Independent Entities

No. of Counties	No. of Centers that Are Independent Legal Entities
1	12
1	11
1	7
1	6
1	3
3	1
34	0

Source: World Bank survey of residential centers (2020)

Most RCs are gender mixed. Of the 289 RCs, only a small number are designated as women-only (five) or men-only (eight) institutions, with two counties, Bucharest and Mureș, accounting for most of these, each with five. Not all types of RCs have gender-specific institutions: only CAbRs (eight centers); CIAs (three centers); and CRRPHs and CRRNs (one center each).

There has been a massive investment in opening new centers in the past 20 years. While the weight of the socialist inheritance is significant and is a valid explanatory factor for the current system, in terms of form and organizational culture, to rely simply on that explanation can obscure the ways in which the current system also is the result of recent decisions and choices. These choices were made in the context of a massive influx of European Union (EU) funds and of external pressures to reform the system and move toward reducing the capacity of existing centers and establishing new smaller

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[36] It also is worth noting that in Sibiu, Prahova, and Neamț, all centers are part of a service complex. Those centers in the country operating under valid licenses issued for five years comprise 62.5 percent, while only a small number of centers operate under temporary licenses. Almost one-third (28 percent) do not have a valid license or have no license whatsoever.

centers—more than half of the institutions date from 2000 or later[37]—and also to invest in the existent ones, in order to address severe deficiencies in the standard of living of the residents. Moreover, over 16 percent of today's centers—meaning, 47 centers—were opened subsequent to 2009 (Table 4).

Table 4: Distribution of Residential Centers by Year They Were Opened

	<1970	1970-1979	1980-1989	1990-1999	2000-2009	>2009	Total
Percent of all institutions	20.4	16.3	4.8	7.3	34.9	16.3	100
Number of institutions	59	47	14	21	101	47	289

Source: World Bank survey of residential centers (2020).

1.2. Profile of Beneficiaries

1.2.1. Demographic profile

Age

The age distribution of beneficiaries might reflect historical legacies (nationally and system-wise), as well as current systemic state, community, and family failures to care for those leaving the child protection system, in addition to the elderly population. The post anti-abortion law[38] generations (born after the late 1960s and into the late 1980s) account for most of the resident population, reflecting not only a national demographic boom, but also an increased population of institutionalized children (and later institutionalized adults) at that time, since more than 50 percent of residents are between 30 and 55 years old (Table 5). The wave peaks around those born in the late 1980s (now 30 to 34 years old), when restrictions against abortion overlapped with an acute degradation of living conditions in the country, followed by an abrupt drop—most likely due to the legalization of abortion and contraceptive methods in 1989—as well as deinstitutionalizing some of the children within the system. One would expect the older segments to taper down, but they actually are increasing slightly. This is not surprising, given that, for example, more than 42 percent of the people who entered the system of RCs between 2019 and 2020 are people over 60 years of age.

Table 5: Age Distribution of Beneficiaries in Residential Centers

Age Group	Number	Percent

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[37] Part of these residential centers were financed by the Phare Programme 2003/005-551.01.04 (November 29, 2005 - October 29, 2007) which represented the first important European financing in Romania and included the development of a number of 36 contracts finalized with the development of 77 social services (41 in urban areas and 36 in rural areas), as follows: 44 sheltered houses, 13 CIA, 10 CRRN, 5 CITO, 4 day centers, 1 respite center.

[38] Decree No. 770/1966.

18-19 years	88	0.67
20-24 years	825	6.31
25-29 years	1160	8.87
30-34 years	1987	15.20
35-39 years	1396	10.68
40-44 years	1239	9.48
45-49 years	1033	7.90
50-54 years	1038	7.94
55-59 years	677	5.18
60-64 years	832	6.36
65-69 years	830	6.35
70-74 years	665	5.09
75-79 years	431	3.30
80–84 years	451	3.45
85 years and over	423	3.23
Missing information	1	0.01
Total	**13,076**	**100**

Source: World Bank survey of residential centers (2020).

The age profile of residents for each type of center shows older populations in CIAs and, to some degree, in CRRNs, and much younger populations in CPVIs. More than 40 percent of residents in CIAs are people over 60, and 98 percent of those living in CPVIs are under the age of 44 (Table 6). While this might suggest differing needs for the residents of those two types of centers, it probably shows a propensity to allocate beneficiaries differently to opportunities for benefiting from the deinstitutionalization process. Those younger might be seen as more “worth investing in,” while the older can be left in facilities closer to palliative/end-of-life care.

Table 6: Age Distribution of Residents, by Type of Center (percent)

Age Group	CAbR	CRRPH	CIA	CRRN	CITO	CPVI
18-19 years	0.9	0.3	0.9	0.5	0.0	0.0
20–24 years	7.5	8.0	6.0	5.1	5.6	14.8
25–29 years	10.7	10.9	7.6	9.2	6.8	18.5
30–34 years	19.5	18.5	13.0	14.5	15.8	35.2
35–39 years	13.9	14.7	7.4	11.8	13.1	14.8
40–44 years	12.1	13.2	6.1	9.9	17.1	14.8
45–49 years	7.7	8.4	5.6	9.6	18.5	0.0

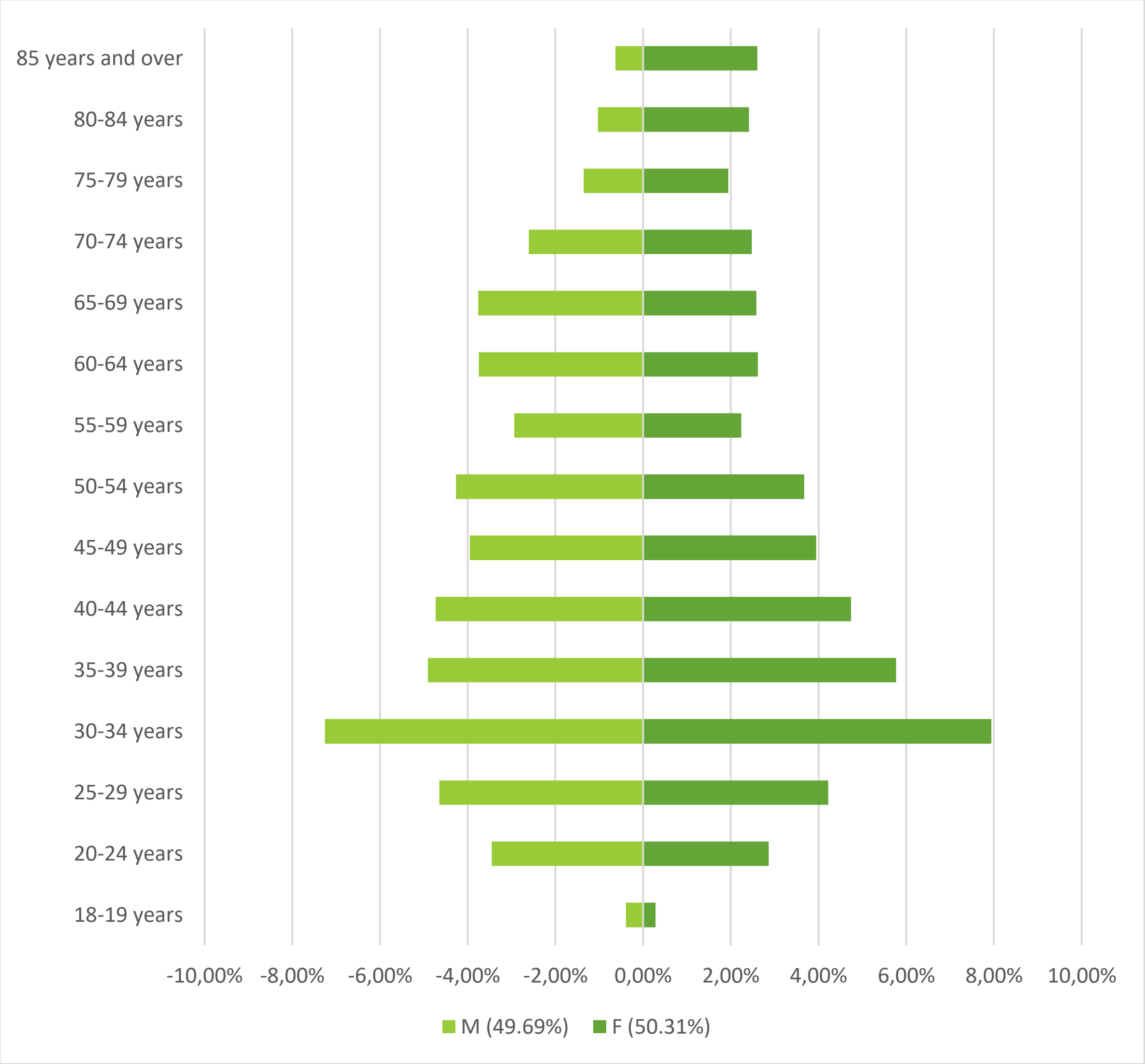
50–54 years	8.3	7.7	7.4	8.7	10.1	1.9
55–59 years	4.5	4.0	5.2	6.6	4.6	0.0
60–64 years	4.4	4.7	7.8	6.7	3.4	0.0
65–69 years	3.1	3.9	8.7	6.3	2.3	0.0
70–74 years	2.1	2.1	7.6	4.8	2.1	0.0
75–79 years	1.8	1.1	5.4	2.5	0.0	0.0
80–84 years	1.5	1.5	5.7	2.3	0.1	0.0
85 years and over	2.0	1.2	5.6	1.6	0.3	0.0
No information	0.0	0.0	0.0	0.0	0.0	0.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: World Bank survey of residential centers (2020).

Gender

While overall, the gender distribution of residents seems to be balanced on average, it varies according to age group. While roughly half of the residents are men and half are women, there are more women institutionalized in the 30–39 and 75 and over age groups, with more men in the 20-29 and 50–69 age groups; for other age groups, distribution is relatively balanced (Figure 8).

Figure 8: Age and Gender Distribution of Beneficiaries in Residential Centers

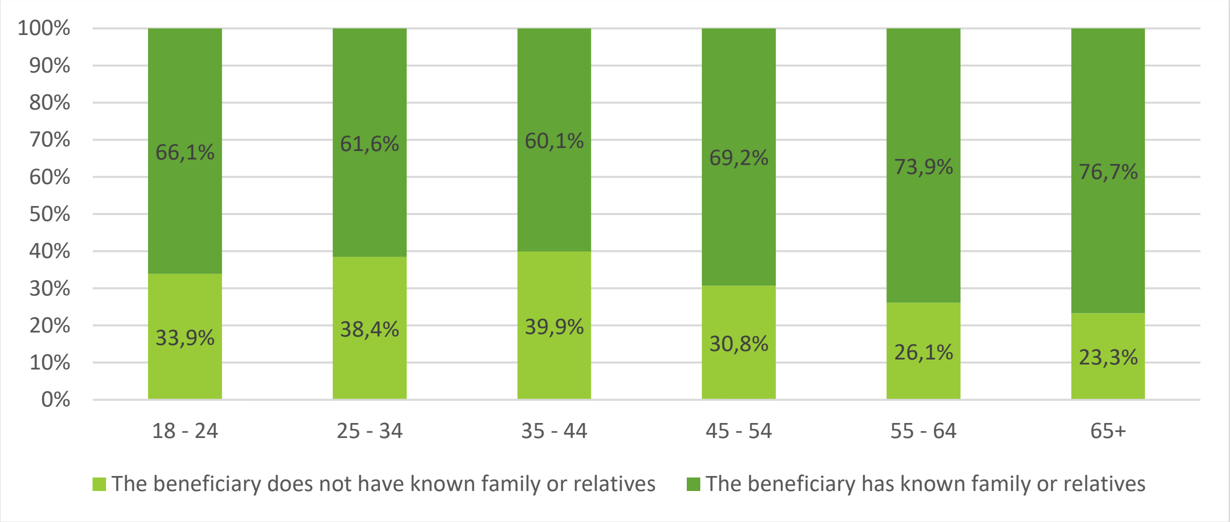


Source: World Bank survey of residential centers (2020).

Family and marital situation

In a higher proportion, beneficiaries with known family or relatives are older. On average, 67.5 percent of the 13,076 beneficiaries have known family or relatives. The distribution by age and degree of disability is, however, counterintuitive but somewhat consistent with other characteristics of the resident population. Thus, the age group with the lowest proportion of people with known family is 18 to 44 years old and, in particular, those between 25 and 44 years old, while those with higher proportions are those over 55 and, in particular, over 65 years old (Figure 9). This might have several explanations. Younger generations partially overlap with the generations born in the late 1980s and are more likely to have been institutionalized as children—with no known family, or simply losing touch with it. Also, younger adults and middle age people are more likely to be kept in the family if they can provide some help, especially in rural areas. Moreover, elderly residents are more likely to be simply taken to an RC by family members who no longer can, or are willing, to care for them (they represented, as previously mentioned, over 42 percent of the entries in the system during 2019–2020). This means that there are compact generations that have spent most of their lives in an institution, and generations of elderly residents that actually seem to be increasing.

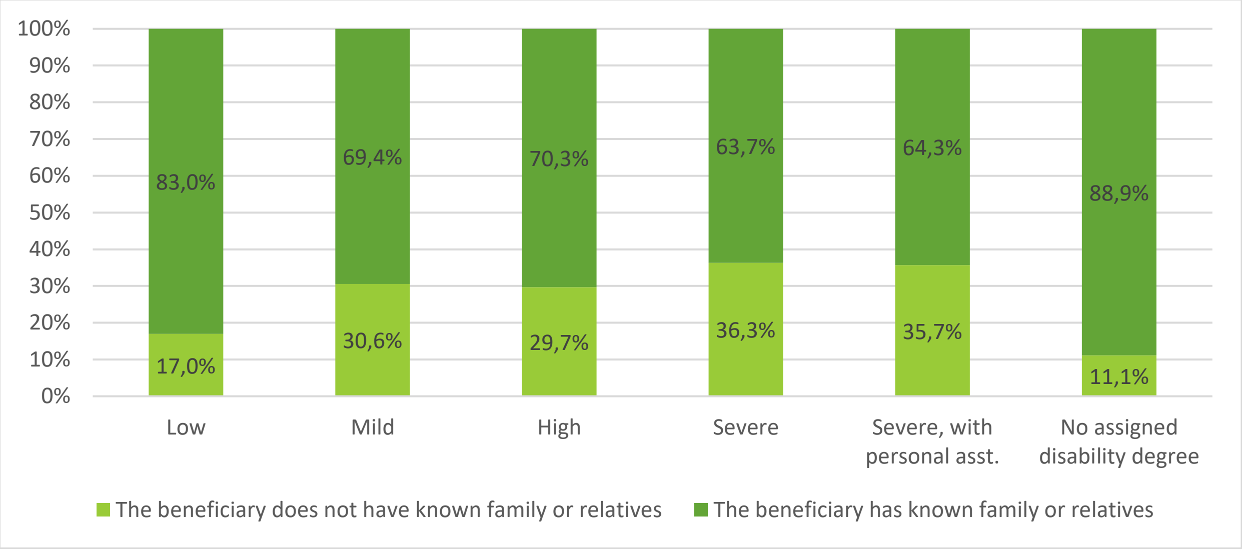
Figure 9: Distribution of Beneficiaries with Known Family, by Age Group



Source: World Bank survey of residential centers (2020).

In a higher proportion, beneficiaries with known family or relatives have lower degrees of disability. About 83 percent of residents with low degrees of disability (and 89 percent of those with no assigned degree of disability) have known immediate or extended family, much more than the average of 67 percent (Figure 10). This situation raises the question about their trajectories of institutionalization and deinstitutionalization in a way that also may point to a lack of access to financial and material resources, as well as mainstream services in the community for these residents and their families, in addition to limited access to disability-related services. Residents with known immediate or extended family are older in a higher proportion, but the statement cannot be generalized.

Figure 10: Distribution of Beneficiaries with Known Family or Relatives, by Degree of Disability



Source: World Bank survey of residential centers (2020).

Only a small percentage of residents are married or in a partnership, and one-third of those live in the same RC as their partner/spouse. The majority of beneficiaries are single, and a significantly small percentage are married or in a form of partnership (1.8 percent and 0.7 percent, respectively). Of the 322 beneficiaries who are married or in a relationship, a little more than one-third live in the same center as their partner—and have probably built their relationship and married while there. Moreover, 70 of them live in the same dormitory as their partner/spouse.

Education

Most beneficiaries have a low level of education or have never attended any form of education. About 44 percent of the beneficiaries have never attended any form of formal schooling, and an additional 27 percent never went beyond an 8th Grade education. The added consequences of having a disability in Romania and being institutionalized for all or a good part of one's life translates in little or no access to education. Even today, according to a 2020 World Bank report,[39] children and young people with disabilities in Romania have great difficulties in accessing education, due to lack of accessibility of the physical and institutional infrastructure, lack of adoption of the curriculum, and insufficient preparation of teachers and specialists to assist these students.

Income and assets

Most of the residents are extremely poor, have insufficient or no independent income or assets, and are completely and financially dependent on the institutional system. Only about 30 percent of beneficiaries (i.e., close to 4,000 people) have a source of income; over half of these receive a retirement pension and about 37 percent some form of disability income (benefits for persons with severe visual impairment,

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[39] World Bank (2020, 242-273).

attendance allowance for pensioners with Type I disability, disability pension, monthly allowance for people with HIV/AIDS) or social benefits, with smaller percentages for salaries or other types of income. Average income is small (about 70 percent of those with an income receive less than €200 a month) and insufficient to support an independent life outside of the institutions or to benefit from other forms of state support. The assets owned by beneficiaries are also insignificant. Only 2 percent of beneficiaries own a house or an apartment, and those over 65 and those with mild degrees of disability are more likely to do so.

Work

The ability to work should not become a selection principle in the process of transition to community living. Work and the ability (or lack thereof) to work are intrinsic to the logic of the Romanian system of RCs and can become a trap in the process of deinstitutionalization, if not treated critically. More specifically, even before 1989, the lack of productivity/ability to contribute to the society through productive work justified segregation and institutionalization. A similar approach—this time intertwined with an ethos of financial autonomy and worth, tied to working and not using social assistance money—is also justifying the continued segregation and lack of social support for people with disabilities.[40] The state codifies the lack of ability to work and its legal consequences by categorizing people with disabilities as “can no longer work,” and offers them pensions, which are then partially transferred to RCs. Moreover, staff in centers also will use subjective evaluations to assign their beneficiaries to the “cannot work” category. The two categories do not actually overlap but have important consequences.

Persons with disabilities in RCs have different occupational statuses and work capacities. About 12 percent of beneficiaries in residential institutions have worked but have been established by specialized medical doctors as having lost their work capacity.[41] This entitles them to invalidity pensions, based on their contributions to the state budget. A further 23 percent are forbidden to work because they are placed under guardianship and lack legal capacity to enter employment contracts. More than a third of residents have been subjectively assessed by RC staff and declared unfit for work.[42] Only about 4 percent are considered fit to work, and only 1.4 percent of residents in RCs were working at the time of the survey (full time, part time, or occasionally) (Table 7).

Table 7: Distribution of Beneficiaries by Occupational Status

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[40] A situation that is most likely akin to the one in neighboring Bulgaria (Mladenov, 2017, 1109-1123).

[41] The assessment of work capacity is carried out by a medical doctor from the local branch of the National House for Public Pensions (Guideline of applying the provisions of Law no. 263/2010 regarding the unitary system of public pensions from 20.03.2011, Art. 81 para. (1)), according to the provisions of Decision No. 155/2011 for the approval of criteria and norms of clinical diagnosis, functional diagnosis, and assessment of work capacity, used for establishing invalidity Degree I, Degree II, and Degree III.

[42] Approximately 45 percent of them have a high degree of disability and more than half are below 50 years old.

Occupational Status at the Time of the Survey	Able To Work?	Numbe r	Percen t
Disability pension Type I or Type II	No	1,596	12.2
Disability pension Type III	No	219	1.7
Retired (because of age)	No	1916	14.7
Person who cannot work, but has not been evaluated officially	Unclear	4,717	36.1
Person who is not allowed to work because he/she is placed under interdiction	No	3,048	23.3
Person with the ability to work, but not currently working	Yes	371	2.8
Working full time	Yes	56	0.4
Working part time	Yes	53	0.4
Working occasionally	Yes	74	0.6
No occupational status	Unclear	2,220	17.0
Total beneficiaries		**13,076**	**100**

Source: World Bank survey of residential centers (2020).

There is a reciprocal relationship between the capacity to work and institutionalization. The ability/lack of ability to work creates, for the beneficiaries in the system, a dilemma: on the one hand, not being able to work justifies institutionalization, as lack of work capacity can often lead to the loss of personal autonomy; and, on the other hand, institutionalization leads to the categorization of people as not fit to work, denying them a suite of opportunities and services (e.g., leaving the center, access to the community, access to educational and other kinds of opportunities) to benefit from, since they are seen as unnecessary. This is consistent with the general physical and social separation and isolation that beneficiaries of the system are experiencing, a result of not only structural causes in the system but also contributions of individual centers and their staff.

Lack of work capacity for more than half of the residents could lead to prolonged institutionalization. The current institutional set up creates further complications and conundrums: tying transition to community living to work and ability to work could reproduce some of the problems of the institutionalization process, by favoring people with a productive capacity for deinstitutionalization and creating new spaces of institutionalization for the rest. Having a disability, lacking formal education and employment experience, and failing to access a job market that is profoundly discriminatory has led to solutions that could translate into new forms of institutionalization. For instance, the European Agency for Fundamental Rights advises against opening sheltered forms of employment and warns that they can "confirm and reproduce institutional models of service provision and keep people with disabilities isolated from the community."[43]

1.2.2. Disability profile

The disability assessment system in Romania uses 10 types of disability to ascertain a persons' condition. In order to be recognized by the state as having a disability and thus be entitled to different forms of medical and social assistance, every person with a disability has to undergo a process of evaluation and be assigned (1) a type of disability and (2) a degree of disability.[44] The result of the evaluation is inscribed in a disability certificate that can be permanent or can require re-evaluation at a later time.[45]

Currently, only persons with disabilities with a certificate can be admitted to RCs; however, this is not the case for all residents. Quality standards require that any person admitted to an RC must have a valid disability certificate.[46] While this is the case for the majority of adults in RCs, 18 people[47] do not have a certificate attesting their disability status, raising questions about how they could be admitted and kept within the system, as well as about how the system can address their particular needs, since they also lack the needs assessments documents and recommendations that accompany any disability certificate.

Most beneficiaries have permanent disability certificates that do not require any subsequent disability assessment. Almost 96 percent of beneficiaries have disability certificates which are permanent, meaning that the certificate does not need to be revised by the assessment committee after a certain time.[48] Usually, permanent certificates are issued for people who have severe disabilities and have been assessed as having no prognosis for further rehabilitation.[49] While this may be the case for many adults with disabilities in RCs, it is likely that some persons in residential institutions have been assessed as having a permanent type and level of disability, due to lack of needed habilitation and rehabilitation services in RCs or in the community at the time

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[43] European Agency for Fundamental Rights (2018, 67-68).

[44] Government Decision No. 430/2008 for the approval of methodology regarding the organization and functioning of committee for the assessment of adults with disabilities, further amended and supplemented.

[45] A detailed analysis of the disability assessment system is included in Output 1: "Modernizing the Disability Assessment System in Romania", elaborated under the Reimbursable Advisory Services Agreement on "Modernizing the Disability Assessment System in Romania" signed between the National Authority for Persons with Disabilities and the International Bank for Reconstruction and Development on June 30, 2020.

[46] Order No. 82/2019, Annex 1, Module 1, Standard 1, Minimum Requirement 4.

[47] The 18 persons come from nine RCs, situated mostly in the northwestern part of Romania. Most persons (14) have been in RCs for at least 10 years.

[48] Currently, the validity of revisable certificates is 12 to 24 months.

[49] Law no. 448/2008 Art. 87(1^1) states that "For people with disabilities, whose affection has generated functional deficiencies and/or irreversible structural-anatomic deficiencies and who cannot pursue recovery programs, the Assessment Committee will establish a permanent disability certificate, without the obligation of periodic reevaluations." The law does not specify whether the impossibility of pursuing recovery programs is caused by the lack of programs or by the state of the person.

of the assessment, as well as a model of disability assessment, based on medical criteria about what the person cannot do rather than on what the person needs in order to live independently and inclusively in society.[50] A permanent certificate can be an indicator for permanent institutionalization, and may deprive residents of the possibility for future assessments that could identify changes regarding their type and level of disability, as well as needed services and activities.

The population in RCs is significantly different from the general population of adults with disabilities in Romania. A higher percentage of people with severe, intellectual, and psychosocial disabilities are institutionalized. Stigma and prejudice against persons with intellectual and psychosocial disabilities, as well as lack of services and support in the community for these persons and their families, may explain the higher rates of institutionalization. RCs also house a higher proportion of people with severe disabilities, and a lower proportion with a high degree of disability, while the rest of the categories (mild and low) are fairly close (Table 8). Overall, almost 45 percent of beneficiaries have been assigned a high degree of disability; 17 percent, severe; and 29 percent, severe, with the right to a personal assistant. Less than 8 percent are considered to have a mild degree of disability. Also, there are significant differences when it comes to physical, somatic, intellectual, and psychosocial disabilities. Although persons with intellectual disabilities represent 16 percent of the general adult population with disabilities, they, in fact, are the great majority in RCs—over 58 percent. Similarly, 17 percent of persons in RCs have psychosocial disabilities compared to 10 percent in the general adult population with disabilities. The relationship is reversed in the case of physical disabilities (almost 27 percent in general and only 7 percent institutionalized) and somatic (almost 20 percent compared to less than 1 percent in centers) (Figure 11).

Table 8: Comparison of Distribution of Degrees of Disability in the General Adult and in the Institutionalized Adult Populations (percent)

	Low	Mild	High	Severe
Adults with disabilities	0.9	9.3	51.6	38.2
Institutionalized adults with disabilities	0.8	7.9	44.8	46.3

Source: World Bank survey of residential centers (2020) and data from the National Authority for the Rights of Persons with Disabilities, Children and Adoptions, September 2020.

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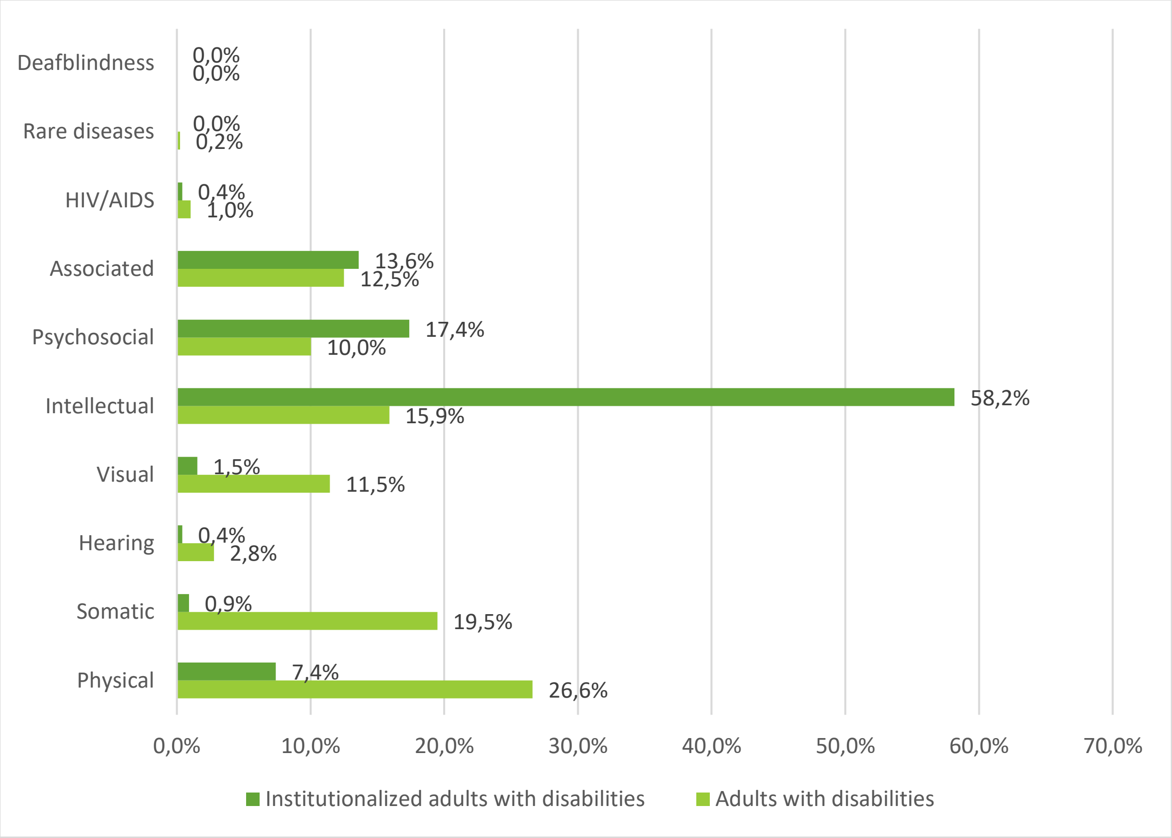
[50] The Ministry of Labor and Social Protection issued Methodological Instruction No. 6/2014, applicable from 31.07.2014, regarding the *List of Affections that Create Irreversible Disabilities and which Enable the Issuance of a Permanent Disability Certificate*. According to the methodological instruction, the confirmation of the irreversible quality must be attested by the absence of a functional benefit, caused by different therapeutical interventions, and is to be supported by specific medical documents. Thus, the evaluation of the irreversible quality of a disability is grounded on the existence of therapies at the time of the evaluation, rather than on aspects regarding the state of the person.

Figure 11: Comparison of Distribution of Types of Disability in the General Adult and in the Institutionalized Adult Populations



Source: World Bank survey of residential centers (2020) and data from the National Authority for the Rights of Persons with Disabilities, Children and Adoptions, September 2020.

While there are no significant gender differences in terms of disability degree, there are some in terms of type of disability. Men are slightly more likely to have physical disabilities than women, whereas women have more intellectual disabilities than men (

Table 9).

Table 9: Distribution of Type of Disability by Gender (percent)

	Physical	Somatic	Hearing	Visual	Intellectual	Psycho-social	Associated	HIV/ AIDS	Rare Diseases	Deaf Blindness
Men	9.60	1.00	0.40	1.20	55.90	17.10	14.40	0.30	0.00	0.00
Women	5.20	0.90	0.40	1.80	60.40	17.70	12.90	0.50	0.00	0.00
Total	**7.4**	**0.9**	**0.4**	**1.5**	**58.2**	**17.4**	**13.6**	**0.4**	**0.00**	**0.00**

Source: World Bank survey of residential centers (2020).

Age structure of beneficiaries in terms of disability degree and type is uneven. This situation reflects generational differences, current and past patterns of admission, differential rates of survival depending on the severity of the disability, and possible historically contingent procedures of assessment and allocation of degrees of disabilities. The persons who enter the system (those under 30 and over 60 years of age) have, in a higher proportion, more severe degrees of disabilities than the rest of the residents. The high number of deaths in the system[51] has affected those with higher degrees of disabilities more so, while those who are left (long-term residents, most in their middle age) have less severe forms of disabilities. Also, standards and procedures for assigning degrees of disability have changed over the past decades,[52] and this is likely to affect the way different people have been assessed, based on the time of assessment. At the same time, the deleterious effects of long-term institutionalization on motor skills and physical, emotional, and intellectual development, as well as on language and brain development, are well researched[53] so that it is more likely for long-term residents to have been placed in the RCs with milder forms of disabilities in the absence of other solutions, once they have left the children's residential system.

There are three types of generational profiles emerging (see Figure 12, Figure 13, and Annex-Table 5 for complete data):

- **The younger generations** (18 to 44 years of age) are more likely to have severe degrees of disability, with higher percentages for those who are younger. They also have—almost exclusively—intellectual, psychosocial, and associated disabilities. The age group of 30 to 34 years olds has the highest percentage of people with intellectual disabilities, as well as most of the people with HIV/AIDS (44 out of 53). Both characteristics are, most likely, the heritage of being the last generations born and probably institutionalized around 1989.

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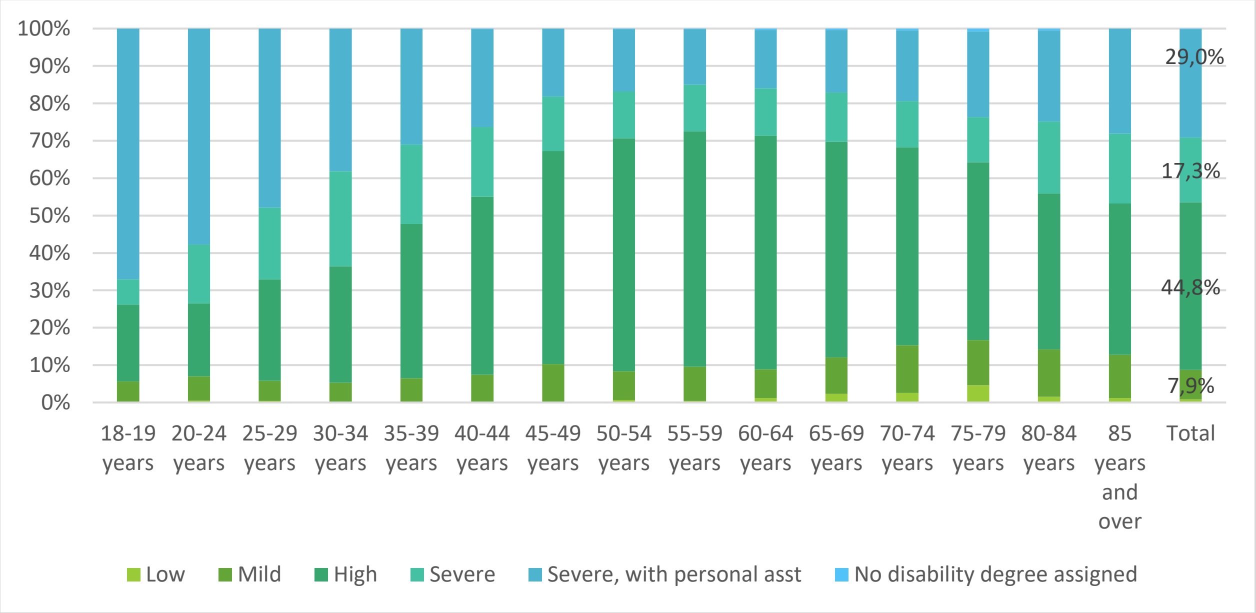
[51] According to a study carried out by the Center for Legal Resources between September 2017 and September 2018, 1,447 people with disabilities have died in residential institutions in Romania (Center for Legal Resources, 2019a). See data analysis, below, on the deaths registered in the protection system in 2019.

[52] Order no. 12.709/1.10.2002 (updated in 2015) on the criteria on the basis of which the degree of disability for children is established and their special protection measures are applied and Order no. 762/31.08.2007 for the approval of the medical-psychosocial criteria that establishes the degree of disability, which underwent multiple modifications between 2008 and 2019.

[53] Mulheir, G. & Browne, K. (2007, 11-19) and EEG (2012: 47-49).

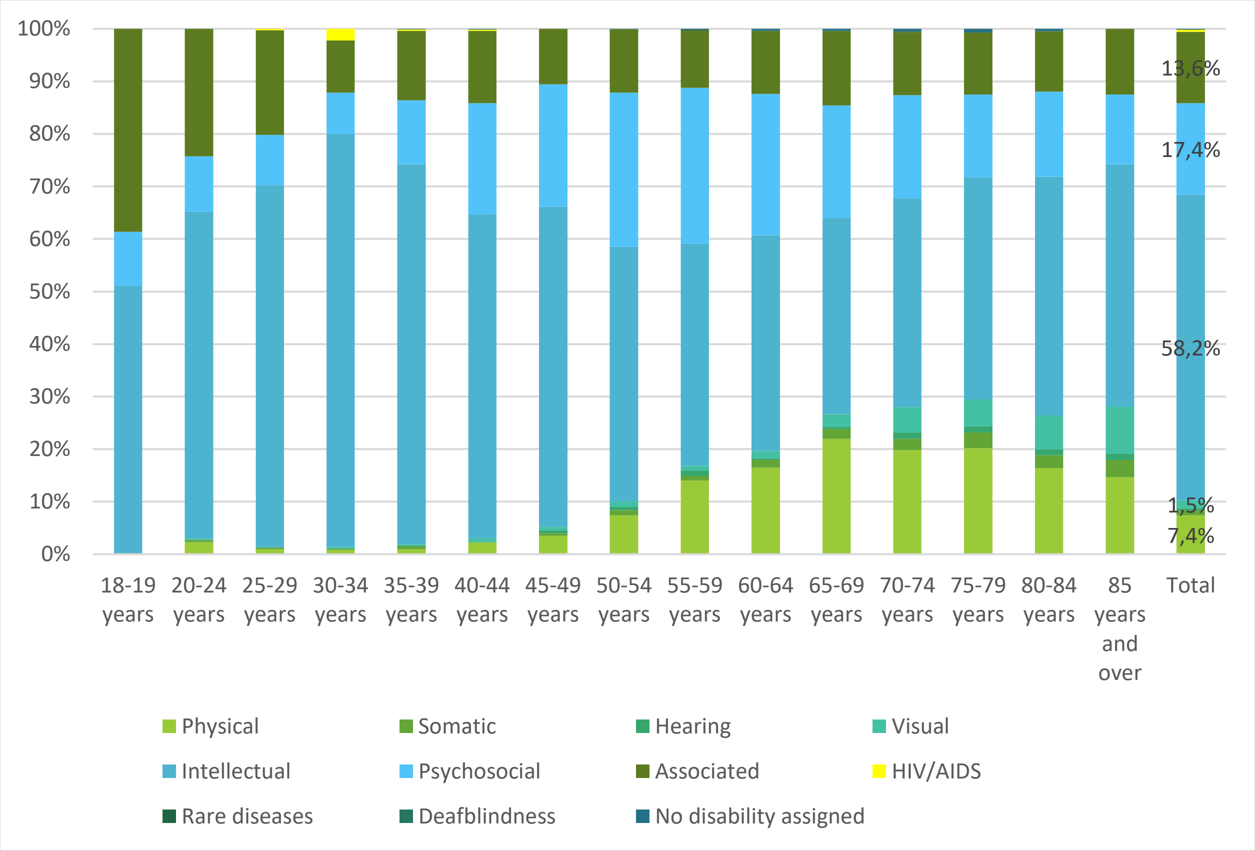
- **The middle aged/slightly older generations** have the lowest proportion of severe degrees of disability, as most are in the "high degree" group. These have decreasing proportions of intellectual disabilities, and higher of psychosocial. For instance, the age groups with the highest proportion of psychosocial disabilities are those of 50 to 64.
- **The elderly generation** (65 years old and above) have proportions of high and severe forms of disability that are approaching the average of the resident population, but much higher of low and mild forms. This suggests that residential institutions are used as a "solution" for the elderly in the absence of other possibilities within the family and the community. Also, while most have intellectual, psychosocial, and associated disabilities, they account for most of the people with somatic, visual, and auditory disabilities, which means that they are those who will need more physical and sensory accessibility accommodation.

Figure 12: Distribution of Degree of Disability, by Age Group



Source: World Bank survey of residential centers (2020).

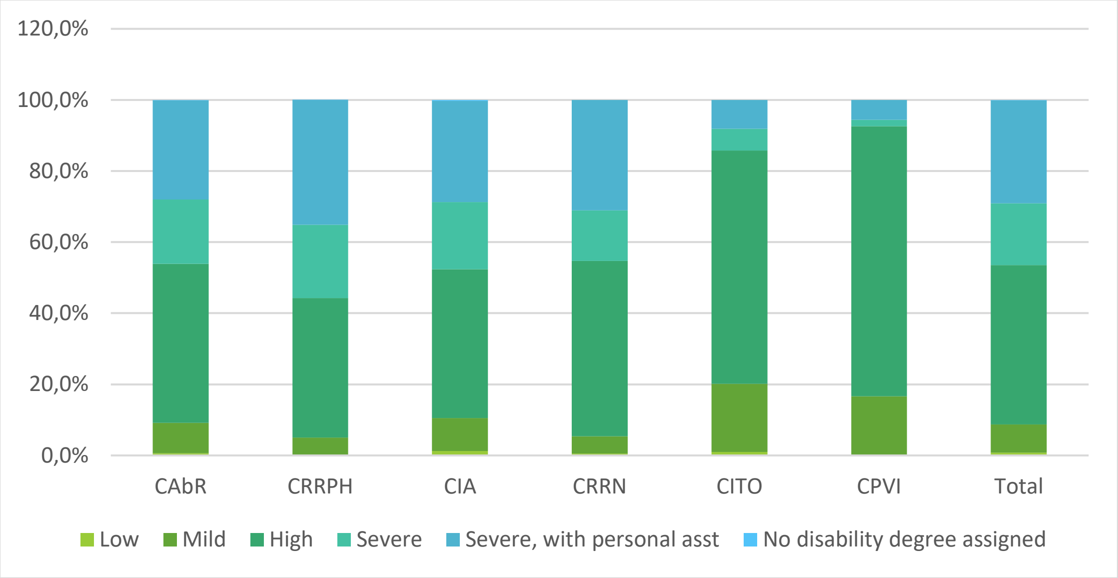
Figure 13: Distribution of Types of Disability, by Age Group



Source: World Bank survey of residential centers (2020).

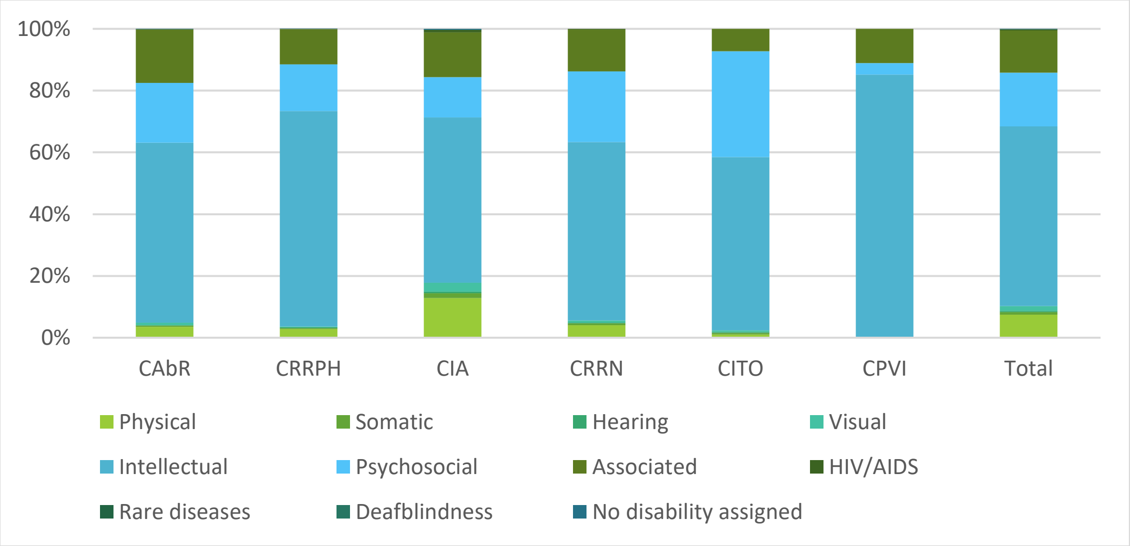
There is a tendency to concentrate persons with more severe forms of disabilities in larger, older types of institutions. On the one hand, CIAs, CRRPHs, and CRRNs house much higher percentages of persons with severe forms of disability, and lower proportions with mild and high forms. On the other hand, in CPVIs, only a small percentage of residents have severe degrees of disability—7.5 percent compared to the average of 46 percent in institutions, and more than double the average of people with mild forms. Moreover, CPVIs concentrate the highest percentage of persons with intellectual disabilities, and the lowest with psychosocial. CITOs are similar, in that they have lower proportions of persons with severe disabilities, and higher with mild and high. CITOs, however, have much higher-than-average proportions of persons with psychosocial disabilities. It also is interesting to note that CIAs and CRRNs have higher proportions of persons with physical disabilities (Figure 14 and Figure 15).

Figure 14: Distribution of Degree of Disability, by Center Type



Source: World Bank survey of residential centers (2020).

Figure 15: Distribution of Types of Disability, by Center Type



Source: World Bank survey of residential centers (2020).

1.3. Trajectories of Institutionalization

1.3.1. Entering the System

A large number of admissions to RCs are still being processed. Between January 1, 2019 and October 1, 2020, 858 adults entered the system. One-third of them were under 29 years old, and one-third over 65, a trend that is consistent with the reality of the past few decades; namely, people entering the system after leaving some form of child protection measure (especially RCs) or after becoming old and not being able to care for themselves (or be cared for by their families).

The profile of people entering the system during this period is different from that of those already in the system. Persons recently admitted to RCs have, in a greater proportion than those already in the system, severe forms of disabilities (58 percent compared to 44 percent), a physical disability (the percentage is double), or an associated one. The proportion of newly admitted people with intellectual disabilities is much lower, and that of people with psychosocial disabilities just slightly lower.[54]

Most newly admitted persons were placed in the old type of RCs. Despite undergoing a restructuring process that is meant to transform large, traditional centers, the system is still replenishing those centers with newcomers. About 70 percent of those, who requested admission to the system in 2019, had their request approved to traditional centers (CRRNs, CRRPHs, and traditional CIAs). At the same time, approximately 90 percent of people entering the system between January 1, 2019 and October 1, 2020 went to CRRNs, CIAs, CRRPHs, suggesting that placements are made depending on the availability of places rather than need or plans to implement reform.

There are two main routes to enter the system of RCs for adults: (1) from the community, due to lack of community resources and the family's inability to care for the person; and (2) from the public system of RCs for children (Table 10). Of course, there are other ways to enter the system, but the percentages are much smaller: some originate from psychiatric hospitals or other types of hospitals, some from centers for the elderly, and some come directly from the street or a night/emergency shelter for homeless people.

Table 10: Reasons for Institutionalization, by Age Group (multiple answers)

	Age at the Time of Filling Out the Questionnaire (percent of age group)						
	18–24	25–34	35–44	45–54	55–64	65+	Total
Family/relatives were not able to care for them	33.9	37.6	43.5	59.0	70.3	73.7	53.4
Loss of personal assistant	1.1	1.0	0.3	0.2	0.3	0.8	0.6
Come from the child protection system and were transferred due to lack of alternatives within the community	54.3	52.6	38.7	22.2	7.1	1.9	29.0

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[54] The percentages are as follows: for physical disabilities 15.4 percent for those who just entered the system compared to 7.4 percent for those in the system; for intellectual disabilities, 41.7 percent compared to 58.2 percent; for psychosocial, 14.7 percent compared to 17.4 percent; and for associated, 22 percent compared to 13.6 percent.

Come from the child protection system and were transferred due to other reasons	26.0	22.0	19.3	11.5	4.4	1.4	13.7
There are no care-at-home services in the area where they live	1.9	2.8	3.8	8.2	13.7	17.3	8.2
There are no other types of service they need within the community	3.3	4.2	6.2	9.8	16.4	16.9	9.5
Other reasons, as follows:	1.1	1.9	3.8	5.0	8.0	10.2	5.2
Transfers from another residential center; no information on the reasons of institutionalization	0.1	0.9	1.6	1.8	2.9	2.3	1.7
Social case (no family, no income, no place to live)	0.1	0.6	1.4	2.3	3.4	4.3	2.1
Transfer from a psychiatric hospital	0.0	0.1	0.2	0.3	0.3	0.3	0.2
Need for specialized services	0.3	0.1	0.2	0.2	1.1	2.9	0.8
No information on the reasons for institutionalization	6.3	8.8	9.1	9.9	8.5	8.9	8.8
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: World Bank survey of residential centers (2020).

Entering from the community

Lack of family support is one of the main reasons for institutionalization. Of all the people in the system, more than half were institutionalized because their families could not care for them and chose to place them in a state facility. For those who entered the system between January 1, 2019 and October 1, 2020, that percentage is higher, rising to 64 percent. Elderly people are more likely to be institutionalized due to lack of family support. More than 80 percent of those over 65, who entered the system after January 2019, did so because their family was not able to care for them. One-third of them died before October 2020.

RCs are most likely used by families as care facilities for the elderly, and this has implications for the process of transition and deinstitutionalization. The overall percentage of people, who have known family or relatives, is high (almost 68 percent), but it goes up to 83 percent in the case of those with low degrees of disability and almost 77 percent for those who are over 65 years old. It is not surprising, then, that more than a third of people, who entered the system between January 1, 2019 and October 1, 2020, were those over 65 years old. The main reason for entering the system is primarily because the family was not able to care for them.[55] It also is worth noting that three-quarters of residents who own a house or an apartment are also those over 65, and these are more likely to be people who have entered the system as older adults than earlier in their lives. Even with the higher mortality rate,[56] the elderly represent, then, a steady and persistent segment of the resident population,[57] posing a challenge to how the centers and the system will handle the process of deinstitutionalization. It already is clear that the younger people and those with less severe forms of disabilities are favored for transfers and deinstitutionalization,[58] and are seen as more "fit" for independent life and more "worth" investing in for reintegration into the community. For this reason, the process of transition and deinstitutionalization must find ways to prevent older people from being left behind and not treat them as only beneficiaries of palliative/end-of-life care.

Lack of community services contributes to institutionalization. While most people are institutionalized because their families no longer can take care of them, the lack of community services appears to be another predominant cause. The expectation for families to take on the responsibility of offering services to adults with disabilities is also a necessity currently in Romania due to lack of other community-based services and means to offer support. Services could assist people with disabilities to live independently or they could provide support to the family carers. Of the 13,076 people in the system regarding whom data were collected for this report, 8 percent have been institutionalized because of no home care services available in their communities, and almost 10 percent because there were no other kinds of support. For persons admitted during the period 2019–20, the numbers are even higher: 16 percent and 14 percent, respectively. Moreover, before entering the system, most who came from the community had not experienced any disability-specific social service. The service that had most been benefitted from was in-home care (22 percent), followed by personal assistance (5 percent), and rehabilitation services (1 percent). These numbers reflect the abysmal situation in the country in terms of social services: out of more than 4,400

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[55] The percentage of people who have entered the system because their families cannot care for them any longer goes up progressively, from about 34 percent for 18–24 years old to 74 percent for those over 65.

[56] See Section 1.3.3.

[57] Data from the NARPDCA website show that the number and proportion of residents over 65 has remained relatively stable over at least the past six years. For example, in 2014, there were 4,188 people over 65 out of a population of 19,985 residents and, in 2017, there were 4,275 people over 65 out of 19,985 (GOR, 2020).

[58] The age structure of the newly created CPVIs shows that most people are young (98 percent are under 44 years old).

people, only 21 had prior services to prepare them for independent living, 15 had received support from day centers and, three, mobile unit services.

Entering from public care

Having been a child with disabilities within the public care system and, in particular, in the residential system, makes him/her extremely dependent on institutionalization as an adult, possibly for the rest of his/her life. Children with disabilities have a higher chance of ending up in the public care system, and not necessarily because of abuse and neglect, but because of tradition as well as the lack of services in the community that would support parents to care for them. Children with disabilities also tend to spend more time within the system.[59] Once the special protection measures under which they fall under expire,[60] many are faced with no other solution than to continue being institutionalized. They have never lived independently, the institutional culture did not allow or teach them to make decisions for themselves, and they have not been integrated in a community. Their entire social experience has solely been with other residents, institutional staff, and the relationships they have created within the confines of the institution. They are forced to live in an environment not set up to accommodate their needs in the mainstream nor through the offer of social services.[61]

It is not surprising, then, that a 2020 report—published by SOS Children's Villages Romania and based on data collected between 2014 and 2017[62] —points out that close to 60 percent of children with disabilities, who leave the child protection residential system, continue their institutional route by being transferred from one institution to another, ending up in one for adults. What is even more concerning is that according to the same project's unpublished data, children with other types of placement measures also end up being institutionalized in RCs meant for adults.[63] This brings the proportion of children with disabilities, who left the child protection system in the period 2014–17 and continue being institutionalized as adults, to 46 percent.[64]

The overwhelming majority of young people entering the system come from the child protection system, with a majority of them having been institutionalized as children. During 2019 and 2020, 76 percent of those entering the system at age 18–24, as well as 24 percent of those at age 25–44, came from the child protection system.

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[59] Stănculescu et al. (2017).

[60] According to the law, special protection measures cease when a person reaches 18 years of age. At 26 years old, those who continue their studies or are maintained, on request, on a two-year period (e.g., when they do not continue their studies and have no possibility of returning to their families), they face the risk of social exclusion. Law No. 272/2004 regarding the protection of promotion of children's rights, Art. 55.

[61] World Bank (2020).

[62] SOS Children's Villages Romania (2020).

[63] Approximately 21 percent of youth who have been placed in foster care with a Professional Maternal Assistant, and 2 percent of those who have been placed with the family, ended up in RCs for adults with disabilities, once their protection measure had expired.

[64] Ibid. Data collected by Sociometrics from the 47 GDSACPs within the project.

Moreover, out of 696 young people with disabilities, for whom the protection measure ended in 2020, over 65 percent were approved admission into the adult residential system or were near approval. Almost three out of four young people entering the system from the children's public care have intellectual disabilities (a proportion much higher than for the rest of the residents); more than 10 percent have psychosocial disabilities, and 15 percent have associated disabilities; other types of disability are barely represented. Furthermore, the disabilities tend to be of a severe degree.

The public child protection system has been a major source from where those in the adult residential system originate and continues to be so. More than four in 10 persons with disabilities currently in RCs (regardless of when they were admitted) were institutionalized as children and, most likely, have spent the better part of their lives in a residential institution. Over the past few decades, they have made the transition, either because there were no alternatives within the community or for other reasons. The greatest influx, in terms of numbers, appears to the generation born in the late 1980s, who were—at the time of data collection—in the 30 to 34 age group. This is the last generation born and abandoned in state orphanages during the socialist era's pro-natalist measures (abortion was illegal and heavily criminalized and controlled), and their profile and challenges highlight the damaging effects of institutionalization for children in the late 1980s and early 1990s. A study on Romania, commissioned in 1991 by UNICEF, estimates that there were between 142,000 and 200,000 children institutionalized in the country at the time, or 4 percent of the child population.[65] Another UNICEF study estimates that about 11 percent of children were abandoned in the system because they suffered from a disability or HIV/AIDS.[66] Moreover, the same study suggests that institutionalization also has caused children to suffer from additional disabilities or it has exacerbated existing ones due to neglect, poor treatment, and the general conditions of institutionalization. The generation of children born during those years also presented high prevalence of infections with HIV and later high mortality due to HIV/AIDS, and many of those children were part of the institutional system. A Human Rights Watch report published in 2006 [67] gave warning of this, including the challenges this generation will face once they leave the child protection system. It is not surprising that most of the adults, who are currently institutionalized in RCs and living with HIV, fall within this age group.

While still high, the proportion of those from the child protection system entering the adult residential system is lower than previously, partly due to demographic changes within the general population and partly to structural changes within the child public care system. One out of three people entering the system, between

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[65] Himes, Landers, & Kessler (1991).

[66] UNICEF Child Development Centre (1996).

[67] Human Rights Watch (2006).

January 1, 2019, and October 1, 2020, came from the child public care system, down 10 percent from the average 40 percent for those already in the system. This represents a drop most easily explained by increased entries in the rest of the age groups (particularly the elderly). The proportion for the older generations, who have been institutionalized as children, is getting smaller, all the way down to 3 percent for residents over 65—most likely an effect of dilution due to an influx of older residents coming in from the community. There are additional factors, however, that contribute to this change. The child's public care system has undergone some important structural changes over the past few years, increasingly favoring family-type residential solutions over institutional ones, in particular for the initial placement, but also for some of the children already in the system.[68] It is likely that this might have an influence, however small.

1.3.2. Moving within the System

The residential system works as a long-term and, often, final option for its beneficiaries. Entering the system most likely condemns the beneficiary to a lifetime of institutionalization. Indeed, more than half of residents have spent at least 10 years within the system, and almost a quarter have spent more than 20 years. A disturbing 10 percent of residents have been institutionalized in RCs for adults for at least 30 years, a rather significant proportion considering the high mortality rate (to be discussed in the next section). While there is some mobility within the system, a significant number of residents have remained institutionalized in the same center for a significantly long time: 6 percent of beneficiaries have spent the last 30 years (some more) in the same center; 15 percent, the last 20; and 40 percent, the last 10 years (Table 11).

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[68] Stănculescu et al. (2017).

Table 11: Distribution of Beneficiaries by Length of Institutionalization in the Protection System for Adults with Disabilities and in the Current Residential Center

		Length of Institutionalization in the Protection System for Adults with Disabilities		Length of Institutionalization in RC*	
		Number	Percent from Total Number of Beneficiaries	Number	Percent from Total Number of Beneficiaries
Number of years	<= 2 years	1,479	11.3	2,234	17.1
	3–5 years	1,852	14.2	2,516	19.2
	6–10 years	2,762	21.1	3,102	23.7
	11–15 years	2,349	18.0	2,295	17.6
	16–20 years	1,608	12.3	914	7.0
	21–25 years	946	7.2	587	4.5
	26–30 years	811	6.2	592	4.5
	31+ years	1,247	9.5	836	6.4
	Missing information	22	0.2	0	0.0
	Total	**13,076**	**100**	**13,076**	**100**

Source: World Bank survey of residential centers (2020).

There is a fair amount of mobility within the system, likely accelerated by the restructuring process, but it may come with emotional and social costs for the residents. About one-third of people in the RC system have been moved to another center at least once, and this number is bound to increase as restructure takes place, requiring the breakup of larger centers and the transfer of residents to sheltered housing or places where there are vacancies.[69] The restructuring process will remove over 4,000 residents from their current placement, and will transfer them to new living situations (i.e., completely new social settings). While mobility, in itself, is a requirement of the deinstitutionalization process, there is a risk that the selection of residents to be moved, as well as the new centers where they will be placed, will not include sufficient consultation with the residents themselves.[70] While the transfer only can be processed through written request, initiated and signed by the residents themselves (in the case that they have legal capacity), it is unclear exactly how that process will operate in practice.

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[69] More data on the transfer of beneficiaries from centers with more than 50 undergoing restructuring to other residential centers are included in Chapter 3.

[70] These aspects, and the way residents were consulted on their transfer options, is discussed in Section 3.

Mobility within the system might signal a lack of alternatives. The transfers that are part of the restructuring system are, by design, a process of moving residents around the county or within the country, depending on where the vacancies are located. Moreover, moving from an RC to a sheltered house does not mean leaving the system for good. During the period 2019−20, more than 100 people entering RCs came from such sheltered housing, which seems to have failed to function as a transition toward independent living and inclusion within the community.[71]

1.3.3. Leaving the System

Even though more people leave the system than come in, the difference between entries and exits is small and does not mean that the system will become depleted. At the time of the survey for this report, there were 1,388 people on waiting lists to be admitted into an RC. Between January 2019 and October 2020, 858 adults were admitted into the system, while 1,617 left due to the end of their contract. An additional 331 moved to other centers, 22 people had their contracts suspended, and two were admitted to psychiatric units as a safety measure. This downward trend in the total institutionalized population also is evidenced in NARPDCA public data, indicating that the number of residents has been steadily decreasing over the past four years by almost 1,000 people. Even so, assuming that the trend continues at the same rate, it would take 64 years for the system to run out of beneficiaries.

People leaving the system are older, have spent less time in the system, and have a higher proportion of physical disabilities, while in terms of degrees of disability, their profile is very similar. Almost 60 percent of those who were discharged from the system were 65 years old or older (compared to 21 percent of the resident population), 15 percent of whom had a physical disability (compared to 7 percent). What is remarkable, but consistent with the profile of an older resident relinquished in the system towards the end of her/his life, is that 60 percent of those who left the system have spent less than two years in these institutions. (Figure 16, Figure 17, and Figure 18). This points to a conclusion that is consistent with the rest of the data—that RCs act as end-of-life solutions for adults with disabilities who have spent most of their lives within the community, living either independently or with their families. This suggests that, even with family or material support of the family and with some social and material resources (they have higher proportions of people who have family and own a house/apartment), they lack the services and the support necessary to continue to live at home.

Figure 16: Profile of Center Residents (October 1, 2020), Newly Admitted Residents, Residents Who Exited the System, and Residents Who Have Died (January 1, 2019 to October 1, 2020), by Age Group

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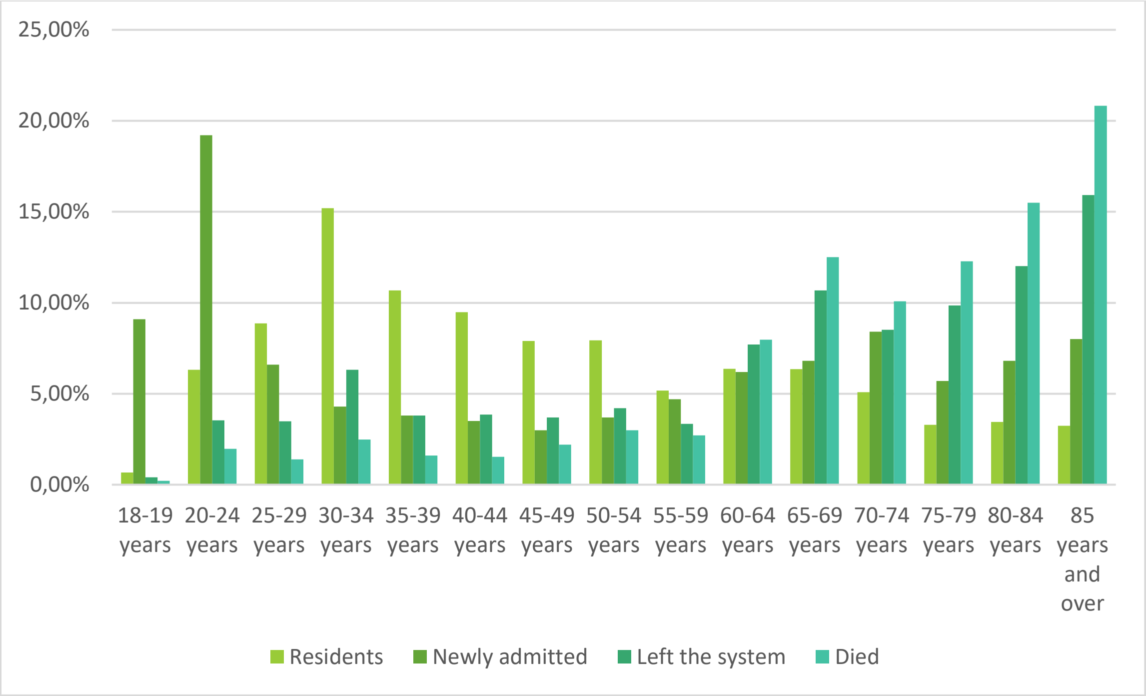
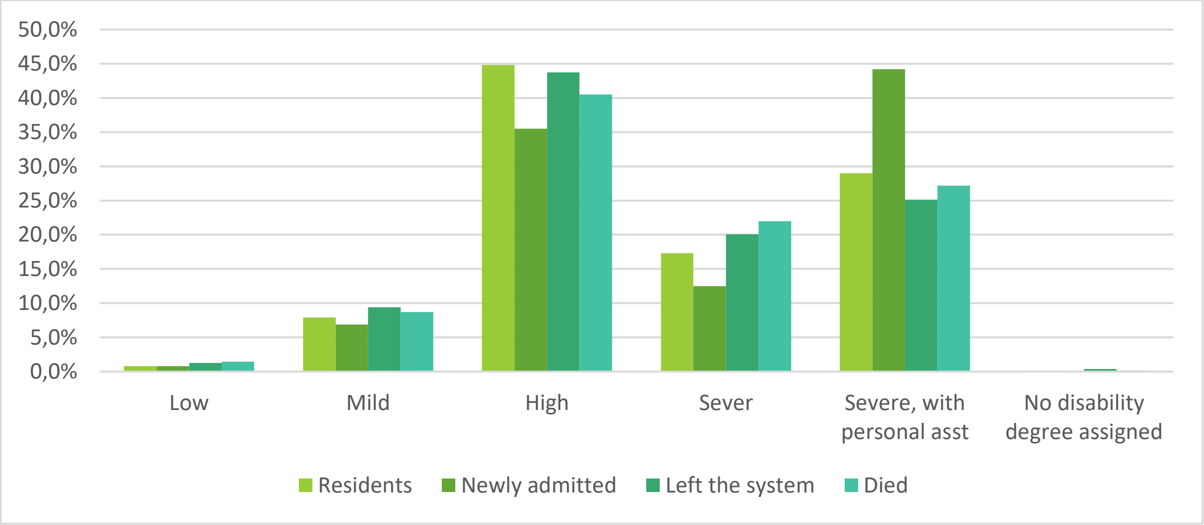
[71] An analysis of how sheltered houses fulfil their role of preparing persons with disabilities for independent living is included in Output 9: "Complex diagnosis report of the services for adult persons with disabilities at the community level".



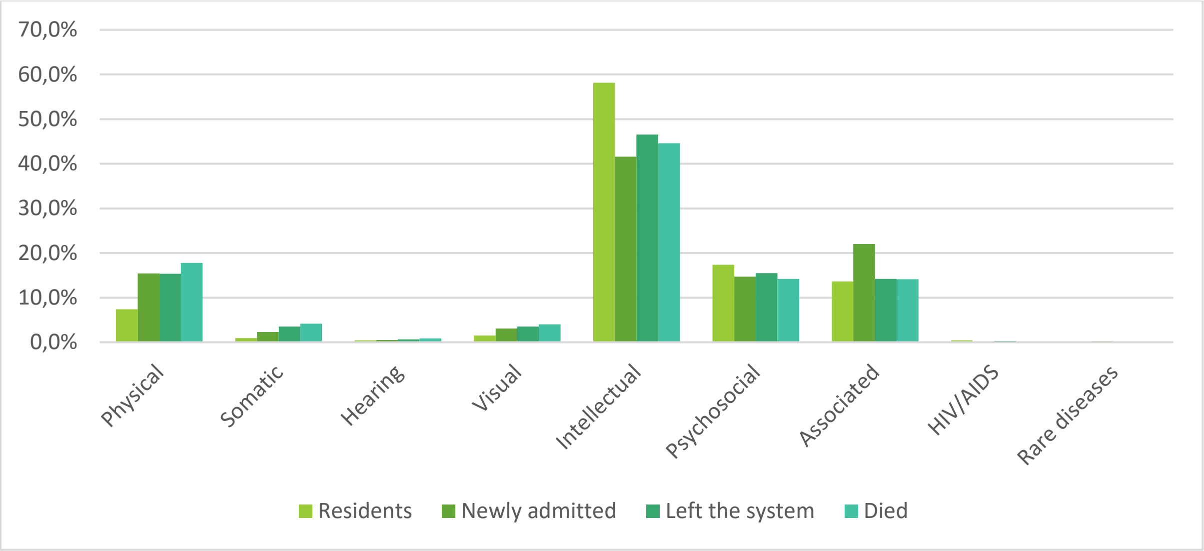
Source: World Bank survey of residential centers (2020).

Figure 17: Profile of Center Residents (October 1, 2020), Newly Admitted Residents, Residents Who Exited the System, and Residents Who Died (January 1, 2019 to October 1, 2020), by Degree of Disability



Source: World Bank survey of residential centers (2020).

Figure 18: Profile of Center Residents (October 1, 2020), Newly Admitted Residents, Residents Who Exited the System, and Residents Who Have Died (January 1, 2019 to October 1, 2020), by Type of Disability



Source: World Bank survey of residential centers (2020).

Deaths

The residential system works as a life-long "solution" for its residents as the mortality rate of beneficiaries of RCs is considerably high, and the main way of leaving it is death. About 70 percent of those who left the residential system during the period 2019-2020 had died, that is 1,368 persons amounting for 6 percent of the entire resident population. From a legal and administrative standpoint, the system works as a final option for its beneficiaries, when there are no other alternatives which would allow them to stay in the community.[72] The situation is surprisingly similar to the one in 2014, when the cause for leaving the system was death for 76 percent of residents (IPP, 2015: 18).

Death certificates of residents who died between January 1, 2019 and October 1, 2020 indicate a various number of causes. Data collected shows that of the 1,368 deaths, 60 percent took place in the center, approximately 40 percent took place in a hospital setting, and for 299 cases, there was sufficient cause for a criminal inquiry. Inquiries, however, concluded that there were no cases of neglect, abuse, or mistreatment. The majority of death certificates states the main and secondary causes of death as having been due to "cardio-respiratory arrest" or conditions related to cancers, although a number of death certificates included other causes such as: 32 cases of sepsis/toxic-septic shock associated with infections (including 10 cases of peritonitis not associated with other conditions, and one to multiple decubitus ulcers); 13 cases of mechanical asphyxia (including one by drowning, two by hanging, five with food); four contusions; one intoxication from polyethylene glycol; and one from ketoacidosis. This data is congruent with a report by the Center for Legal Resources (2019a), which identified 948 deaths in RCs for adults with disabilities and 479 in psychiatric hospitals or wards between September 2017 and September 2018, including

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[72] According to Law no. 292/2011, Art. 89 para. (1) and Law no. 448/2006, Art. 51 para. (5).

some of the deaths presenting causes that may suggest neglect and poor care (e.g. respiratory infections, mechanical asphyxia with food, intestinal occlusions, hepatitis B and C, malnutrition, cachexia, peritonitis, intoxication with a corrosive substance, decubitus ulcers over-infected with E-Coli, and Bacillus Pyocyanic). Consequently, data collected for this assessment require further investigation to analyze the contexts in which these deaths occurred in order to prevent them and increase the quality of care.

Table 12: Mortality rate of beneficiaries of residential centers (per thousand)

	Residential Centers (average of 2019 and 2020)
20-24 years	16.4
25-29 years	8.2
30-34 years	8.6
35-39 years	7.9
40-44 years	8.5
45-49 years	14.5
50-54 years	19.7
55-59 years	27.3
60-64 years	65.5
65-69 years	103.0
70-74 years	103.8
75-79 years	194.9
80-84 years	235.0
85 years and over	336.9

Source: World Bank survey of residential centers (2020).

Mortality and morbidity indicators for beneficiaries of RCs in Romania need to be further examined. Persons with disabilities have the same rights related to access to health services as the rest of the population. Understanding mortality and morbidity causes and eliminating factors that are not strictly related to comorbidities associated with disabilities would help identify disparities in access to health services, in particular prevention/screening and treatment, as well as remedies.[73]

A useful approach is to examine the health problems that are prevalent among the population of persons with disabilities, and the response of health services. For example, with regard to various types of cancer, in different countries, persons with

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[73] For example, data from a study on mortality among persons with intellectual disabilities institutionalized in Israel compared to the general population, are recommended to be used to improve services, to eliminate or reduce some risk factors and to help the Ministry in establishing a permanent mortality database that can be used to monitor the quality of care for this population, Merrick, J. (2002).

disabilities are diagnosed in a higher percentage at a more advanced stage of the disease and receive treatment in a lower percentage than the general population. The situation is more serious in patients with severe disabilities and mental or communication impairments. Major disparities exist especially in terms of screening[74] and access to specific health services.[75] Thus, these disparities have been documented for a variety of cancers, such as gastric,[76] lung,[77] prostate,[78] and breast and cervical cancers,[79] and have been attributed in particular to disparities in testing rates/screening and access to services. Collecting data on the incidence of such health problems and analyzing them in relation to the health services that are actually provided in RCs is essential as a sustained approach by the authorities to identify risk factors and increase the quality of care.

Another measure used to understand the mortality rate among adults with disabilities in a country/region is the ratio between the mortality rate of this population and the mortality rate of the general adult population in the same country/region. The ratio, especially when broken down by types of morbidity and causes of death affecting both types of populations, can provide valuable insights into the equity/inequity of access to health services (especially screening and early diagnosis) and specific needs, information that may lead to measures to improve health indicators. For example, in the United States, the ratio between the mortality rate in adults (over 20 years) with intellectual and developmental disabilities and the mortality rate in the general population of the same age is 1.8.[80] The authors of the cited study point out that differences in morbidity and mortality rates in the two populations are, of course, associated with existing disabilities, but a significant part are due to other factors such as poverty, access to adequate health and care services, and health problems, communication and self-advocacy. In the UK overall, the ratio is 3 for persons with intellectual disabilities[81] and specifically for England the ratio is 2.[82] A study conducted in two regions of Germany showed that this ratio is about 1.5 aggregated for all age groups (persons with intellectual and multiple disabilities, except for those with mild disabilities), but the ratio is close to 1 for people over 65 years.[83] The collection and analysis of such data is recommended, as well as the implementation of necessary

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[74] Merten, J. W., Pomeranz, J. L., King, J. L., Moorhouse, M., & Wynn, R. D. (2015).

[75] Cuypers, M., Tobi, H., Huijsmans, C., van Gerwen, L., Ten Hove, M., van Weel, C., Kiemeney, L., Naaldenberg, J., & Leusink, G. L. (2020).

[76] Kim, H. W., Shin, D. W., Yeob, K. E., Cho, I. Y., Kim, S. Y., Park, S. M., Park, J. H., Park, J. H., & Kawachi, I. (2020).

[77] Shin, D. W., Cho, J. H., Noh, J. M., Han, H., Han, K., Park, S. H., Kim, S. Y., Park, J. H., Park, J. H., & Kawachi, I. (2019).

[78] Shin, D. W., Park, J., Yeob, K. E., Yoon, S. J., Jang, S. N., Kim, S. Y., Park, J. H., Park, J. H., & Kawachi, I. (2021).

[79] Horner-Johnson, W., Dobbertin, K., Andresen, E. M., & Iezzoni, L. I. (2014).

[80] Lauer, E., & McCallion, P. (2015).

[81] McCarthy and O'Hara (2011: 382–386).

[82] Heslop, P. and Glover, G. (2015).

[83] Dieckmann, F., Giovis, C. and Offergeld, J. (2015).

measures such as testing/screening and ensuring early access to treatment, in order to improve both the health of the beneficiaries in the system and their chances of survival.

Returning to the community

Less than 9 percent of people leaving RCs return to the community. People leaving RCs most likely return without much support in terms of social services in their home communities; however, they may have the advantage of other types of support (family, partners, friends), or have a degree of autonomy that allows them some form of independent life. About 56 percent of those who returned to the community live with their partner or their immediate/extended family, and another 22 percent live with a substitute family or another person they know. Less than 10 percent live by themselves. The number and the proportion of those returning to the community are lower than in 2014, from 18 percent (250 beneficiaries) in 2014 to 9 percent (162 beneficiaries) in the period 2019–20.[84]

For those returning to the community, an RC works as a temporary measure, as they tend to spend less time in the center than the rest of the residents. About 31 percent of those who returned to the community had spent less than two years in the system (compared to 11 percent for other residents). They also have a particular age profile, in that one-half are between 30 and 50 years old, one-third are over 65, and one-tenth are over 85.

Sheltered housing

A minimal number of residents leave RCs to transfer to sheltered housing. Less than 2 percent of those who left RCs between 1 January 2019 and 1 October 2020 (34 people) transferred to sheltered house. At the time of data collection, a surprising number of people (109) living in RCs had previously lived in sheltered housing and, for unknown reasons, had requested re-admittance to the residential centers. Sheltered housing is the main instrument for deinstitutionalization that is pursued for now in Romania. By the end of 2021, another 1,239 people will have been transferred to sheltered housing, an ambitious undertaking considering that it has taken two years to transfer the 34 people mentioned above. There are no criteria or guidelines for selecting candidates for such housing, although qualitative data from interviews with GDSACP directors suggest that it is likely that people with more severe forms of disabilities—including those with intellectual, psychosocial, or associated disabilities—will less likely be selected. There are no current and systematic plans to prepare residents for transfer nor in relation to the accommodation process.

1.4. Profile of Staff

Employment in RCs is generally full time and open ended. On October 1, 2020, there were 13,439 employees in RCs for persons with disabilities in Romania. Most employees have a full-time employment contract, with only a few (3 percent) on part-time

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[84] Institute for Public Policy (2015, 17-18).

contract. Others work in centers as collaborators or are on other types of contracts. CITOs have the lowest percentage of full-time employees, at 52 percent. At the same time, more than 70 percent of staff works on open-ended contracts, primarily at GDSACPs but also at RCs. Generally, few employees work simultaneously for other GDSACP services, other than doctors, physical therapy/kinesiology specialists, psychologists, social workers, and art therapists.

The highest numbers of employees work in CIAs, CRRNs, and RCs with a capacity of more than 20 places. Most employees work in CIAs and CRRNs, which accommodate most persons with disabilities in the residential system. Most employees also work in residential institutions with 20 places or more (94 percent), while almost half work in RCs with 50 places or more, which are those that will undergo restructure to decrease capacity[85] (Annex-Table 6).

The general profile of employees in residential institutions is that of a workforce composed mainly of women and middle-aged staff who have completed secondary education. Close to 80 percent of staff in RCs is comprised of women, with almost 88 percent employed in a specialized capacity. This is not surprising, since RCs intersect with the public sector, support services, and care work—domains that have a high concentration of females. Management and administrative roles also are dominated by women, who make up around two-thirds of all positions. The level of education of most is secondary and post-secondary vocational, given that the predominance of nurses and certain types of specializations, including some administrative positions, requires only a secondary level education at most. The relatively low number of university graduates (7 percent) is mainly concentrated in positions of management and some types of specialization (e.g., medical doctors, social workers, psychologists, and kinesiotherapy specialists) (Annex-Table 7). Nearly half of employees are of middle age, a percentage that registers little variation across different types of positions (management, specialized, and administrative staff), reflecting the age structure of active population at the national level.[86]

A large number of staff in RCs has the profile of medical care provider, while the number of habilitation and rehabilitation employees is much lower. Approximately 69 percent of employees in RCs are specialized staff, while the rest are in management and administrative positions, at approximately 2 percent and 29 percent, respectively. Medical assistants and nurses predominate the specialized staff in RCs (20 percent and 52 percent, respectively). The number of other types of specialized staff (e.g., habilitation and rehabilitation) is much lower (Figure 19). This distribution suggests that

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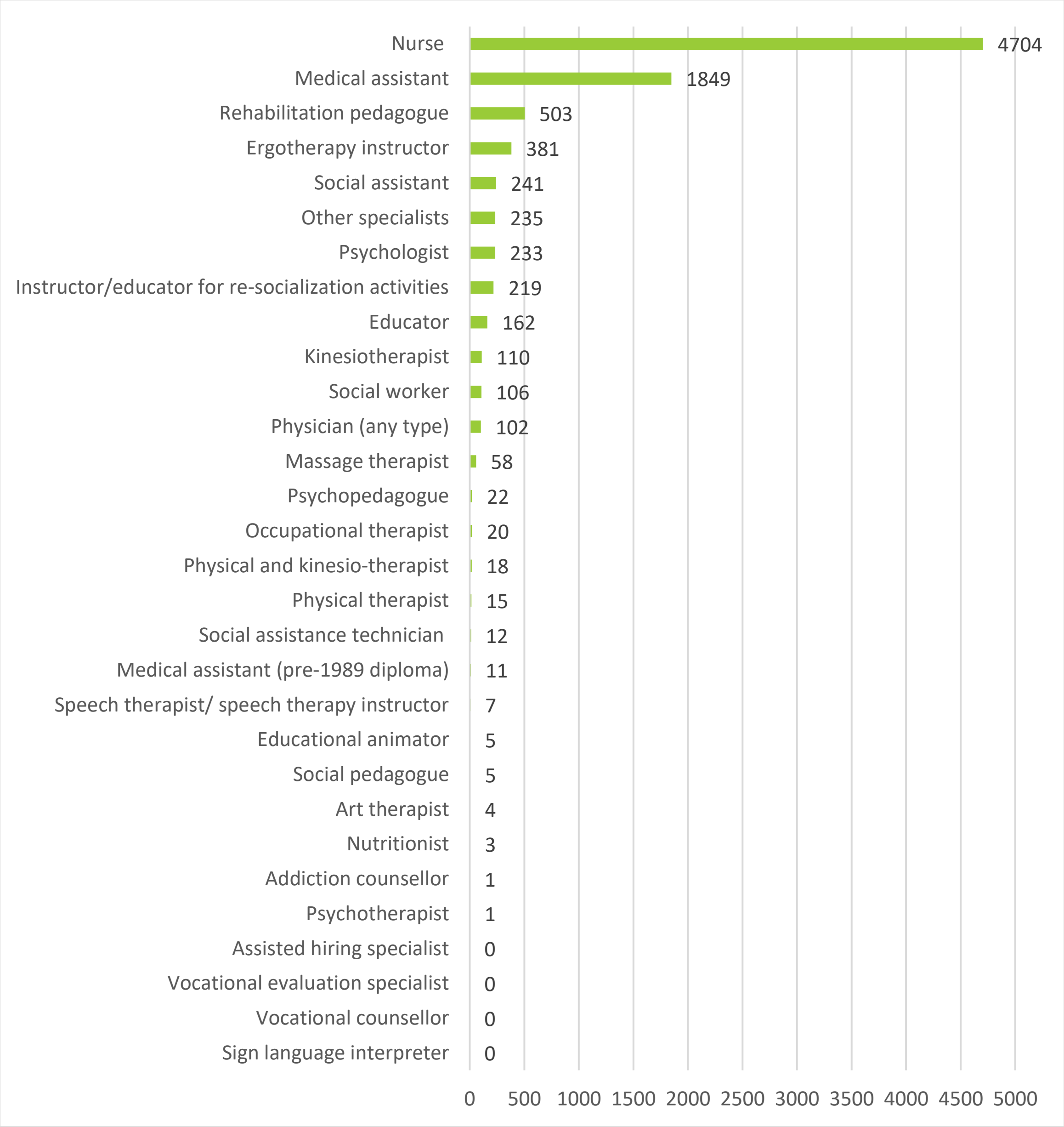
[85] According to Government Emergency Ordinance No. 69/2018 for amending and supplementing Law No. 448/2006 regarding the protection and promotion of the rights of persons with disabilities.

[86] National Institute of Statistics indicator AMG110A, available in Tempo database.

RCs provide more care and assistance to residents than they do habilitation and rehabilitation.

Figure 19: Number of Specialized Staff in Residential Institutions by Type of Specialization



Source: World Bank survey of residential centers (2020).

The high number of vacant positions in the residential system may have a considerable negative impact on the quality of service. There currently are 3,384 vacancies in the residential system, amounting to approximately 20 percent of positions indicate on organizational charts. Most vacancies are for specialized staff (close to 71 percent), with the rest for administrative staff. CITOs and CPVIs are most affected by staff shortages, with vacancies accounting for approximately 40 percent. In addition, certain number of counties have a high vacancy rate (approximately 40 percent), such as Bistrița-Năsăud, Covasna, and Sibiu.

Most positions have been vacant for a long period of time, suggesting recruitment challenges, especially within certain professions. Close to half of all vacant positions in RCs have remained unfilled during the past two years, although this varies by type of RC. While 96 percent of positions in CITOs have remained unfilled for longer than two years, 87 percent in CPVIs have been vacant between six months and one year. For specialized staff, more than half of the vacancies representing doctors, nurses and associated professionals, educators, movement therapists, masseurs, and speech therapists have been vacant for more than two years (Annex-Table 8). There appears to be no interest in filling these positions since in the majority of cases there was no public attempt to hire adequate professionals, pointing most probably to lack of recruitment resources. Eight out of ten positions, including those for specialized professionals (e.g., psychotherapists, social educators, occupational therapists, vocational counselors, or addiction counselors), were never publicly advertised. More unusual is the case of CPVIs, where half the vacancies were not advertised, and the other half was advertised more than three times, albeit unsuccessfully (Annex-Table 9).[87]

Many centers do not comply with the staff/beneficiary ratio established by current legislation. RCs that are licensed as social services (i.e., CAbRs, CIAs, and CPVIs) are expected to have a ratio between specialized staff and residents: 1/1.20 for CIAs, 1/1.23 for CAbRs, and 1/1.33 for CPVIs.[88] The majority of centers, however, remain noncompliant: 69 percent of CAbRs, 96 percent of CIAs, and 100 percent of CPVIs.

Retirement is the main reason for leaving employment in RCs. Over the past two years,[89] approximately 36 percent of RC staff that ended employment did so at the age of retirement. This is more common in centers of a maximum capacity of over 100 places (45 percent). The majority of these centers date from before 1989 (37 out of 41), a time with lower labor mobility, which may explain the higher percentage of staff that leave the RC only when they retire.[90] While transfer to other GDSACP services represents close to 9 percent of staff, those that left to work in a private social service amounted to only 1 percent. A significantly small number (5 percent) of staff that left was employed in a different field.

A large number of RC employees commute to work. Less than 60 percent of RC employees live and work in the same town, while 42 percent live in a different locality from the RC and have to commute to work. Management staff is more likely to commute than specialized and administrative staff; and staff that work in centers located in rural areas are more likely to commute than those in urban areas, at 48 percent and 36 percent, respectively. While expenses relating to commuting to work should be

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[87] The only CPVI in Brăila county that advertised its one job opening for a social worker/cook did so seven times.

[88] Government Decision No. 426/2020 (Annex 2) regarding the approval of cost standards for social services.

[89] January 1, 2019 to September 20, 2020.

[90] In addition, close to 60 percent of all retired staff had worked in centers dating from before 1980.

reimbursed from county budgets, according to the law,[91] only GDSACP Gorj county reimburses this expense for its RC employees.[92]

1.5. Financial Resources of Residential Centers for Adults with Disabilities

Analysis of RC financial resources focuses on revenues and expenditures in 2018 and 2019, based on data provided by GDSACP financial departments. In Romania, the funding of social services is based on minimum cost standards[93] and is covered by (1) state budget revenues, approved for this purpose through annual budget laws and assigned to each county; and (2) the budgets of the local public administration. If the costs necessary to provide a service exceed the threshold provided by the cost standard, the difference are to be covered from the local budgets of the counties and municipalities running that service. RCs for adults with disabilities are funded from the state budget through the GDSACPs to which they fall under.[94] RCs also can be funded from the monthly contributions of beneficiaries, donations, or other contributions from individuals and companies in Romania and abroad, as well as external reimbursable and non-reimbursable sources.

1.5.1. Revenues of residential centers

County Councils allocate funds to RCs based on the current number of residents and the average monthly cost per beneficiary, which are set every year by way of a Council Decision.

There are major differences in the average monthly costs set by county councils per beneficiary for the same type of service between counties and within the same county. County councils have uneven practices when defining these expenditures and can choose to (1) adopt the value set in national-level minimum cost standards (e.g., Dâmbovița, Hunedoara, and Harghita); (2) define the average monthly cost, based on the type of service (e.g., Alba, Giurgiu, and Galați); or (3) define the average monthly cost for each existing residential service in the county, regardless of its type (e.g., Arad, Bacău, Bihor, Vaslui, and Teleorman). There are counties in which the average monthly cost per beneficiary in a center is 50 percent higher than in other similar centers that are also managed by GDSACP (e.g., Iași, Bihor, and Bacău). This raises

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[91] Law 448/2006. Art. 56(1) and (2).

[92] In 2018, GDSACP Gorj spent RON 82,000 for the reimbursement of commuting expenses, increasing the budget to 100,000 in 2019. At the time of data collection, there were 195 commuting employees receiving an approximate reimbursement of RON 40 a month.

[93] A cost standard is the minimum amount needed to provide social services, and is set as a unitary cost per beneficiary, per type of social service defined at a national level. The minimum cost standards are the base for the county councils and the local council of Bucharest districts to set the average monthly costs for providing care to a person with disabilities, who resides in an RC managed by those councils, as well as for estimating the annual operational budget needed for those services. The cost standards during the reference period were those approved by GD No. 978/2015. Meanwhile, the cost standards were updated by GD No. 426/2020, this being needed as a consequence of the change of the minimum mandatory quality standards applicable to social services for people with disabilities, as well as to reflect the actual average costs for care provided to the beneficiaries of those services.

[94] Law No. 448/2006 on protecting and promoting the rights of people with disabilities, Art. 94, Law No. 292/2011 on social assistance, GD. No. 426 of 2020 on approving price standards for social services.

doubts about the way in which some social service providers define the cost while provide similar services to beneficiaries at the same level of quality. Furthermore, data show that for the same type of services and quality, average costs may be up to 80 percent higher between counties (compare, for example, Dolj or Giurgiu with Covasna or Satu Mare). No consistent link was found between the characteristics of the centers and the differences in average monthly costs, suggesting that it is more an efficiency issue in the way resources are planned and spent, rather than an issue of unequal access to services.

Average monthly costs, defined by county councils, have increased in most counties from 2018 to 2019. The average monthly cost per beneficiary across the entire system for persons with disabilities increased by 20.6 percent in 2019 compared to the previous year. Average monthly costs, defined by county councils, have been increasing yearly compared to the minimum cost standard at the national level. In 2018 and 2019, average monthly costs were 1.5 times and 1.8 times higher, respectively, than the standards set in late 2015. The main reason for this is because of a change in legislation, whereby public sector staff wages were increased.[95] GD No. 420/2020 took the higher wages into account and generally aligned minimum cost standards to the actual average cost per beneficiary at the national level (Table 13). The new cost standards should, in practice, lower the burden on county councils' budgets, as the current values of the standard costs mean that a higher share of the average monthly costs are currently supported by the state budget.

Table 13: Average Monthly Costs Defined by County Councils and Minimum Cost Standards at the National Level (RON)

	Minimum Standard Cost/Month/Beneficiary Set By GD No. 978/2015	Average Monthly Cos per Beneficiary in 2018 Set by County Council Decision	Average Monthly Cost per Beneficiary in 2019 Set by County Council Decision	Minimum Standard Cost/Month/Beneficiary Set by GD No. 426/2020
CIA	2,819	4,374	5,336	5,571
CRR	2,993	4,384	5,415	-
CRRN	3,156	4,937	5,724	-
CITO	2,273	3,302	4,198	-
CPVI	2,528	3,092	4,499	5,392
CAbR	-	5,476	6,502	5,660

Source: World Bank survey of residential centers: Financial resources (2020).

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[95] Framework Law No.153 per 2017 on the remuneration of staff paid from public funds, which set a unitary salary policy to be applied gradually until 2022. In 2018, for most staff categories in the public sector, the law brought an increase of 25 percent of gross monthly salary. At the same time, medical staff salaries have risen directly to the level scheduled for 2022, which has meant increases between 70 percent and 172 percent compared to December 2017.

The increase of average monthly costs in 2019, compared to 2018, was uneven across counties and type of RC. County councils had different approaches when establishing the average monthly costs in 2019: some did not change the value for 2018; some almost doubled them. At the same time, there are significant discrepancies among counties in terms of the amounts assigned to fund operating costs. While comparing various types of RCs, the lowest average cost increase during the analyzed period was in CRRNs (15.9 percent), while the highest was in CPVIs (45.5 percent).

Budgeted monthly cost for goods and services per beneficiary (a part of the monthly cost for providing care services to adults with disabilities) also increased, yet to a lesser extent. Overall, costs for goods and services, established by county councils, increased from RON 1,111 per beneficiary per month in 2018 to RON 1,245 in 2019, (12.1 percent). The proportion of goods and service costs, however, slightly decreased at the national level, mostly because of the higher increase in the percentage of staff costs. There are quite significant variations among RCs in terms of the proportion of goods and service costs per beneficiary—from 10 percent of total costs in the case of an RC for persons with disabilities in Satu Mare to 51 percent for a CPVI in Brăila.

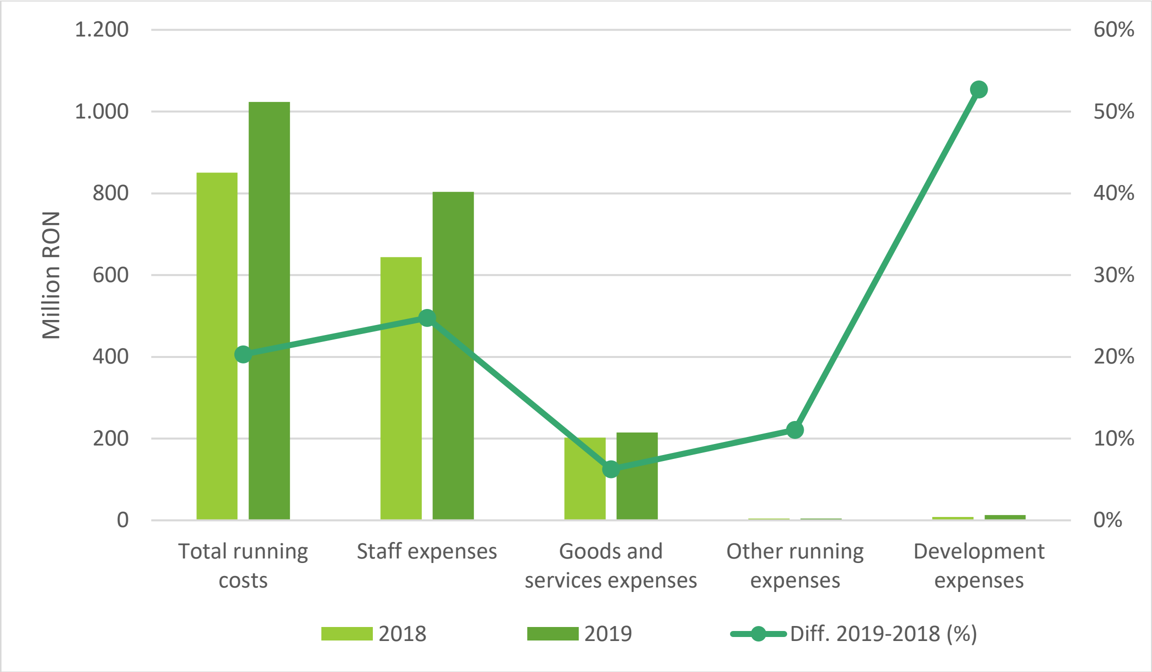
Overall, about 97 percent of RC revenues derive from county councils and from the state budget. At the national level, county councils and the state budget contributed to the funding of RCs with approximately RON 1 billion (approximately EUR 210 million) in 2019, representing an increase of 20 percent compared to 2018. Given that only around one-third of RC beneficiaries concluded a payment arrangement for the services they are provided with, their contributions in 2019 amounted to only 2.2 percent of total RC revenues. Financial resources from donations and sponsorship are a tiny share of overall revenues. None of the RCs reported to have received EU funding.

1.5.2. Expenditures incurred by residential centers

There are two categories of costs that were analyzed, based on the budget execution data that was collected from GDASCPs: (1) recurrent costs, which refer to regularly occurring expenditures for maintaining and operating the service, including staff salaries, goods and services, and other types of regular operational costs; and (2) capital or development costs, which are investments—most often fixed assets, such as buildings, means of transport, and equipment.

Total RC expenditures increased by 20 percent, to reach around RON 1.1 billion in 2019. The average overall annual expense per beneficiary amounted to RON 56,505 in 2018 and to RON 67,646 in 2019. There are significant variations, depending on the type and size of the RC and the county where it is located. Average overall annual costs per beneficiary are higher in CAbRs and in smaller centers with up to 20 beneficiaries (Table 14). At the county level, annual average costs incurred in 2019 ranged from RON 46,225/beneficiary in Brăila, to more than RON 100,000/beneficiary in counties such as Dolj, Giurgiu, and Bucharest. Operational costs accounted for 99 percent of overall RC expenditures incurred in 2018 in 2019. Although development expenses rose by 52.7 percent in 2019, they account for only 1.2 percent of total expenditures (Figure 20).

Figure 20: Evolution of the Expenditures in Residential Centers 2018–2019



Source: World Bank survey of residential centers – Financial resources (2020).

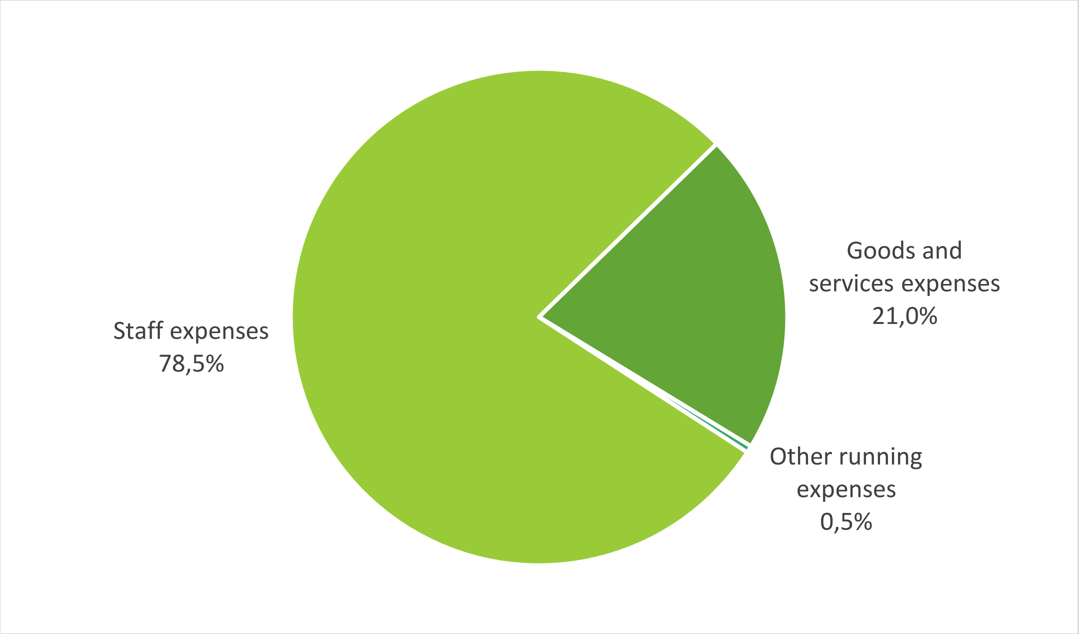
Table 14: Average Annual Operational Costs per Beneficiary in 2018 and 2019, by Type and Size of Residential Center

		2018 (RON)	2019 (RON)	Difference 2019–2018 (percent)
Average		**56,505**	**67,646**	**19.7**
Residential center type	CAbR	58,179	75,277	29.4
	CRRPH	56,149	66,705	18.8
	CIA	56,700	69,717	23.0
	CRRN	58,342	66,499	14.0
	CITO	40,253	48,240	19.8
	CPVI	47,838	38,461	-19.6
Size of residential center	<= 20	72,259	83,405	15.4
	21–50	56,555	70,169	24.1
	51–100	56,817	67,406	18.6
	> 100	54,329	63,069	16.1

Source: World Bank survey of residential centers: Financial resources (2020).

Incurred staff costs in the residential system for adults with disabilities account for more than 78 percent of overall operational expenses and have increased in recent years (Figure 21). The share of staff costs slightly increased in 2019, while those for goods and services slightly decreased. The proportion of staff costs at the county level ranges from 62.5 percent in Sălaj to 93.4 percent in Giurgiu. Recently adopted cost standards by the Romanian government dictate that staff costs should not exceed 80 percent of the value of the standard, which means that some counties will have to adjust the structure of their operational expenses. In 2019, 12 out of 42 counties exceeded this threshold. Furthermore, the increased cost of staffing is the main factor that accounts for the overall increased cost per beneficiary in 2018 and 2019, rising by almost 25 percent in 2019, while expenditures for products and services increased by 6.2 percent. These figures widely vary among counties and depend on the type and size of RC (Annex-Table 10 and Annex-Table 11).

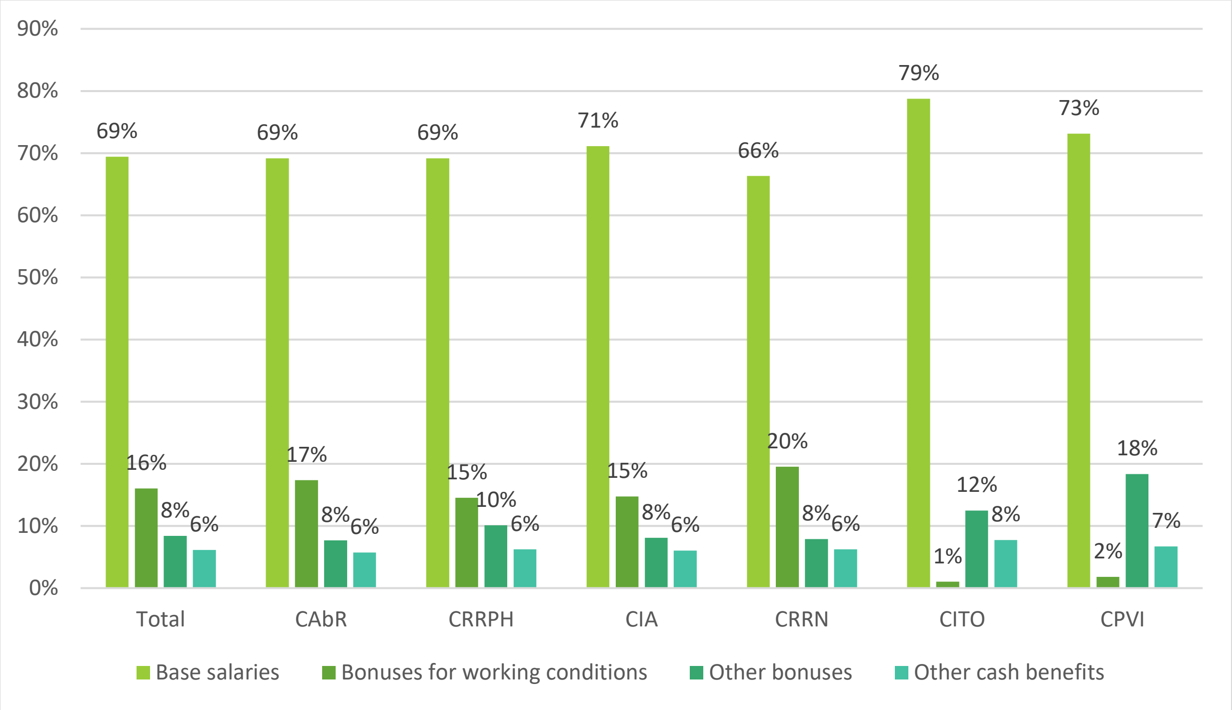
Figure 21: Structure of Residential Center Operational Costs



Source: World Bank survey of residential centers: Financial resources (2020).

Bonuses accounted for almost a quarter of staff costs in RCs in 2018 and 2019. The structure of staff costs in 2018 and 2019 does not show significant change, as cash salary expenses accounted for around 95 percent of overall staff expenses. Bonuses are a legal practice to increase the net wage of employees, but may be vulnerable to political factors and, thus, can be highly unstable. Base salaries were 69.4 percent of all staff expenses in 2019, those being supplemented by bonuses for difficult labor conditions (16 percent), as well as other bonuses (8.4 percent of all staff expenses), with some differences depending on the type of RC (Figure 22). The salary policy varies among counties, with bonuses representing less than 10 percent of total personnel expenses in counties such as Argeș and Hunedoara, while bonuses accounted for a third of total expenses in Cluj, Brașov, Dolj, and Timiș. In 11 counties, expenses inclusive of bonuses and other cash benefits doubled or even tripled in 2019 compared to 2018. At the national level, RC staff salary expenses rose by almost 25 percent, while bonuses and other cash benefits accounted for half this increase.

Figure 22: Structure of Salary Expenses of Residential Centers in 2019, by Type of Center

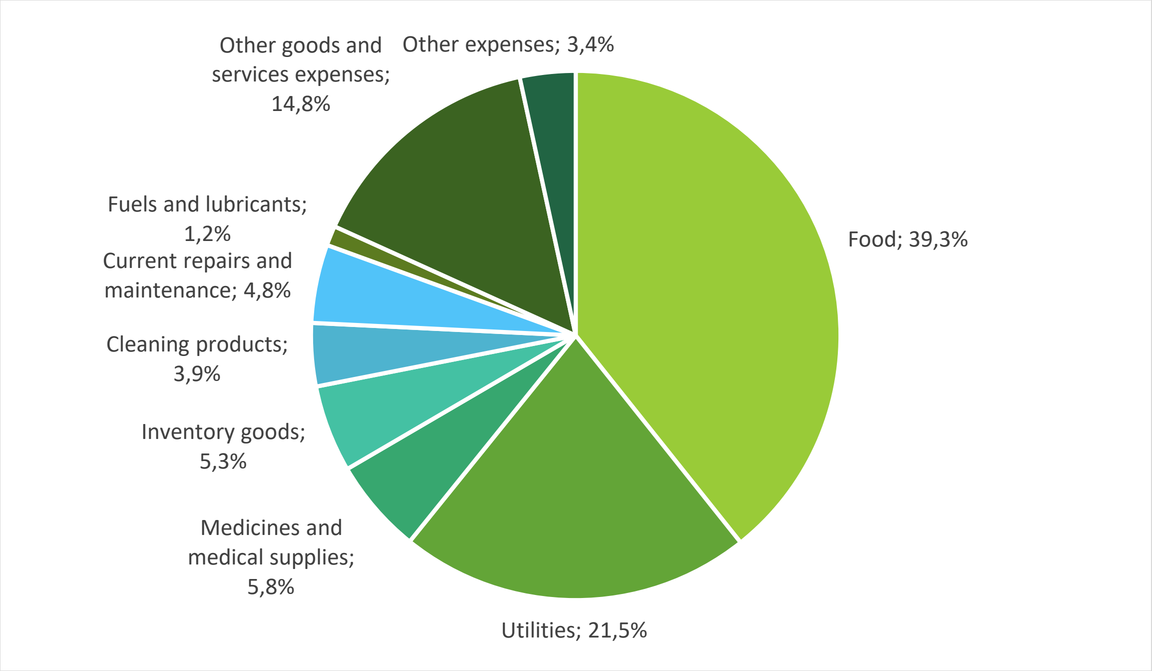


Source: World Bank survey of residential centers: Financial resources (2020).

Incurred costs show that very little is invested in the professional training of personnel. Average expenses incurred in RCs to provide professional training for staff per employee per year were RON 48.2 in absolute terms, which is 0.3 percent of overall RC expenses relating to products and services at the national level. This suggests that most of the mandatory training for RC staff is organized in-house.

Around 40 percent of overall expenditures of goods and services are represented by food for beneficiaries (Figure 23). In absolute terms at the national level, the average expense of goods and services per beneficiary, per month, amounted to RON 1,190 in 2019, out of which RON 468 related to food. Utilities are the second largest category of expenses relating to goods and services. Overall, the structure of expenditures for goods and services did not change significantly during the analyzed period. The share of various categories of cost, however, varied significantly across counties. Food costs ranged from less than a third (e.g., Bucharest, Arad, and Sălaj) to more than a half (e.g., Teleorman) of total goods and services. Expenses relating to utilities, medicines and medical supplies, and current repairs and maintenance also showed large variances in terms of proportion in total expenditure of goods and services.

Figure 23: Structure of Goods and Services Expenditures of the Residential Centers at the National Level (2019)



Source: World Bank survey of residential centers: Financial resources (2020).

Development expenditures of RCs represent approximately 1.1 percent of total cumulative expenses for 2018 and 2019. The total amount reached about RON 20.6 million (approximately EUR 4.4 million). Main RC investments were in construction (38.2 percent), cars, equipment, and means of transport (34.4 percent), although there were significant variations depending on county. Of the 42 counties, two did not record expenses with investments in fixed assets in any of the two years, while six counties accounted for more than half of total spending on fixed assets.

2

DIMENSIONS OF CARE AND SUPPORT IN RESIDENTIAL SERVICES FOR PEOPLE WITH DISABILITIES

2. Dimensions of Care and Support in Residential Centers for People with Disabilities

This section of the report offers an assessment of the material, human, and financial resources of the residential system for adults with disabilities, as well as systematic information about residents, so as to provide a comprehensive overview of their quality of life. While information about the availability and quality of resources in the system can further inform deinstitutionalization planning at the national and local levels, an assessment of the living conditions and service provision in residential institutions is missing. This assessment can subsequently provide the necessary solid basis for developing a public policy reform of the social protection system that respects and promotes human rights.

The assessment of living conditions and standards of care and support in RCs is structured around five dimensions. The areas covered by the RC analysis in this section are similar to those in *WHO QualityRights Toolkit to Assess and Improve Quality and Human Rights in Mental Health and Social Care Facilities*.[96] The WHO toolkit is the most comprehensive system, used internationally for assessing living, care, and support conditions in institutions for people with disabilities, with the aim of improving them to ensure quality services, thus respecting human rights and responding to the wishes and preferences of people with disabilities. The instrument comprehensively assesses five dimensions that correspond to one or more CRPD rights, while covering relevant aspects that RCs must observe in order to ensure an adequate standard of living, care, and support for residents while residing in institutions (Box 3).

Box 3: Five Dimensions of the Assessment of Residential Centers

Dimension	**(1) Adequate standard of living**
Corresponding CRPD* article(s)	Art. 28: Adequate standard of living and social protection
Assessment of living conditions in terms of the state of the building, comfort and privacy of sleeping areas, sanitary and hygiene standards, and access to food, water, and clothing, according to the needs and preferences of residents. Also evaluates conditions conducive to an environment that is stimulating and motivates participation and social interaction, while ensuring the residents' privacy, home and family life.	
Dimension	**(2) Enjoyment of the highest attainable standard of physical and mental health**
Corresponding CRPD article(s)	Art. 25: Health

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[96] World Health Organization (2012).

<table>
<tr><td colspan="2">Assessment of the level and quality of services offered to residents: general health services (including services regarding sexual and reproductive health) and specific services (e.g., habilitation/rehabilitation, support services, and mental health services, among others). Assessment of the extent to which services correspond to the expressed will and preference of each resident.</td></tr>
<tr><td>Dimension</td><td>(3) Exercise of legal capacity and the right to personal liberty and security of person</td></tr>
<tr><td>Corresponding CRPD article(s)</td><td>Art. 12: Equal recognition before the law
Art. 14: Liberty and security of the person</td></tr>
<tr><td colspan="2">Analysis of the conditions to allow residents to fully exercise their legal capacity in all aspects of their lives in the residential centers, as well as the mechanisms to prevent forced institutionalization, treatment, and/or service provision without the expressed consent of residents.</td></tr>
<tr><td>Dimension</td><td>(4) Freedom from torture or cruel, inhumane, or degrading treatment or punishment; and from exploitation, violence, and abuse</td></tr>
<tr><td>Corresponding CRPD article(s)</td><td>Art. 15: Freedom from torture or cruel, inhumane, or degrading treatment or punishment
Art. 16: Freedom from exploitation, violence, and abuse</td></tr>
<tr><td colspan="2">Assessment of each residential center in terms of instances of abuse, restraint, or seclusion;[97] medical experiments; or torture and degrading treatment, as well as steps taken to ensure that the occurrence of such treatment to any resident is prevented (including complaint mechanisms in place, adequate training of staff, and independent monitoring), and that there are adequate services in the case of such events (e.g., legal support and rehabilitative care).</td></tr>
<tr><td>Dimension</td><td>(5) Living independently and being included in the community</td></tr>
<tr><td>Corresponding CRPD article(s)</td><td>Art. 19: Living independently and being included in the community</td></tr>
<tr><td colspan="2">Evaluation of the level of support residents receive in to access adequately the necessary means to secure independent community living: housing, social benefits, employment, education, specific support services, access to active social and political participation, and other aspects to promote an inclusive community life.</td></tr>
<tr><td colspan="2"><i>Source</i>: WHO (2012).</td></tr>
</table>

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[97] Restraint and seclusion imply the use of mechanical and chemical ways to prevent a person’s movement.

*CRPD.

2.1. Adequate Standard of Living

While a universal human right, the enjoyment of an adequate standard of living remains a challenge for many persons with disabilities. The right to an adequate standard of living is a fundamental human right to health and wellbeing requiring that everyone should enjoy their basic needs, such as access to housing, adequate food and nutrition and clean water in conditions of dignity. Poverty affects many persons with disabilities;[98] it not only is a cause but also a consequence of disability. Limited access to education, healthcare, transportation, adequate housing, nutritious food, clean water, basic sanitation, credit—aggravated by additional costs—to achieve an adequate standard of living for persons with disabilities[99] significantly marginalizes persons with disabilities. Furthermore, inadequate access to resources and services may lead to actually acquiring a disability.

While persons with disabilities often find themselves in institutions when seeking care as a result of life circumstances marked by deprivation, institutions often fail to ensure the adequate standard of living they deserve. Placing persons with disabilities in institutions is a practice often justified by their need for treatment and care that cannot be provided elsewhere. In many cases, however, institutionalization is, in the first place, an effect of limited access to affordable and accessible housing for persons with disabilities and their families.[100] In turn, institutionalization often is characterized by overcrowding, improper heating, sanitation and hygiene deficiencies, lack of clothing and food, violence and abuse, as well as severe deprivation of personal choice and autonomy with regard to social and personal livelihoods.

An adequate standard of living relates to a variety of aspects that are specific to all domains affecting one's quality of life. An adequate standard of living includes not only the provision of food, clothing, and appropriate living conditions from a material point of view, but also—and especially—the necessary conditions, services, and devices that will enable a person to live independently and with dignity within the community.[101] Thus, an adequate standard of living must include the ability to make choices about one's everyday life; to build and sustain relationships; to enjoy family life; to have the right to work, to an education, and independence; and to pursue one's own interests (Box 4). While material conditions in a residential institution are

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[98] "One billion people, or 15 percent of the world's population, experience some form of disability …" (World Bank, 2021).

[99] Compared to nondisabled persons, ensuring an adequate standard of living is more costly for those with disabilities, since additional spending is needed to ensure accessibility to health care services, assistive devices, transportation, heating, laundry, special diets, and/or personal assistance (WHO and World Bank, 2011: 43–44).

[100] Human Rights Council (2017a, para. 51-54); CRPD Committee (2017a, para. 17); and Human Rights Council (2017b: para 17).

[101] CRPD Committee (2017a, para 13). CESCR General Comment No. 5: Persons with Disabilities Adopted at the Eleventh Session of the Committee on Economic, Social and Cultural Rights, on 9 December 1994 (1995, para. 33).

essential, they cannot compensate for the segregating and damaging effects of institutionalization.

Box 4: Right to an Adequate Standard of Living and Social Protection (Art. 28 of the CRPD)

Many people residing in residential facilities have inhumane living conditions, including overcrowding and poor sanitation and hygiene. Residents lack proper clothing, clean water, food, heating, decent bedding, and privacy. The social environment is often no better: people are denied the opportunity to communicate with the outside world; their privacy is not respected; and they experience excruciating boredom and neglect, with little or no intellectual, social, cultural, physical, or other forms of stimulation. Art. 28 of the CRPD requires, among others, that those with disabilities be provided a standard of comfort that includes adequate food, clothing, clean water, and assistance with relevant disability devices, as well as continuing effort to improve living conditions.

Source: WHO (2012: 4).

The assessment of material resources of public RCs for adults with disabilities aims to present two perspectives. First, as a partial measure of residential standards of living, a review is made of existing infrastructure and the provision of utilities. Second, an attempt is made to understand the significance of the investment process and the updates of the material base for the future process of deinstitutionalization.

While it is imperative that living conditions in RCs require immediate improvement, this should not be relied on as the only investment strategy; rather, the process of deinstitutionalization also should be supported. An improvement of the individual's living conditions in residential institutions should be a key goal, but at the same time it can become a hindrance to the process of deinstitutionalization in the medium and long term.[102] The option is to target the temporary failures within the system rather than to provide systemic change. Investing in building construction and repairs will use what little funding is available to the detriment of deinstitutionalization, will only encourage attachment by the authorities and decision makers to existing infrastructure and centers, and will provide a justification for the resistance to closing them.

RC infrastructure and material resources should be considered as resources able to support the deinstitutionalization process in the long term, not as a rationale for maintaining persons with disabilities in institutions. The material base and, in particular, the built infrastructure, should not be seen as a future housing option for people with disabilities (which might be used as a justification for further investment) but rather as capital to be sold or rented and to possibly generate an income that can be used in furthering deinstitutionalization.[103] There is also a risk to supporting parallel systems by continuing to invest in and maintain the institutional system to provide housing for people with disabilities. It may result in providing a higher chance for some

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[102] European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities (2009, 15).

[103] European Expert Group on the Transition from Institutional to Community-based care (2012, 60).

people to enter into the community and live independently, while others could be left to remain in RCs.[104] Furthermore, constant investment to improve material infrastructure justifies the status quo, thus challenging transformation of the system toward deinstitutionalization.[105]

2.1.1. Buildings and infrastructure

In the past 20 years, there has been considerable investment in the existing material infrastructure of RCs. The construction of new buildings, renovations, improvements, and modernization of utilities that has taken place was originally meant to improve the appalling living conditions of RCs, as well as to comply with required minimum regulatory standards. Based on RC self-evaluations, buildings are generally well-maintained, thus providing the potential for comfortable living conditions; however, they cannot offer the level of provisions necessary for people with disabilities.

Investing in new buildings has continued since 2010, reflecting a commitment to institutionalizing people with disabilities. Notably, 14 percent of RCs—including in rural areas and, in particular, those of medium size (21 to 50 places)—have been built since 2010 (Table 15). In absolute numbers, this amounts to 29 buildings built to house institutionalized adults with disabilities, especially following Romania's ratification of the CRPD. A further larger RC of 51 to 100 places also has been built since.

Table 15: Distribution of Centers According to the Age of the Building, Where Residents Are Housed, by Type and Size of Center (percent)

	<1970	1970-1989	1990-2009	2010-2017	Total	Total Number
CAbR	9.4	21.9	43.8	25.0	100	32
CRRPH	9.1	27.3	63.6	0.0	100	33
CIA	21.3	36.2	26.6	16.0	100	94
CRRN	19.0	38.1	31.0	11.9	100	42
CITO	0.0	66.7	33.3	0.0	100	3
CPVI	0.0	50.0	0.0	50.0	100	2
Total	**16.5**	**33.5**	**35.9**	**14.1**	**100**	**206**

	<1970	1970-1989	1990-2009	2010-2017	Total	Total Number
<=20	7.7	15.4	66.7	10.3	100	39
21−50	14.4	26.9	35.6	23.1	100	104
51−100	25.7	51.4	20.0	2.9	100	35

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[104] European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities (2009, 15-16).

[105] European Union Agency for Fundamental Rights (2018, 43).

100+	25.0	60.7	14.3	0.0	100	28

Source: World Bank survey of residential centers (2020).

Investments in renovating and consolidating buildings have been significant. In almost 75 percent of centers, buildings where residents are housed have undergone renovations since 2010, with slightly higher percentages for those of medium and large size. Most likely, the renovations were necessary, given that many of the centers are old, half of which date back to before 1989, and were possibly built for other purposes, while following what could be now out-of-date standards and regulations. The larger centers, especially, are somewhat older and were built in quantity before 1989,77 percent of the centers with 51 to 100 places and 86 percent of those with over 100 places) continue to house beneficiaries in buildings from before 1989 (Table 15).

Buildings and their various components have been assessed by RC representatives as being in good and very good condition. Components of buildings include the façade, roof, windows and doors, plumbing, sewage, electrical system, heating, and thermal insulation (Table 16). From the perspective of RC representatives, many of the buildings are well maintained and in good shape, as well as able to create a comfortable living environment for center residents.

Table 16: Distribution of the Residential Center Self-Evaluations of Building and Building Component Conditions (percent)

	Very Bad	Bad	Neither/ Nor	Good	Very Good	Total	Total Number
Roof	0.7	4.2	8.0	50.2	37.0	100	289
Facade	0.7	2.8	9.7	45.7	41.2	100	289
Door, windows	0.0	2.4	6.9	55.7	34.9	100	289
Plumbing	0.7	4.2	11.1	60.2	23.9	100	289
Sewage	1.4	4.5	10.0	58.5	25.6	100	289
Electrical	0.3	2.4	5.9	58.1	33.2	100	289
Heating	0.3	1.0	3.8	53.6	41.2	100	289
Thermal insulation	2.8	5.9	11.8	43.3	36.3	100	289

Source: World Bank survey of residential centers (2020).

Not all RCs are physically accessible, thus challenging efforts to provide adequate services in response to the specific needs of residents. Lack of accessibility is impactful, not only on the quality of life of residents and their access to other types of services, but it also poses health risks, especially in the case of disaster or emergency. CRPD Art. 9 on Accessibility stipulates that RCs comply with the minimum social service standard requirement of providing physical accessibility to adults with disabilities.[106]

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[106] Order No. 82/2019. Annex 1. Module 1. Standard 2. Minimum Requirement 3.

RCs that have adopted these requirements range from a little over 90 percent for simple adaptations (e.g., access ramps and handrails) to approximately 26 percent (e.g., elevators) or 8 percent for such items as tactile warning surfaces (Table 17). The proportions are somewhat higher in the case of larger institutions, although only slightly higher in the case of RCs with residents who need such conversions. Translated, it appears to make no difference to the RC whether or not residents have a need for conversion.

Table 17: Existing Adaptations for Physical Accessibility

Percent of Centers That Have Adaptations	Access Ramps	Tactile Warning Surfaces	Wide Entrance Doors	Elevators	Longer Ramps	Handrails	Sound Systems	Accessible Bathroom
Out of all centers	91.3	8.3	92.4	26.3	491	79.6	23.9	68.9
Out of centers with beneficiaries who need such adaptations	95.8	8.4	94.5	28.6	53.4	82.4	25.6	76.9

Source: World Bank survey of residential centers (2020).

2.1.2. Sleeping quarters

Sleeping quarters in RCs are unable to ensure privacy or resident control over everyday life activities. Sleeping quarters are areas that should provide residents a sense of privacy, independence, and freedom. Due to institutional culture and the pressure of economies of scale, however, residents are forced to sleep, live, and attend to their bodily needs in close proximity to others not of their choice, especially during their most private and vulnerable moments. Sleeping quarters are also living quarters—this is where residents store their belongings and spend most of their day. While there are minimum legal standards that require a maximum number of beds per room and a minimum area per resident, these are not enforced and thus do not resolve the issues of living in an institution.

Many RC bedrooms are overcrowded. The average number of residents per bedroom, in addition to living space, in the public residential system is 2.9, with slightly higher averages for CRRNs, for larger centers, and for those in rural areas (Table 18). While minimum quality standards require a maximum of three residents per bedroom,[107] almost 40 percent of RC bedrooms have four or more beds (rising to 82 percent for those with over 100 places). Almost 6 percent of RCs have only rooms with four beds or more, and four RCs have even more residents than approved number of beds. On average, sleeping rooms allow a total of 7.4 m^2 per resident. While the minimum

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[107] Order No. 82/2019. Annex 1. Module 1. Standard 2. Minimum Requirement 12.

standard requires a minimum space of 6 m^2, and a minimum of 8 m^2 for residents with a wheelchair,[108] this appears insufficient, given that this one area also may be assigned not only as a bedroom but also as a room for sleeping, storing one's belongings, socializing, and engaging in various daily activities—a space where numerous residents may spend most of their time during the day.

Table 18: Average Number of Residents per Room in Rural and Urban Settings, by Type and Size

		Average Number of Residents per Room	Total Number of Residents	Total Number of Centers
Type of center	CAbR	2.5	1,229	36
	CRRPH	2.9	1,883	50
	CIA	2.6	6,709	136
	CRRN	3.7	5,465	56
	CITO	3.1	749	8
	CPVI	2.1	59	3
	Total	1.0	5,517	289
Size of center	<=20	2.6	713	53
	21–50	2.5	5,917	144
	51–100	3.0	3,771	51
	100+	3.5	5,693	41
Rural/urban area	Rural	3.0	7,951	133
	Urban	2.8	8,143	156

Source: World Bank survey of residential centers (2020).

Residents do not have access to personal items of furniture, as required by the minimum quality standards for residential social services for adults with disabilities. Minimum quality regulatory standards require that every resident should have access to personal items of furniture in the bedroom (e.g., wardrobe, nightstands, lamps, and clothes stands) that they can use personally and independently to store clothing and

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[108] Order No. 82/2019. Annex 1. Module 1. Standard 2. Minimum Requirement 11. In most counties, the average is above the minimum area stipulated by the standards, with some counties registering an average of 10 m^2, such as Mehedinți and Satu Mare.

other personal items.[109] Nightstands, in particular, offer the option to personalize one's immediate space with photographs and other sentimental items, as well as create an intimate space for individuality and a sense of independence, so much so as to counter the depersonalization of institutional living. It contributes to a sense of ownership over one's immediate space. RCs in the Romanian public system, however, remain remote from offering these human assets. Only 50 percent of residents have access to a personal nightstand and only 41 percent to a wardrobe in their bedroom (Table 19). Furthermore, approximately 29 percent of RCs fail to offer any piece of furniture, and only 4 percent (i.e., 11 centers in the entire country) offer all four of the above-mentioned items of furniture (Table 20). This raises serious questions regarding the mechanics of everyday life for people with disabilities in RCs, especially in terms of limited access to bathroom facilities.

Table 19: Access to Wardrobes, Nightstands, Lamps, and Clothes Stands

Bedroom Furniture	Number of Residents	Percent of Residents' Access to Furniture
Wardrobe	6,611	41
Nightstand	8,108	50
Lamp	3,416	21
Clothes stand	1,151	7
Total	16,094	100

Source: World Bank survey of residential centers (2020).

Table 20: Personal Furniture Items in Resident Bedroom

Available Furniture in Bedrooms	**Number of Centers**	**Percent of Centers that Do or Do Not Offer Furniture**
None of the Items	82	28.9
One out of four items	59	20.8
Two out of four items	80	28.2
Three out of four items	52	18.3
All four objects	11	3.9
Total	**284**	**100**

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[109] Order No. 82/2019. Annex 1. Module 1. Standard 2. Minimum Requirement 12.

Source: World Bank survey of residential centers (2020).

2.1.3. Hygiene and sanitation

Comfort, accessibility, and privacy continue to be an issue in terms of RC bathrooms. RC quality standards stipulate that bathrooms must include toilets, showers/bathtubs, sinks, and other essential needs for hygienic purposes. Privacy (including separate facilities for men and women), comfort, and accessibility are essential, as well as are the provision of hot and cold running water.[110]

Not all residents have direct access to a bathroom/shower or a toilet. Only 50 percent of centers have sleeping quarters with an ensuite bathroom, representing 38 percent of bedrooms in the system. This means that for the balance, residents must go outside their sleeping quarters, either on the same level or on a different floor or part of the building—sometimes a different building—to shower or wash. In all probability, this routine is not on an individual basis; rather, it most likely requires residents to ask for permission or adhere to procedures imposed by the institution. In over 90 percent of centers, hot water is offered on a continual basis, although not necessarily on schedule.

Not all centers ensure bathroom privacy, as required by law. In addition to offering the use of en suite bathrooms and fewer beds per dormitory, a way to ensure privacy and safety, particularly for women, is to provide residents with gender-specific bathrooms. There are centers that continue, however, to illegally offer the use of unisex bathrooms,[111] with the average number of residents per bathroom being slightly higher than for gendered bathrooms (4.2 and 3.7–3.8, respectively). In six counties, bathrooms have an average allotted number of users above the legal maximum of six,[112] rising to as high as 10.[113] The reasons for this are due to overcrowded sites that are unable to comply with regulatory standards and do so only through superficial interventions.

Not all centers offer accessible bathrooms for people with physical disabilities. Although RCs are required by law[114] to provide at least one accessible bathroom to their residents, only around 60 percent of RCs meet this requirement. Moreover, 4 percent of RCs continue to offer squat toilets as opposed to the safer and more accessible sitting toilets that are required by law.

The provision of laundry services and personal hygiene products without individual choice or control, while essential, contributes to a sense of depersonalization in

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[110] Idem. Standard 2. Minimum Requirements 19 and 20.

[111] Order No. 82/2019. Annex 1. Module 1. Standard 2. Minimum Requirement 20.

[112] Order No. 82/2019. Annex 1. Module 1. Standard 2. Minimum Requirement 19.

[113] Alba, Buzău, Ialomița, Maramureș, Teleorman, and Vaslui have averages of more than six residents per bathroom.

[114] Order No. 189/20013 for the approval of technical regulation “Normative regarding the adaptations of civil buildings and urban space to the individual needs of persons with disabilities, NP 051-2012" Section 6, V.6.1 (2), stipulates that all buildings of public interest and utility, including rehabilitation centers, must have at least one bathroom adapted and adequately equipped to enable its use by persons with disabilities.

RCs. On average, 95 percent of centers offer toiletries, toilet paper, sanitary pads for women, towels, and other essential personal hygiene and care items. Usually, supplies are bought and offered in bulk, with little or no regard for individual preference and the option of residents. Moreover, laundry is done in bulk, either on the premises (93 percent of RCs) or through outside contractors or institutions, whereby the dirty laundry is collected and ultimately returned to residents. This method results in the difficulty of residents to keep track of their clothes, thus escalating the depersonalization issue and loss of individuality.

In general, RCs take measures to ensure clean and safe environments for residents, albeit with some exceptions. Most RCs periodically treat against vermin, with 88 percent applying protection against insects at least once every six months, while 82 percent do so against rodents with the same frequency. With regard to waste collection, more than 90 percent of RCs have procedures in place for the selective collection of dangerous and nondangerous medical waste, as well as for domestic waste. Nevertheless, certain types of centers are called into question. For instance, 22 percent of CRRPHs fail to ensure that only authorized personnel access areas for dangerous medical waste, thus potentially exposing residents to material that may endanger their health. In addition, 18 percent of CRRPHs fail to arrange for the separate collection of dangerous and nondangerous medical waste and domestic waste.

2.1.4. Provision of food, water, and clothing

While essential for the survival and physical well-being of residents, RCs tend to consider food, water, and clothing simply as basic needs and do not provide residents with options or the freedom to select. The freedom to choose what to eat (when, how, and with whom); about what to wear; and how to present oneself are basic rights, in order to maintain one's individuality, identity, and autonomy. Adhering to legal minimum quality standards can fall into a “basic needs trap”, as they only give broad coordinates coherent with the logic of a total institution, of governing and providing for many bodies at once, while not specifying procedures and ways for involving the residents and addressing their individual needs in making these decisions.

Most RCs provide clothing and footwear to their beneficiaries. Around 80 percent of RCs provide the necessary new clothing and shoes for each resident, and around 70 percent do so at least once every six months. The numbers are slightly higher for those centers in rural areas.[115] For now data is lacking on whether or not clothing acquisitions are made in keeping with minimum standards; that is, whether the clothing is appropriate in terms of season/weather, or whether it is personalized in terms of age and gender. It also is unclear how involved a resident may be in the selection process, or whether or not there is any provision for personal preference and taste. Sheets and towels for each resident are entirely provided by 94 percent of institutions. Regardless of the size of institution, these proportions appear similar, with the exception of small centers of 20 residents and under, where they are significantly lower. What is

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[115] This also may be due to the limited potential of residents in rural RCs to buy clothing and footwear from shops.

concerning, however, is that almost one in four centers offers new items of basic personal use only once a year or even less often (Table 21).

Table 21: Provision of Basic Personal Items in Residential Centers

	At Least Once Every Three Months	Once Every Four to Six Months	Once A Year	Less Than Once A Year	Total
New clothes	26.4	45.5	25.0	3.1	100
New shoes	20.8	51.4	22.6	5.2	100
New sheets and towels	20.8	51.4	22.6	5.2	100

Source: World Bank survey of residential centers (2020).

The subcontracting of meals to third parties might be used as a solution to having sub-standard cooking and food storage facilities. While most RCs appear to comply with minimum quality standards relating to kitchen, food storage, and dining room facilities, some—especially smaller ones—do not. Eight percent of all RCs do not have kitchens that are up to standard, 10 percent do not have appropriate food storage areas, and 6 percent fail to have dining areas that comply with minimum standards. A partial solution, at least to the kitchen problem, is to subcontract the provision of meals. Indeed, approximately 18 percent of RCs (almost 36 percent with regard to small centers) subcontract food from external providers, either a catering firm or another similar institution, part of GDSACP).

Many centers organize meals in shifts to speed up the process, most likely rushing residents through their meal. For residents who can eat in the dining room, the serving is done, in 97 percent of the centers, by the center's personnel, and only in less than 3 percent of centers, residents can serve themselves. Eating usually takes place in shifts, given that dining rooms, in general, tend to be too small to accommodate all residents at once (Table 22). While smaller dining rooms have the advantage of creating a more intimate and friendly space where to eat, it risks providing only a limited time for them to eat before the next shift is scheduled to set in. Based on set standards, residents must be allowed sufficient time in which to eat.[116] For example, 10 percent of centers with over 100 residents have dining areas with less than 20 seats, theoretically meaning that there are at least five shifts for each meal (Table 23).

Table 22: Distribution of Residential Centers with Dining Rooms Smaller than the Number of Residents, by the Size of Center

Size of Center	Number	Percent	Total Number
<=20	6	14.3	42

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[116] Order No. 82/2019. Annex 1. Module 1. Standard 3. Minimum Requirement 16.

21–50	62	44.6	139
51–100	44	88.0	50
100+	33	84.6	39
Total	**145**	**53.7**	**270**

Source: World Bank survey of residential centers (2020).

Table 23: Distribution of Residential Centers by Maximum Capacity of Dining Room and Size of Center

Size of Center	<=20 Seats	21–35 Seats	36–50 Seats	51+ Seats	Total	Total Number
<=20	92.9	7.1	0.0	0.0	100	42
21–50	16.5	30.9	49.6	2.9	100	139
51–00	14.0	26.0	20.0	40.0	100	50
100+	10.0	10.0	15.0	65.0	100	40
Total	**26.9**	**23.2**	**31.4**	**18.5**	**100**	**271**

Source: World Bank survey of residential centers (2020).

More than 4,600 residents eat their meals in their rooms each and every day. Quality standards require that meals be served in the residents' own rooms in cases when "their state of health does not allow them to go to the dining area."[117] The number and proportion of residents who take their meals in their own rooms are, however, high and warrant a series of explanations. Close to one-third of adults housed in the Romanian system of RCs (i.e., 4,617 people) do not leave their room to have their meals (Table 24). Some are those with extremely reduced mobility or those who cannot feed themselves either independently or at all. This may reflect reduced accessibility residential buildings, a reduced capacity of dining areas, limited human and material resources to organize meals, or it may even be the unwillingness of an RC to create the necessary environment for residents to eat their meals away from their sleeping quarters. Regardless, confining residents to their sleeping areas deprives them their rights to dignity, nonsegregation, and inclusivity—a serious failure of any institution to attend to the individual's needs.

Table 24: Proportion of Residents Receiving Meals in Own Room, by Type and Size of Center

	Percent	Number of Residents Eating Meals in Own Room	Total Number of Residents	Total Number of Centers

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[117] Order No. 82/2019. Annex 1. Module 1. Standard 2. Minimum Requirement 11.

Type of center	CAbR	15.1	186	1,229	36
	CRRPH	27.8	504	1,815	48
	CIA	35.3	2,371	6,709	136
	CRRN	26.7	1,460	5,465	56
	CITO	12.8	96	749	8
	CPVI	0.0	0	59	3
	Total	**28.8**	**4,617**	**16,026**	**287**
Size of center	<=20	15.1	105	694	52
	21–50	25.3	1,482	5,868	143
	51–100	33.3	1,255	3,771	51
	100+	31.2	1,775	5,693	41
	Total	**28.8**	**4,617**	**16,026**	**287**

Source: World Bank survey of residential centers (2020).

At least nominally, efforts are made to secure a degree of involvement for residents in meal activities. Residents are involved in various ways and to various degrees in activities relating to food consumption—deciding on the menu, preparing the meal, setting the table and serving, washing dishes, and buying food (Table 25). Resident involvement can bring a sense of self-determination and can be a good opportunity for learning and practicing everyday life skills. It is unclear, however, how the involvement of residents is carried out in practice and how much of it is actually compensating for a deficit in human resources. In addition, while 96 percent of centers offer snacks in between meals (most of them twice a day), only 15 percent have a special place where residents can help themselves to a snack, whenever they want.

Table 25: Residents' Involvement in Meal-Related Activities (% of centers)

	Every Meal	Only Certain Meals In the Day	Occasionally Involved	Never Involved	Total	Total Number
Deciding on the menu	49.0	18.1	23.6	9.4	100	288
Preparing the meal	6.9	6.9	22.9	63.2	100	288
Setting the table	38.9	14.2	29.5	17.4	100	288
Serving the meal	26.0	12.2	22.2	39.6	100	288

Washing the dishes and cutlery	26.0	4.9	17.0	52.1	100	288
Buying food	0.3	0.3	10.1	89.2	100	288

Source: World Bank survey of residential centers (2020).

Resident involvement extends, in some cases, to working in the gardens and farms of RCs and participating in producing the food for the centers' own consumption. Resident participation can be beneficial to their mental and physical wellbeing, while providing opportunities for developing useful skills and knowledge. It should not replace, however, other forms of occupational therapy and, especially, should not be used as a form of forced labor to supplement the centers' human resource needs. About 83 percent of centers own an orchard, 37 percent a place for keeping domestic animals, and only a very small percentage have vegetable gardens or greenhouses (16 percent and 17 percent, respectively). These percentages seem to relate to the size and location of centers, as rural and larger centers usually have these types of facilities. Eleven percent of residents within the system, with higher percentages for small and rural centers, are involved in work on these premises. The much higher percentages of residents in CITOs and CPVIs involved in such activities suggest that working in the centers' own gardens and farms is treated, or possibly disguised, as occupational therapy and preparation for independent living (Table 26).

Table 26: Number and Proportion of Residents Involved in the Gardens and Farms of the Residential Centers

		Number	Percent	Total Number of Residents of Centers with Garden/Orchard/Farm
Type of center	CAbR	241	23.0	1,049
	CRRPH	180	12.1	1,488
	CIA	488	8.2	5,961
	CRRN	442	9.3	4,762
	CITO	110	41.0	268
	CPVI	44	74.6	59
	Total	**1,505**	**11.1**	**13,587**
Size of center	<=20	155	27.6	562
	21-50	783	15.9	4,921
	51-100	288	8.7	3,294
	100+	279	5.8	4,810

Rural/urban area	Rural	858	12.1	7,073
	Urban	647	9.9	6,514

Source: World Bank survey of residential centers (2020).

Centers regularly offer fruit and homemade desserts although, at the same time, they offer processed foods. Quality standards require that centers serve fresh fruit and homemade desserts (not store-bought) at least three times a day,[118] which does take place at 82 percent and 40 percent of centers, respectively. At the same time—and contrary to standards—more than half the centers serve processed foods at least three times a week. A significant number of centers (17 percent of all centers, and almost 26 percent of those in rural areas) use food that they themselves have grown in preparing meals for residents, which is something that standards recommend in order to improve the quality of the foods served.[119] Only 3 percent of centers do not have access to drinkable water.

2.1.5. Indoor and outdoor environments

A welcoming, comfortable, and stimulating environment is essential to enhance active participation and interaction. Persons with disabilities in RCs should have access to indoor and outdoor spaces that are comfortable, ample, and in good condition, more so as centers, for the most part, are the only spaces that residents have access to on a regular basis. Also, the layout and the furnishings should be conducive to interaction between and among residents, staff, and visitors, and this includes having spaces specifically designated for socializing and leisure. In addition, centers should offer the necessary equipment for leisure and active participation on the part of residents.

Many RCs offer well-maintained spaces for socialization and leisure. Almost all centers (99 percent) offer spaces specially designated as socialization areas for residents and 83 percent offer a specially designated space in which to receive visitors. In addition, 60 percent of centers—in particular the very large centers and CPVIs—offer additional space for leisure and recreation. The size/number of residents ratio as well as the number of residents per socialization space are highly variable among centers (Table 27, Table 28), signaling not only structural and individual differences that depend on the size and type of center, but also the high physical variability of the architectural layout of centers and, possibly, different approaches in their management. The self-assessment by center representatives of the state of the buildings described the interior spaces (i.e., halls, corridors, common rooms) as being in good and very good state in 96 percent of centers.[120]

Table 27: Average Number of Residents per Socializing Space,

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[118] Order No. 82/2019. Annex 1. Module 1. Standard 3. Minimum Requirement 5.

[119] Order No. 82/2019. Annex 1. Module 1. Standard 3. Minimum Requirement 5.

[120] Data collected indicate the existence, and not necessarily the quality of indoor and outdoor spaces and various features that could create the conditions for active participation and interaction on the part of residents.

by Type and Size of Center

		Average Number of Residents	Total Number of Centers
Type of center	CAbR	10.0	36
	CRRPH	15.5	49
	CIA	17.8	133
	CRRN	24.2	56
	CITO	30.0	8
	CPVI	9.8	3
	Average	18.3	285
Size of center	<=20	8.7	53
	21–50	13.6	141
	51–100	24.6	50
	100+	27.2	41
	Average	18.3	285

Source: World Bank survey of residential centers (2020).

Table 28: Average Surface of Socializing Space per Resident, by Type and Size of Center, Including Rural/Urban Areas

		Average Surface Size (m^2)	Total Number of Centers
Type of center	CAbR	23.4	36
	CRRPH	17.4	48
	CIA	4.2	133
	CRRN	7.1	55
	CITO	1.7	8
	CPVI	3.8	3
	Average	8.1	283
Size of center	<=20	5.3	53
	21–50	13.6	140
	51–100	1.9	49
	100+	6.8	41
Rural/urban area	Rural	10.1	129

	Urban	6.1	154

Source: World Bank survey of residential centers (2020).

Not all centers offer sufficient outdoor space and facilities for their residents. Outdoor space is also important, since it would offer residents access to green space, as well as leisure and sports facilities. Moreover, a larger outdoor area offers the potential for in-house food production (e.g., greenhouses, orchards, vegetable gardens, space for raising animals) which, in turn, would contribute to increased access to clean, fresh foods and opportunities for activities and involvement on the part of residents. Almost all centers offer a leisure space, with benches, gazebos, or other outdoor furniture. A smaller percentage of centers (about 60 percent) offer a space with sports/movement equipment. However, the provision of green space that can be accessed by residents appears to be an issue, since only 25 percent of centers offer this kind of space. The larger centers, as well as those in rural areas tend to offer green space in slightly higher proportions. It is worth noting that centers located in rural areas tend to offer these facilities more than those in urban areas, the difference being more significant in the case of green space and the chapel (Table 29).

Table 29: Provision of Outdoor Space and Facilities of Residential Centers, by Type and Size of Center, Including Rural/Urban Areas (percent)

		Outdoor Space with Benches, Gazebos, Among Others	Outdoor Space with Movement/Sports/ Recreation Equipment	Green Space	Chapel
Type of center	CAbR	97.2	75.0	11.1	30.6
	CRRPH	100.0	64.0	10.0	30.0
	CIA	94. 9	47.8	33.8	27.9
	CRRN	100.0	66.1	26.8	41.1
	CITO	100.0	75.0	12.5	62.5
	CPVI	66.7	66.7	33.3	66.7
	Average	**96.9**	**58.5**	**24.9**	**32.5**
Size of center	<=20	94.3	60.4	11.3	26.4
	21–50	96.5	59.7	25.7	31.9
	51–100	100.0	56.9	31.4	35.3
	100+	97.6	53.7	31.7	39.0
Rural/urban area	Rural	97.0	60.9	29.3	44.4
	Urban	96.8	56.4	21.2	22.4

Source: World Bank survey of residential centers (2020).

2.1.6. Personal and social life, community life and activities

RCs create the material conditions for intra-institutional socializing, although they offer limited infrastructure for intimate socialization and communication outside the institution. The right to independent living for people with disabilities also entails the ability to make their own choices and sustain autonomous relationships (i.e., friendships, intimate relationships, relationships with family and other people inside and outside the institution) through distant or face-to-face communication and interaction. Intra-institutional autonomous sociality cannot and should not replace the lack of opportunities to socialize with and integrate into the rest of the community, despite them being essential to the autonomy and dignity of individuals. In Romania, although almost all centers offer a community room in which residents can socialize, with about 80 percent offering a special space in which to receive visitors, less than a third offer an intimate room for couples.

Access to means of information and communication, as well as privacy of communication, are particularly important in restrictive institutional environments such as RCs. They constitute an important component to be able to sustain social and family relationships with people outside the center or to remain connected to the community and outside world, as well as being a necessary channel to communicate or report grievances, abuse, or irregularities. These rights are guaranteed by Art. 21 and Art. 22 of the CRPD,[121] but are difficult to respect in the absence of free and private phone and Internet access granted to residents. Nominally, in 80 percent of centers, beneficiaries have access to the Internet, although it is unclear what that means (e.g., how many terminals, conditions of use, privacy, and how many residents know or receive support to use it, especially given the high rate of illiteracy). 69% of residents have not talked at all on the phone with family or friends between 2019 and 2020. Regardless of what the cause is, this indicates isolation and lack of communication.

Trips organized by RCs are insufficient and, in 2019, most residents never went on a trip outside the center. Trips organized by centers might be the only opportunity to travel outside of the center's confines, other than for medical or administrative purposes. Outside trips would potentially interrupt the boredom and isolation experienced by residents, as well as offer an opportunity for them to experience the outside world, even if the trips are short and exceptional occurrence. Still, in 2019, only 77 percent of centers organized at least one trip for their residents (an average of 4.2 trips per center). The trips are not evenly distributed across counties or inside the same institution. Overall, more than 63 percent of residents in the system never had an opportunity to go on an organized trip outside their center in 2019. This, however, is not surprising; as previously mentioned, 29 percent of residents never reach the RC dining room. It is most likely that center personnel repeat similar choices that condemn

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[121] Art. 21: Freedom of expression and opinion, and access to information; and Art. 22: Respect for privacy.

a part of the residents to immobility and inactivity, placing most of their concentration on residents who are less challenging and more independent in terms of movement and behavior.

2.1.7. Respect for family life, for all matters relating to marriage, family, parenthood, and interpersonal relationships

The institutional setting in RCs generally does not allow residents rights to family, parents, and family life. According to Art. 23 of the CRPD, states must ensure that people with disabilities have the right to family and a family life, including marriage and partnerships on a free and consensual basis; home life; and the ability to make their own decision about fertility and reproduction. In addition, the article stipulates that all measures and accommodations are made to prevent the separation of persons with disabilities from their children, unless it is in the best interest of the children. In practice, residential institutions cannot, and do not, provide the exercise of these rights, despite a few weak exceptions.

Intimate relations and partnerships are almost nonexistent, invisible, or hidden from staff. A minimal percentage (2.5 percent) of beneficiaries are married or have a partner, with more than one-third living in the same RC. It is likely that the number of intimate/romantic relationships in RCs is larger, albeit perhaps not obvious or not having been reported by staff who completed the questionnaires. A 2014 report showed[122] that institutionalized persons with disabilities who attempt such relationships, at best are tolerated and/or ignored by RC staff. In the worst-case scenario, they are threatened or punished, sometimes by transferring one of the partners). Data collected for this report indicate that any effort to accommodate or protect these relationships is minimal and considered an exception. Less than a third of RCs offer a dedicated room for intimate relationships. At the same time, within the entire system and based on RC staff, there are only 59 couples with both partners in the same center. Of these, 35 couples share the same room.

Family connections are difficult to sustain within institutional settings, especially for long-term residents, even though these may be essential for deinstitutionalization. Although a significant number of residents have known immediate or extended family (a little over two-thirds), only 41 percent had any contact with a family member in the 12 months prior to the Covid-19 pandemic. About one-third had at least one phone conversation or had a family member visit them at the center during the previous year. Only 16 percent of residents were able to see a family member outside the center. Physical isolation and the stigma of being in an institution most likely contribute to such low numbers. Since the start of the pandemic, it is highly likely that these numbers have worsened. As discussed above, a good proportion of those returning to the community have returned to their families, giving good reason to establish that family ties correlate well with the better odds of leaving the centers and returning to the community. In the absence of state and community

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[122] Gîrlescu et al. (2014).

support, however, the only tool that exists in terms of deinstitutionalization is family and family support.

RCs do not offer the support or conditions necessary for parenthood and family life. Data collected suggest that separating a newly born child from its mother, who is institutionalized, is normal practice. In our sample of 265 fertile-age women, there were three pregnancies and two births; in both cases, the child was automatically placed within the public protection system. Institutional settings are improper for protecting the mother-child relationship and for creating the conditions that would prevent their separation. On the contrary, the high prevalence of contraceptive use[123]—most likely nonconsensual and used administered widely to fertile-age women as a preventative measure—suggests that the centers are not interested in making accommodations for possible births. In addition, the previously mentioned 2014 report indicates that in institutions such as these, conditions for non-consensual sterilizations can occur.

2.2. Enjoyment of the Highest Standards of Physical and Mental Health

This section provides an overview of the manner and extent to which the support and care needs of residents are adequately addressed in RCs, in an effort to provide residents with services and activities that are tailored to their needs and preferences. The provision of an RC service that is individualized requires (1) a comprehensive and person-centered assessment of the needs and preferences of the resident; and (2) the delivery of the service in as prompt and acceptable a manner that will respect the dignity and autonomy of the person with disabilities, in order to enhance his/her independence. This further requires an adequate number of specialized staff and access to onsite and community health services as well as other community resources to ensure the highest standard for the physical and mental health of the resident.

2.2.1. Assessment and case management

Assessing the situation and needs of persons with disabilities in RCs is the first step to ensure a person-centered service provision. Within 5 days upon admission of any resident and at least once a year thereafter, a multidisciplinary team must assess the person's general state; level of autonomy as well as any needs related to habilitation and rehabilitation; independent living skills; care and assistance needs; and education and cultural aspects; among other characteristics in order to offer the person ways in which to lead a meaningful life. The objective of the assessment is to provide each resident the tailored services and activities she/he needs and the level of frequency and duration, as well as the necessary materials or equipment. Such characteristics should be recorded and monitored in the resident’s Personalized Plan, developed by the multidisciplinary team and updated every six months.[124] Residents must be actively

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[123] The sample indicates close to 26 percent of fertile-age women.

[124] Order No. 82/2019, Annex 1, Module 3, Standards 1 and 2.

involved in the assessment process relating to the Personalized Plan, and multidisciplinary teams must consider their opinions.

The initial assessment carried out by a multidisciplinary team must take into account the recommendations outlined in the ISP and IRSIP, however not all files included such documents, or the documents were inadequately filled in. Quality standards[125] require multidisciplinary teams to carry out an evaluation of RC residents, based on the (1) medical, educational, professional, and social activities required for rehabilitation, training, and social inclusion of persons with disabilities, outlined in the Individual Program for Rehabilitation and Social Integration (IRSIP); and (2) intervention and support methods required to carry out those activities and services, according to the short-, medium-, and long-term objectives outlined in the Individual Service Plan (ISP). At the time of data collection, 20 percent of resident files failed to include an ISP or IRSIP, while close to 15 percent with plans in place had no recommendation for receiving social assistance. At the same time, although required, information was missing in approximately 72 percent of ISP files on whether or not residents had accessed disability-specific services within the community over a period of two years prior to institutionalization. As a result of the absence of information on adults with disabilities from previous IRSIP evaluations by Assessment Committees at the county level or by case managers in ISP, there is good reason to believe that RC multidisciplinary teams, too, will miss essential information about their residents. As such, the comprehensiveness of such evaluations at the RC level potentially can be compromised, resulting in residents not receiving the tailored services they require.

Multidisciplinary teams must include at least three staff members with differing specializations. Quality standards require that all RC multidisciplinary teams must include on their staff at least three of the following 11+ professionals: medical doctor, medical assistant, social worker, psychologist, psychological educator, occupational therapist, kinesiotherapy specialist, physiotherapist, specialist in vocational evaluation, rehabilitation educator, and education instructor, as well as other relevant therapists. The structure of multidisciplinary teams in the residential system mirrors the structure of specialized staff in RCs. Medical assistants are the most represented specialization in multidisciplinary teams (32 percent), followed by nurses (16 percent), rehabilitation educators (7 percent), social workers (7 percent), psychologists (8 percent), and ergotherapy instructors (7 percent). Kinesiotherapy specialists and medical doctors make up approximately 3 percent each.

While case managers are essential to ensure that each person with disabilities in an RC receives tailored services, not all residents are assigned one. Quality standards require that each resident is assigned a case manager to coordinate, monitor, and

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[125] Order No. 82/2019, Annex 1, Module 3, Standard 1, Minimum Requirement 9.

evaluate progress, based on the resident's Personalized Plan. Each month, the case manager is expected to meet with members of the multidisciplinary team who implement the Personalized Plan to discuss the welfare and progress of each resident.[126] Case managers, together with the multidisciplinary team, are supposed to revise, as necessary, the Personalized Plan every six months.[127] Close to 9 percent of residents do not have an assigned case manager, which raises questions about the efficacy and efficiency of providing such services to RC residents.

Case managers of persons with disabilities in RCs are either employees or are externally sourced. At present, nearly 39 percent of persons with disabilities have an assigned case manager who is an employee of the RC, with some variation by type of RC.[128] This varies significantly across counties, with some employed as RC staff[129] and more than half with no case managers employed as staff of RCs.[130] The larger the center, the more likely case managers are RC employees: more than half centers with over 100 places, but only one in four small institutions with under 20 places has employees assigned as case managers.

The number of case managers employed in RCs suggests a possible overload and a risk for case management responsibilities being carried out ineffectively. There are currently 249 employees in 103 RCs, who act as case managers for 6,575 persons with disabilities. The average caseload per case manager is 26.4 residents, rising to 50 in some counties.[131] The maximum caseload is 121 residents in CRRNs and RCs with over 100 places that are located in rural areas, particularly. This is also the caseload in Mureș County. Minimum quality standards for case management[132] fail to specify a case manager/beneficiary ratio,[133,134] leading to increased work pressure, ineffectiveness, and inefficiency in service delivery.

Case managers are most frequently social workers and psychologists. Unlike the structure of multidisciplinary teams dominated by medical assistants and nurses, case management positions are often filled by social workers, psychologists, and

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[126] Order No. 82/2019, Annex 1, Module 3, Standard 3.

[127] Order No. 82/2019, Annex 1, Module 3, Standard 2, Minimum Requirement 4.

[128] A large number of CRRNs and CITOs have employees who act as case managers: 56 percent and 57 percent respectively; while the approximate percentage for CRRPHs is 23 percent; CIAs, 36 percent; CPVIs, 33 percent; and CAbRs, 41 percent.

[129] Argeș, Bacău, Bistrița-Năsăud, Brăila, Buzău, Caraș-Severin, Mureș, and Vrancea.

[130] Bihor, Botoșani, Călărași, Covasna, Dolj, Galați, Giurgiu, Ialomița, Ilfov, Olt, Sibiu, Teleorman, Tulcea, Vâlcea.

[131] Harghita, Iași, and Suceava.

[132] Order No. 1218/2019.

[133] Government Decision No. 797/2018 from November 8, 2017, regarding the approval of framework regulations for the organization and function of public social assistance services, as well as the structure of staffing, stipulates one case manager per 50 adults with disabilities in RCs.

[134] In comparison, as of September 30, 2019, the average social work caseload in the United Kingdom is 16.9 persons with disabilities per case manager (UKGOV, 2019).

kinesiotherapists (approximately 70 percent). While this difference can be explained by the requirement that case managers have a university degree,[135] a level of instruction that very few nurses and medical assistants have, the situation also indicates the more psycho-social dimension of case management. In addition, this type of specialist is more likely to be present in RCs with more than 100 places (90 percent), unlike those with less than 20 places (only 45 percent). This situation also may explain the predominance of case managers as staff in larger centers, compared to smaller ones that lack qualified case managers.

2.2.2. Health profile and health service

The health status of RC residents and their access to health care are particularly difficult to assess from an institutional setting, particularly in view of self-administered questionnaires that may hold reporting discrepancies, as well as difficulties connected to data privacy and GDPR policies.[136] The CRPD may provide useful guidance in assessing the health status and health care access of RC residents, based on Romania's ratification of the CRPD in 2011 and its guarantee to citizens, including those with disabilities, "…enjoyment of the highest attainable standard of physical and mental health.” The CRPD makes it clear, through its human rights approach to disability, that health/health issues should not be equated to disability, and that a medical approach to disability is limiting and discriminatory.[137] This means that the right to health extends beyond disability, although it is recognized that the needs and vulnerabilities that relate to a disability also should be addressed. In particular, the CRPD sets forth four determinants for the right to health: availability, accessibility, acceptability, and quality.[138]

Availability

Medical services and facility availability are a problem for people in residential centers. About half of RCs are located in rural areas, sometimes far from a hospital,[139] and some in urban areas may be located too far from the center of town (see Section 2.5.1. **The right to be included in the community and to not be segregated and isolated** The right to be included in the community, to not be segregated and isolated). Beyond the issues of Romania's health system in terms of the availability of medical services and the need for professionals, the location of many RCs is an added challenge. Depending on location, the medical services that residents need, particularly specialist care, often are far and few.

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[135] Order No. 1218/2019. Mandatory minimum specific quality standards relating to the application of case management methods in the protection of adults with disabilities. Module 1, Standard 1, Minimum Requirement 5.

[136] ITHACA Project Group (2010).

[137] Fina et al. (2017).

[138] CRPD, Art. 25 para. 12.

[139] For example, 44 percent of RCs are more than 10 kilometers from the nearest hospital. Approximately 20 percent of centers, with over 100 places, are located less than 30 kilometers from a hospital, while for CRRNs, it is 14 percent.

Accessibility

Accessibility implies access to existing medical services and facilities, in particular the right of a person not to be discriminated against; the right to physical, social, and economic accessibility; and the right to information and communication regarding one's health (i.e., health services, treatments, illness prevention, and immunizations; among others). A recent study[140] on those with disabilities in Romania notes that while there is limited information relating to the physical and informational accessibility of medical services.[141] Financial accessibility, however, seems to be limited due to the fact that although people with disabilities have the right to free general and specialized medical services, in practice, however, this is not the case in some areas, where one is forced to rely on a private health service, often at a significant cost. This, particularly, is problematic in the area of dental health (i.e., treatment and prevention), whereby most dentists operate outside of the state system and most dental offices are insufficiently equipped to offer services to people with disabilities.

RC residents appear to have satisfactory access to primary care. From the national sample of 820 residents, all but one resident had a general practitioner assigned to them. About 97 percent had seen a doctor at least once during 2019. This suggests that there is no issue for residents to have access to a primary care doctor. The number of visits and how the visits are arranged (e.g., individual or group visits, frequency of visits, kind of examinations) is difficult to establish due to incomplete data.

Access by adults with disabilities to specialized medical services in institutions is likely to be affected by the institutional context in at least three ways. Access is either mediated by RC medical and nonmedical staff, is not individualized, or may be nonconsensual. It is highly unlikely that a resident will be seen by a medical professional on request unless the resident is appropriately accommodated and assisted, either in terms of being provided information, permission to leave the center, transportation, or bringing the specialist into the center. Logistically, this may be a challenge, depending on the size of those institutions (often with over 100 residents). RCs most likely have a "bulk" approach, whereby residents are seen as a group at the same time by a specialist instead of individually, unless the medical issue is acute. This is evidenced by the high number of chronic issues that residents suffer and hospitalizations (i.e., number of people, number of days). From a sample of 820 residents and at the exception of mental, behavioral, and neurodevelopmental issues, almost 80 percent of residents have a documented chronic illness. Most common chronic conditions were related to the nervous, circulatory and endocrine system, as well as associated nutritional and metabolic conditions and those of the digestive system. More than 10 percent of residents had been hospitalized in a nonpsychiatric hospital at least once during 2019, with an average stay of 10 days (Table 30).

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[140] World Bank (2020, 218).

[141] The assessment carried out by the National Agency for Payments and Social Inspection is still ongoing and, so far, reflects limited results.

Table 30: Residents Hospitalized and Days of Hospitalization in a Nonpsychiatric Hospital, 2019

		Number	Percent
Hospitalization frequency (nonpsychiatric hospital)	Never	11,680	89.3
	Once	1,010	7.7
	Twice	255	2.0
	Three or more times	127	1.0
	No information	4	0.0
	Total beneficiaries		
Days of hospitalization (nonpsychiatric hospital)	One day	268	19.3
	Two days	153	11.0
	3–7 days	355	25.5
	8–14 days	389	27.9
	15–30 days	157	11.3
	31 days or more	58	4.2
	No information	12	0.9
Total hospitalized beneficiaries		**1,392**	**100**

Source: World Bank survey of residential centers (2020).

Institutionalized people with disabilities are overexposed to health risk factors, further limiting their access to health services. In the language of the CRPD, the right to health refers not only to access to health care *per se*, but also to “the enjoyment of the ‘underlying determinants of health’”,[142] which include—aside from basic services, such as sanitation and good and safe living conditions—the absence of factors that may risk one's health. For beneficiaries within the Romanian system of residential care, these factors include the case of having to live an almost captive life within the confines of an RC, excessive medication (psychotropic and nonpsychotropic), various addictions (6 percent need counseling and treatment for addictions), diagnostic and treatment overshadowing,[143] insufficient screening and prevention methods, the scale of managing large numbers of residents, power relationships within the institution, and so on.

Life in an institution can be marked by feelings of boredom, attributable to the lack of physical activity due to insufficient space, facilities, and stimulation—all connected to increased incidences of cardiovascular disease, high blood pressure, and metabolic diseases.[144] The lack of outdoor space and facilities, as well as limited

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[142] Fina et al. (2017: 473).

[143] Diagnosis and treatment overshadowing refer to the inadequate provision of health care, either due to poorly informed staff or physical symptoms misattributed to psychosocial or intellectual disabilities rather than to physical illness (ITHACA Project Group, 2010: 17).

[144] ITHACA Project Group (2010).

opportunities to leave the institution are a reality in most RCs in Romania, only 25 percent of which offer green spaces, and only 58 percent some kind of outdoor space with movement/recreational equipment. As elsewhere mentioned in this report, 29 percent of residents do not leave their rooms for their meals, a significantly high figure considering that only 7 percent have disabilities of a physical nature and 14 percent have associated ones.

Residents are heavily medicated, which can be connected to a suite of health problems and conditions including nutritional, endocrine, metabolic, and cardiovascular diseases.[145] Almost 93 percent of residents are on long-term prescription medication treatment, 9 percent nonprescription, and 77 percent on psychotropic medication. While these high numbers imply a high rate of conditions that require treatment and management by way of medication, they also may reflect an approach that is nonindividualized, lacks preventative care and frequent consultation, and signals the physical absence of health care providers (i.e., pills can easily be administered by nonhealth staff).

Administering a heavily medicated approach to disability may overshadow health conditions that are not connected to disability. The process, referred to as "diagnostic overshadowing,"[146] occurs when caregivers are poorly informed and there is the chance of misattributing symptoms (in some cases, physical) to the beneficiary's disability, be it intellectual, psychosocial, somatic, or otherwise. Diagnostic overshadowing can take the form of simple discriminatory and prejudiced views on the part of the health care provider by ignoring the symptoms or by disbelieving the complaints or requests of the beneficiary. This approach also can be interpreted as "treatment overshadowing;" that is, decisions about medical treatment that are influenced by the same type of biases.[147] Decisions regarding certain treatments are based on complex calculations of what would be the best course of action or treatment, interactions with other patient conditions, willingness of the patient to cooperate which, however faulty, should be considered in a "professional" capacity and not to be contested. The result can lead to an underdiagnosis of particular conditions, until they become too chronic to be ignored (see high incidence of chronic diseases and of hospitalization, above), or worse, death, thus leading to unusually high mortality rates (see section 1.3.3.).

Some medical issues and conditions are highly likely to be ignored—or will go unnoticed—until they become acute or cause pain. In contrast to what appears to be a prevalence of chronic conditions and a correlated high mortality rate, reported medical needs are much lower,[148] suggests that the medical health approach

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[145] ITHACA Project Group (2010).

[146] Howard, Jones, and Thornicroft (2008, 169–171).

[147] ITHACA Project Group (2010, 18).

[148] For example, in the sample of 820 residents, 78 persons in 2019 are recorded as having chronic endocrinal, nutritional, and metabolic-related disorders, with only 48 persons having been provided specialist endocrinal and nutrition consultation. Discrepancies also are evident in terms of other chronic diseases, such as those relating to

administered contributes to the unawareness and absence of diagnosis of symptoms until the condition has become acute (see data from our sample of 820 residents, Table 31). For example, the need for dental care is indicated for 20 percent of the residents in the sample, and 21 percent in the total resident population, which, for an adult and elderly population, appears inordinately underestimated. In fact, it contradicts existing studies on the dental health of institutionalized adults with disabilities, which reflect a much higher percentage of untreated cavities and prevalence of gingivitis among these populations.[149] Moreover, a 2008 study on the oral health of children and adults with disabilities in Romania[150] points out serious problems among people with disabilities in accessing dental care. These range from issues of affordability and physical access to the reluctance of dentists to treat them, as well as a focus on the disability medical needs to the detriment of oral health needs. As a result, treatment is offered only on occurrence of pain, with the potential of the condition becoming severe. For example, the authors of the study report, in their sample of athletes with disabilities with cavities, a restoration index of total cavities (10 percent), gingivitis (30 percent), and calculus (33 percent).[151] In a 2018 study on athletes with intellectual disabilities in Romania, from six to 56 years of age, 79 percent showed signs of gingivitis; the restoration index was 20 percent.[152] It only can be assumed that the numbers for the older and institutionalized populations are worse, thus establishing the possibility that the reported 20 percent of residents who were provided dental care need additional investigations.

Table 31: Resident Needs for Specialty Medicine, 2019

		Number	Percent of Sample	Percent of Beneficiaries Who Were Able to Access Service on Each Occasion
Medical Specializations	General/family medicine	749	96.3	96.8
	Dental	155	19.9	75.5
	Ophthalmology	47	6.0	89.4
	ENT	32	4.1	96.9

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the- diseases of the circulatory system (100 persons with chronic diseases and 70 persons reportedly needing pneumology attendance), tumors (9 persons, of which one needed an oncological consultation).

[149] Anders and Davis (2010, 110-117).

[150] Vinereanu et al. (2008).

[151] Vinereanu et al. (2008, 11-14).

[152] Vinereanu et al. (2019).

Psychiatry	521	67.0	96.5
Neurology	126	16.2	95.7
Cardiology	70	9.0	95.7
Endocrinology and nutrition	48	6.2	91.7
Infectious diseases	22	2.8	95.5
OBGYN	34	4.4	94.1
Orthopedy	26	3.3	92.3
Dermatology	48	6.2	95.8
Oncology	1	0.1	1.0
Gastroenterology	24	3.1	1.0
Pneumology	28	3.6	92.9
Recuperation, physical therapy, balneology	45	5.8	88.9
Lab work	377	48.5	95.2
Radiology, medical imaging	92	11.8	8.8
Emergency medicine	47	6.0	89.4
Other medical specialization	47	6.0	100
Total sample of beneficiaries	**820**	**100**	

Source: World Bank survey of residential centers (2020).

There are insufficient screening and preventative measures, thus contributing to negative health outcomes. The lack of individualized medical visits by residents with disabilities and the delayed diagnosis and treatment of their symptoms call for the practice of screening and testing as a useful compensatory tool. It is obvious that residents are at risk of having a series of undiagnosed health conditions or that the diagnosis is made too late, including in the case of cancer, which points to the importance of routine tests and screenings, at least at the level that they are available to the rest of the population.[153] While the proportions are relatively high of those who received basic blood tests, had their blood pressure measured, and received flu shots, the numbers reflected for dental care, tuberculosis, dermatological screening, Pap smears, and other routine screenings are, indeed, worrisome (Table 32).

Table 32: Distribution of Medical Screening Received, by Beneficiaries, 2019

	Number of Residents	**Percent of Residents**

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[153] ITHACA Project Group (2010).

	Who Benefitted	Who Benefitted
Basic blood tests	10,433	79.8
Blood pressure measuring	12,875	98.5
Flu shots	11,940	91.3
Dental exams	2,161	16.5
Dermatological exam	713	5.5
Tuberculosis testing	1,214	9.3
Ophthalmology exam	802	6.1
Ear, nose, and throat exam	273	2.1
Pap Smear (only for women)	227	3.4
Mammography (only for women)	57	0.8
Total beneficiaries	**13,076**	
Total women beneficiaries	**6,762**	

Source: World Bank survey of residential centers (2020)

Acceptability and quality

Acceptability refers to the degree to which the medical services and facilities, as well as treatments, are in accordance with the needs and requirements of the patient, in terms of culture, gender, life stage, and in respect of medical ethics. Quality refers to the quality of services, facilities, and goods, and how scientifically and medically appropriate they are.[154] There is insufficient data to be able to evaluate these dimensions, and more qualitative and on-site assessments are necessary to establish a basis.

2.2.3. Specific activities in residential centers

RCs are expected to offer diverse activities, carried out by specialized staff and with the use of appropriate materials and equipment where needed. Each resident should be able to benefit from a series of activities within the RC, in accordance with his/her Personalized Plan. Those RCs that are licensed for such services, according to Order No. 82/2019, must provide residents with (1) social assistance, so that they are informed and counseled about rights and what social benefits they are eligible for; (2) psychological counseling; (3) habilitation and rehabilitation activities; (4) care and assistance activities; (5) activities meant to develop and maintain independent living skills; (6) a level of education and employment training; (7) decision-making support; and (8) social activities that will involve them in civic community life. Each set of activities should include various subtypes of activities that can be carried out by a diversity of specialists (Box 5).

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[154] Fina et al. (2017, 475).

Box 5: Types of Activities Carried Out in Residential Centers and the Necessary Staff To Do So

Each residential center must provide, depending on beneficiary requirements, the following types of service. Types of service, staff involvement, and standards of service are described in Annex 1 of Order No. 82/2019.

Main Activities	Specific Activities	Type of Staff Involved
Social assistance and information		Social assistant
Psychological counseling	- Psychological counseling - Psychotherapy	Psychologist/psychotherapist
Habilitation and rehabilitation activities	- Speech therapy/psychotherapy - Massage, kinesiotherapy, physical therapy - Hydrotherapy, thermotherapy, balneotherapy - Psycho-sensory motion stimulation - Occupational therapy - Occupational/vocational activities	Speech therapist, kinesiotherapist, physical therapist, massage therapist, rehabilitation pedagogue, occupational therapist, wheelchair evaluation/recommendation/supply and adaptation technician, ergotherapy instructor, social worker, nurse, other therapists
Care and assistance	- Support for getting dressed/undressed, putting on/taking off shoes, selecting appropriate clothing - Support for daily hygiene (washing, drying, caring for one’s own body, toilet hygiene, changing	Social worker, nurse, social pedagogue, rehabilitation pedagogue, ergotherapy instructor, other therapists

	hygiene/sanitary materials etc.) - Support for administering medication, depending on competence and following the recommendations of the specialist/primary care physician - Support for specific problems: catheters, prevention of decubitus sores (treating eschars), and others - Support for changing body position, moving the body from a horizontal position into a different position, moving the body into another side position - Support for transfer and mobilization, moving indoors and outdoors, including shopping - support for communicating	
Maintenance and development of independent living skills	- Maintaining/developing cognitive abilities - Maintaining/developing daily life skills - Maintaining/developing communication skills - Maintaining/developing mobility skills - Maintaining/developing self-care skills - Maintaining/developing self-healthcare skills - Maintaining/developing self-management skills	Psychologist, psychotherapist, speech therapist, occupational therapist, rehabilitation pedagogue, social pedagogue, educational instructor, ergotherapy instructor, social worker, physician, massage therapist, kinesiotherapist, physical therapist, medical assistant, other therapists.

	- Maintaining/developing social interaction skills	
Support for education and employment training		Psychologist, psychotherapist, speech therapist, occupational therapist, social assistant, professional orientation counselor, assisted employment specialist, vocational assessment specialist, social worker, rehabilitation pedagogue, educational instructor, ergotherapy instructor, other therapists.
Support for decision-making		Legal specialist, lawyer, social assistant, vocational counselor, psychiatrist, other specialists.
Social and civic integration and participation		Social assistant, social assistant technician, social worker, psychologist, psychotherapist, occupational therapist, kinesitherapist, physical therapist, rehabilitation therapist, social pedagogue, ergotherapy instructor, educational instructor, art-therapist, educational animator, other therapists.

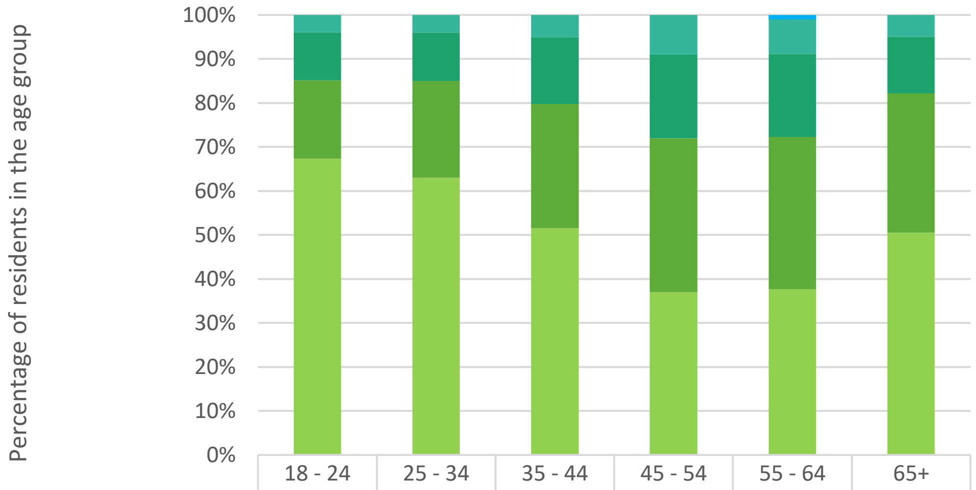
The majority of the beneficiaries were evaluated as needing a set of services that could be described not only as basic but also as addressing the beneficiaries as passive, helpless, and in need of being constantly medicated. Ninety-eight percent of beneficiaries needed assistance in taking their medications, and between 83 percent and 90 percent in need of support to develop the necessary physical and cognitive skills to take care of their own health, information and social assistance, daily life skills, self-care skills, and cognitive skills. In contrast, there were fewer residents in need of skills training to live a more independent life within the community (e.g., vocational/occupational activities, activities relating to education/employment, social and civic participation). This is most likely not a reflection of the lack of need on the part of the beneficiaries (that they are well educated and ready to take on a job, for example), but rather a reflection of how the evaluators see the potential of the beneficiaries to become active participants in their own independent lives. The data show that despite 44 percent of beneficiaries having never attended school, when evaluators were asked what services received during the previous 12 months they considered may have improved the beneficiaries' level of education, for 56% of the beneficiaries, the answer was “it is not the case.”

According to the data we received from the centers, the needs of beneficiaries vary slightly according to the type and degree of disability, and not necessarily linearly. To an extent, these variations are expected—albeit with some anomalies—suggesting there is an incongruity between the objective needs of beneficiaries and how the evaluators viewed their potential to develop and improve the skills to live independent lives. In other words, some categories of beneficiaries are seen as worth investing in by way of specific activities, while others were considered as needing mostly care and assistance. Thus, those with more severe disabilities are receiving in higher percentages services that address them as passive recipients or are not intended to necessarily develop skills for independent living, but rather to simply assist them in their everyday life activities or improve their quality of life (e.g., providing art or sensory therapy and assistance in taking medication, mobility, self-care, changing the position of the body). Those with less serious disabilities are benefiting from these services in far less percentages, and at the same time are receiving in higher percentages services that address them as having potential for developing independent living skills (occupational therapy, vocational/occupational therapy, education and preparation for work, support in decision making, social and civic participation). At the same time, the data show some anomalies. Beneficiaries with mild and high degrees of disabilities are receiving these latter services in higher percentages and the basic supportive services in lower percentages than those with low disabilities (Annex-Table 12). An explanation could be connected to the smaller number of beneficiaries with a low degree of disabilities, which might skew the numbers, but more data—in particular, qualitative data—is needed.

The majority of persons with disabilities in RCs are offered activities to develop and maintain their independent living skills These skills are related to maintenance and development of cognitive skills, skills for day-to-day living, communication, mobility, self-care, healthcare, home management, social and interpersonal relationships, and shopping. These include learning social skills and training for an occupation. While almost all residents benefit from this support, the level tends to vary, since most call for continuous support (over 51 percent), others on a regular basis (close to 29 percent), and yet others only sequentially (14 percent) or minimally (approximately 6 percent). Less than 1 percent of residents have no support needs whatsoever.

Younger beneficiaries have been evaluated as in need of continuous support to develop and maintain independent living skills in greater percentages than those who are older. The relationship holds, albeit in reverse: those who need minimum, sequential, or regular assistance, care, and supervision tend to be older residents, with the exception of those over 65, compared to those who are younger (Figure 24). While seemingly counterintuitive, the relationship is consistent with the profile of younger beneficiaries, who have entered the system in greater proportions with severe degrees of disabilities and in the absence of alternatives within their communities. This might also be a sign of a historical shift, in that younger people with lower degrees of disability are now able to remain in the community in greater proportions, probably in the care of their families, compared with the past, when even those needing lower levels of support were unable to remain in their community. Those residents older than 65 have similar levels of support as do the younger ones, since they also have less option to remain within their communities, given the higher level of needs that cannot be provided by community or family.

Figure 24: Distribution of Degree of Needed Support, by Age Group (percent)



	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65+
■ Doesn't need support	0%	0%	0%	0%	1%	0%
■ Minimally	4%	4%	5%	9%	8%	5%
■ Sequentially	11%	11%	15%	19%	19%	13%
■ Regularly	18%	22%	28%	35%	35%	32%
■ Continuously	68%	63%	51%	37%	38%	51%

Source: World Bank survey of residential centers (2020)

The size of the RC influences certain types of activities offered to residents. Most noticeably, small RCs (less than 20 places) seem to offer, in higher percentages niche activities (e.g., art therapy, sensory therapy), including those development and improvement skills necessary to lead an independent life, activities related to improving the quality of life (e.g., care and assistance) and those to administer medication. These RCs, however, centers offer in smaller percentages services related to mobilization and the manipulation of the body, as well as preventing decubitus sores. It is possible that these smaller centers have more residents (more than half of residents) with severe degrees of disability compared to larger centers, as well as a higher percentage with intellectual disabilities (73 percent) compared to those with physical and associated disabilities.

The type of center influences certain types and levels of activities offered to residents. The differences are on the one hand, the result of objective differences in the profile of the residents and their needs, but on the other they are the result of how the centers/the system selects, addresses, and treats its beneficiaries. Residents of CIAs, for example, benefit in higher percentages from services that entail a low level of autonomy and a high level of support rather than those activities meant to develop skills for independent living. CPVIs, in contrast, have a higher rate of activities for the latter, consistent with their structure as a transitional space in which to develop an independent living). Still, the selection and favoring of particular types of residents for these centers has discriminatory consequences, in the sense that residents benefit less, for example, from services meant to develop independent living skills depending on where they live.

While the skills that residents learn are meant to facilitate their transition into the community, the lack thereof must not be an argument for perpetual institutionalization. Everyday living requires various skills, such as home management (e.g., cooking, cleaning, laundering), maintaining personal hygiene, managing money and shopping, using transportation and other community services, and interacting safely with other community members. Institutionalized persons with disabilities may lack such skills at the level required for unaided living in the community, either as a consequence of prolonged exposure to an institutional culture that encourages dependence at the expense of autonomy; or due to not having had an opportunity to develop such skills. Many residents may never fully develop sufficient independent living skills to navigate within the community, thus having to depend on a wide range of community-based services, including home help and care, as well as personal assistants in seeking the necessary tailored support to address their needs and preferences.[155]

2.2.4. Specialized staff

Although specific services provided in RCs require a large variety of specialized staff, there remains a considerable number of unfilled positions. Specialized staff is still missing in RCs relative to the total number of positions reflected on organizational charts. The proportion of unfilled positions, however, varies across different types of profession. While there are vacant positions in the system for all professions,[156] vacancy rates vary widely. For instance, the proportion of unfilled positions of medical assistant, nurse, rehabilitation educator, educator/childcare educator, instructor/educator for resocialization activities is around 20 percent. Furthermore, the situation of other professions is rather worrying: only 33 percent and 35 percent, respectively, of the number of positions of psychotherapists and speech therapists are filled; and, at the

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[155] European Expert Group on the Transition from Institutional to Community-based Care (2012, 128).

[156] The only type of profession that had no vacant place is the addiction counselor for which there is only one position reflected on an organizational chart within the entire system.

low end, only 16 percent of nutritionist/dietitian positions are occupied[157] (Annex-Figure 1). In general, specialized positions with the lowest vacancy rate are those with the most employees in the system. There are currently neither sign-language interpreters nor vocational counselors employed in RCs.

There is a wide variation of specialized staff vacancies by type of RC. Vacancies are not evenly distributed across type and size of RC. Some types of RCs have quite a low percentage of filled positions. For instance, CRRPHs have approximately 17 percent of medical doctor positions, and CITOs the same percentage of kinesiotherapy specialists. CAbRs have the lowest percentage of rehabilitation educator positions that are filled in, compared to other types of centers—only 29 percent—while CITOs and CPVIs have no filled occupational therapist positions.

While vacancies do exist in RCs, they not always reflect the lack of needed professionals to provide specialized services and activities. According to center staff self-assessments, the number of specialized staff currently employed does not always reflect the number required to offer activities and services to residents. Some professions are currently over-represented in the residential system relative to the number of positions needed, such as medical assistants, nurses, and rehabilitation educators (Annex-Figure 2). Furthermore, with regard to some professions, the actual number reflected on organizational charts is higher than the number of staff required. For instance, positions for social workers**[158]** have a much higher allocation than what is needed (140 percent). Lower percentages— but still above 100—apply in the case of medical assistants, nurses, rehabilitation educator, psychologists, social assistants, social assistance technicians, childcare educator, instructor-educator for resocialization activities, and ergotherapy instructor.

Access to communication to ensure that persons with disabilities can understand, decide, and communicate their wishes and preferences regarding service provision remains a challenge for RCs. Access to sign-language interpreters or other forms of alternative communication is limited. There are only 108 employees in all RCs who are trained in sign-language or other forms communication,[159] the majority of whom are specialized staff (78 percent). This widely varies across counties, with concentrations in only a few counties (Harghita, Bacău, and Iași). Access to communication is of paramount importance during the evaluation carried out by the multidisciplinary

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[157] That is 3 out of 9 charted positions in all RCs. This is particularly worrying, since approximately 13 percent of all residents have endocrine, nutritional, and metabolic disorders.

[158] In Romania, this profession is called *lucrător social*, not to be mistaken for social worker (*asistent social*).

[159] Alternative and augmentative communication is the type of communication used by persons who do not communicate verbally or who find it difficult to do so. As such, they use a range of communication means; for example, signs, symbols, images, pictograms, gestures and facial expressions, and body posture (types of augmentative communication systems include PECS, Bliss, and Makaton, among others).

team,[160] in the update of Personalized Plans, and in all phases of service provision, including everyday interaction with staff. There are 14 RCs, however, that reported having no access whatsoever to sign-language interpreters, and 26 have no access to specialists in augmentative and alternative communications. RCs most often rely on the social service provider (GDSACPs, in most cases) whenever they need support to ensure accessibility in communication is available for the residents, including language interpreters (Table 33).

Table 33: Distribution of Residential Center by potential sources of Human Resources Necessary To Ensure Communication Accessibility for Residents, by Type of Support

	Types of Communication Accessibility (number)		
Potential Sources of Support	**Sign-Language Interpreter**	**Specialist in Alternative and Augmentative Communication**	**Interpreter for Languages Other than Romanian**
Residential center employee	**16**	**16**	**74**
Social service provider	**212**	**210**	**178**
Person from the community	**2**	**5**	**13**
Organization in the county	**42**	**29**	**16**
No access to such resource	**14**	**26**	**5**

Source: World Bank survey of residential centers (2020).

2.2.5. Staff training

Most RCs in 2019 had a training plan for their employees, although in certain counties, there was no such plan. Quality standards require mandatory annual training for employees on (1) equality of opportunities; (2) preventing, identifying, and reporting forms of exploitation, violence, and abuse; (3) respect for diversity; and (4) respect for and encouragement of individual autonomy and independence of persons with disabilities.[161] In 2019, only 4 percent of RCs failed to have a training plan, including a higher percentage of CITOs (13 percent). Some counties have a particularly high proportion of centers without a training plan—40 percent of centers in Giurgiu and Mehedinți; 29 percent in Satu Mare; while Cluj, Dolj, Hunedoara, and Suceava have percentages between 10 and 20 percent.

Not all RCs offered training according to their annual plan or on other relevant topics. While most RCs reported having annual training plans for staff in 2019, the proportion of centers that included different types of courses, let alone organized

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[160] An aspect explicitly mentioned by quality standards. Order No. 82/2019, Annex 1, Module 3, Standard 1, Minimum Requirement 4.

[161] Order No. 82/2019, Annex 1, Module 1, Standard 1, Minimum Requirements 11 and 12.

them, is much lower. This also is reflected in the number of staff trained. For instance, only 21 percent of center staff was offered a course in Respect for Diversity, a mandatory module for all staff in RCs (Annex-Table 13).

Training courses for staff in RCs are offered on a variety of subjects, although persons with disabilities are rarely involved as trainers in these programs. Subjects range from respect for the rights of persons with disabilities, based on the CRPD, to the recognition of instances of abuse and exploitation. Persons with disabilities should be actively involved in providing training to RC employees, especially with regard to issues such as human rights and disability, as well as those aspects that relate to the provision of quality services in a way that will promote independent living. Nevertheless, persons with disabilities were rarely present as trainers in sessions and courses offered to staff in 2019. Their presence varied according to the type of course offered but was never higher than 5 percent.

While a majority of staff needs training, training is not evenly offered across a variety of topics. More than two-thirds of employees in RCs need further training, with that as the most widely identified relating to communication with people with disabilities and carrying out activities with persons with disabilities meant to develop or maintain communication skills. This is followed closely by training in care and assistance, first aid, and assisting people with limited mobility (including support for maintaining or developing mobility). Training needs for ensuring service delivery in such a way as to cater to the preferences of residents (e.g., decision-making support, CRPD, or respect for autonomy and independence), were identified for less than 1 percent of staff (Annex-Table 13).

2.2.6. Volunteers and other collaborations

Volunteer participation in RC activities is limited. GDSACPs and RCs are expected to encourage volunteers for activities to benefit persons with disabilities,[162] according to the law.[163] In 2019, only 71 centers had volunteers, mostly for specialized activities. CPVIs had no volunteers in 2019, while RCs with a capacity below 20 places were less likely to have any volunteers. Only one CITO had 10 volunteers for specialized activities. Many counties had centers with no volunteers, while in Botoșani, Dolj, and Galați, more than 66 percent of centers benefited from volunteer involvement. A total number of 254 volunteers were involved in specialized and administrative activities (180 and 57, respectively). The average number of volunteers was 3.6, as high as 48 in 3 centers in Maramureș and 25 in one center in Alba, carrying out administrative tasks exclusively.

Collaboration with other organizations and institutions can ensure access of residents to knowledge and skills that cannot otherwise be provided in RCs. At the

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[162] Order No. 82/2019, Annex 1, Module 1, Standard 1, Minimum Requirements 16.

[163] Law No. 78/2014 regarding the regulation of volunteering activities in Romania.

time of data collection, only close to 37 percent of RCs were collaborating with NGOs, universities, research institutes, local public institutions, and hospitals, among others, as part of their activity or in specific projects. Collaboration relates to a number of different objectives, such as facilitating access to information about sexual and reproductive health, substance addiction, vocational counseling, and support for decision-making.[164] The proportion of centers varies by type of collaboration, while some types of center had no such collaborations whatsoever (Table 34). Centers in several counties did not collaborate with other organizations, such as Călărași, Dolj, Giurgiu, Ialomița, Ilfov, Teleorman, and Vâlcea.

Table 34: Distribution of Residential Centers, by Type of Collaboration and Center (percent)

	Centers with Collaborations	**CAbR**	**CRRPH**	**CIA**	**CRRN**	**CITO**	**CPVI**
Information about HIV/AIDS	**4.5**	**5.6**	**0.0**	**5.9**	**1.9**	**12.5**	**33.3**
Information about intimate relationship and sex	**3.5**	**2.8**	**0.0**	**4.4**	**1.9**	**12.5**	**33.3**
Information regarding family planning and reproduction	**3.5**	**5.6**	**2.0**	**2.9**	**7.4**	**12.5**	**33.3**
Information regarding illegal substances, alcohol, and nicotine addiction	**5.2**	**5.6**	**2.0**	**5.9**	**1.9**	**12.5**	**33.3**
Theoretical and practical training regarding the use of technologies and access devices necessary to carry out activities for maintaining/ developing cognitive skills	**4.2**	**2.8**	**6.0**	**2.2**	**7.4**	**0.0**	**33.3**
Vocational counseling	**4.9**	**1.1**	**8.0**	**2.9**	**1.9**	**0.0**	**33.3**
Internships, apprenticeships, and volunteering	**12.5**	**19.4**	**16.0**	**9.6**	**11.1**	**0.0**	**66.7**

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[164] All enumerated activities are suggested by quality standards.

Decision-making support	**3.8**	**0.0**	**8.0**	**2.9**	**3.7**	**0.0**	**33.3**
Other aspects	**26.1**	**44.4**	**18.0**	**22.1**	**29.6**	**25.0**	**66.7**

Source: World Bank survey of residential centers (2020).

2.3. Legal Capacity and the Right to Personal Liberty and the Security of Person

Enjoyment of legal capacity on an equal basis with others in all aspects of life must be ensured for persons with disabilities. Legal capacity is the ability to have and exercise one's rights and duties as well as to initiate and conclude legal acts.[165] Restrictions in the exercise of legal capacity may make it impossible for a person to marry, get employed, vote, buy or rent a house, get a loan, decide on a medical treatment and, generally, to exercise all civil, political, economic, social, and cultural rights and make decisions that are essential for everyday living and pursuing one's life goals. Often, persons with disabilities face barriers in exercising their legal capacity by having their decision substituted[166] due to real or perceived deficits in mental capacity or decision-making skills.[167] The State Party to CRPD Romania assumes the obligation to take all measures to ensure the exercise of legal capacity for persons with disabilities, including measures to support persons in deciding for themselves in all life matters.

The exercising of legal capacity for persons in RCs may be restricted due to legal provisions, or whenever a person cannot make decisions in accordance with her/his will and preferences. The impossibility to make decisions regarding any aspect of the life of a person with disability can be (1) an outcome of legal restriction, such as placement under guardianship and the substitution of all decisions by a legal guardian; and (2) a consequence of how persons with disabilities are treated, by being perceived as unable to understand their own life situation and decide accordingly. This type of restriction may lead to the prioritization of staff decisions over and above that of the

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[165] Legal capacity thus encompasses legal standing, recognizing any human being as a holder of rights, and legal agency; that is, acknowledging any person as agent with the power to engage in transactions and create, modify, or end legal relationships, as emphasized also by the CRPD Committee (UN, 2014a, para. 13).

[166] A decision is substituted when "a substitute decision maker appointed by a third party takes decisions based on what he or she considers is in the best interests of the person concerned, even if that goes against the will of the latter." Human Rights Council (2017c, para. 26).

[167] The CRPD Committee warns against the conflation between legal capacity and mental capacity. While legal capacity is to be a holder of rights and an actor before the law, mental capacity refers to decision-making skills and can naturally vary from one person to another, depending on various factors (e.g., environmental, social) (CRPD Committee, 2014a, para. 13). The Committee also emphasizes that "The concept of mental capacity is highly controversial in and of itself. Mental capacity is not, as is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity" (Idem, para. 14).

person with disabilities with regard to RC service provisions, including specific activities relating to care and assistance, daily schedules, and the administration of treatment.

2.3.1. Guardianship

Romanian legislation restricts the exercise of legal capacity for certain persons with disabilities. Legal capacity can be restricted in various substituted decision-making systems that may include plenary and partial guardianship, judicial interdiction, curatorship, conservatorship, and mental health laws that allow involuntary treatment and commitment.[168] Currently, the Romanian Civil Code restricts the exercise of legal capacity of persons declared to lack the mental capacity to care for their own interests, and places them under the guardianship of a legal representative.[169] On July 16, 2020, the Romanian Constitutional Court ruled that guardianship is unconstitutional,[170] as it harms human dignity and it affects the autonomous development of human personality.[171]

A large number of persons with disabilities in RCs are deprived of legal capacity. Approximately 23 percent of residents have legal guardians, which constitutes around 17 percent of persons placed under guardianship in Romania.[172] More than half were placed under guardianship in the past five years, indicating a slight increase compared to previous periods.[173] Guardianship, as a protection measure, seems to have been instituted subsequent to the moment of institutionalization for the majority of persons with disabilities (Table 35), which may point either to a deterioration in their mental capacity during their stay in institutions or to a generalized practice of placing persons under guardianship for administrative reasons. Often, the reason for requesting persons

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[168] Human Rights Council (2017c, para. 26).

[169] Art. 164 (1) of the Civil Code establishes three requirements for an individual to be placed under guardianship: (1) the person must be lacking mental capacity; (2) the cause for their lacking mental capacity is "unsoundness of mind" or "mental retardation," established on the basis of a specialized medical assessment; and (3) the lack of mental capacity does not allow a person to take care of their own interests. The term used by Art. 164 is "discernment." However, the choice to use "mental capacity," instead, is intended to provide a clearer understanding of how the national legal provisions conflict with CRPD principles, as outlined by the CRPD Committee in General Comment 1.

[170] Decision No. 601 from July 16, 2020, regarding the exception of unconstitutionality of the provisions of Art. 164(1) Civil Code, published in the Official Journal No. 88, January 1, 2021. The Civil Code holds that guardianship in the absence of safeguards for ensuring the exercise of legal capacity infringes on the provisions of constitutional provisions of Art. 1 (3), Art. 16 (1), and Art. 50, in its interpretation, in view of Art. 20 (1) and in view of Art. 12 of the CRPD. (www.ccr.ro/wp-content/uploads/2021/01/Decizie_601_2020.pdf)

[171] Idem: 8.

[172] The World Bank estimates that in October 2020, there were 17,570 persons under guardianship, nationwide. However, an official number is yet unavailable. In August 2020, the Ministry of Internal Affairs informed the NARPDCA that there were 77,000 persons under guardianship but, as of November 9, 2019, the Ministry of Internal Affairs (Directorate for Persons Record and Databases Management) estimated 7,024 individuals were deprived of their legal capacity, in response to a request of the Center for Legal Resources (World Bank, 2020: 76).

[173] The increase also has been reported at the national level since 2019, with 4,000 persons being placed under guardianship in 2019 (World Bank, 2020: 76).

to be deprived of their legal capacity in the first place is to allow legal guardians to make decisions regarding various financial, medical, and administrative matters in place of the person.[174]

Table 35: Distribution of Persons under Guardianship Relative to the Time of Admission

Placement under Guardianship Relative to Admission Date	Number	Percent
Before admission to residential center	325	10.7
Same year when the person was admitted to residential center	329	10.8
After admission to residential center	2,389	78.4
Missing information	5	0.2
Total number of beneficiaries under guardianship	**3,048**	**100.0**

Source: World Bank survey of residential centers (2020).

Persons with disabilities deprived of legal capacity in RCs have different levels and types of disability. The Civil Code stipulates that guardianship may be instituted only in the case of persons who lack mental capacity; however, "unsoundness of mind" or "mental retardation" that characterize mental incapacity, according to the law, may be determined as a psychiatric illness, and not always as a type of disability.[175] This may explain why not all residents under guardianship have intellectual (mental) or psychosocial (psychiatric) disabilities. In fact, quite a high proportion of residents under guardianship has a physical disability or lives with HIV/AIDS[176] (Annex-Table 14). In addition, 10 percent have mild and medium disabilities. This situation can be explained by the high proportion of residents with mental, behavioral, and neurodevelopment disorders (77 percent), 26 percent of which are under guardianship (approximately 2,167).[177]

Many legal guardians of persons with disabilities in RCs are in a conflict of interest with the persons they legally represent. CRPD requires that any measures relating to

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[174] These include decisions regarding involuntary medical treatment, as well as assets and income management (World Bank, 2020: 72).

[175] Art. 211, Law No. 71/2011 for the enforcement of Law No. 287/2009 regarding the Civil Code. The Romanian legal terminology is "*alienație*" and "*debilitate mintală.*" Even though it has been considered offensive (Math, Kumar, and Moirangthem, 2015), "unsoundness of mind" is still a term used in various case laws, regulations, and legislation, including the European Convention of Human Rights under Art. 5 § 1(e) (Council of Europe (1952). The European convention on human rights. Strasbourg: Directorate of Information)

[176] Persons living with HIV/AIDS particularly stand out, as 40 percent have legal guardians. In the majority of cases, the legal guardians are the local councils or Guardianship Authorities and in some cases staff from the center where they had been previously institutionalized in the child protection system.

[177] Estimate based on data collected for a sample of 820 residents.

the exercise of legal capacity be free of conflict of interest[178] to avoid any decisions contrary to the persons will and preference. Many residents, however, are in conflict of interest with their legal guardians. Currently, Guardianship Authorities are the legal guardian for approximately 8 percent of residents. Since Guardianship Authorities are local public authorities that monitor the wellbeing of persons under guardianship and the fulfillment of responsibilities by legal guardians, any Guardianship Authority that simultaneously acts as legal guardian is in the position to monitor its own activity. Conflict of interest may also arise in situations where legal guardians are directors or other staff of RCs, as well as GDSACP directors and staff (Table 36). This form of legal representation raises particular difficulties regarding (1) situations when residents may wish to appeal to various complaint mechanisms to notify a right infringement or any dissatisfaction with service provision in an RC;[179] (2) any decisions relating to daily life in institutions that may conflict with what staff or directors may consider is in the best interest of residents; and (3) future plans of deinstitutionalization that may prioritize preferences of legal guardians over those of residents. Conflict of interest can also characterize relationships with family members, as the latter may exercise undue influence over persons under guardianship or merely take decisions instead of the persons represented.[180]

Table 36: Distribution of Residents under Guardianship, by Type of Legal Guardian

Type of Legal Guardian	Number of Persons under Guardianship	Percent of Persons under Guardianship
Family member	1,025	33.6
Local public authorities' representative	572	18.8
Guardianship Authority	246	8.1
Residential center director	304	10.0
Residential center staff	542	17.8
GDSACP director	107	3.5
GDSACP staff	75	2.5
Another person	123	4.0

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[178] Art. 12(4).

[179] Persons with disabilities in RCs are confronted with additional barriers to accessing Internal complaint mechanisms or reaching out to police, prosecutors, or other independent mechanisms, such as the Ombudsman, Monitoring Council, or National Council for Combating Discrimination, as they are sometimes discouraged and sanctioned by RC directors and staff for any attempt (World Bank, 2020: 93–94).

[180] The Special Rapporteur on the rights of persons with disabilities suggests that in some situations, persons with disabilities may have experienced abuse and manipulation by relatives, and such relationships cannot ensure adequate support in the decision-making process in a way that reflects their will and preferences (Human Rights Council, 2018; Human Rights Council, 2017c, para. 57).

No legal guardian appointed	54	1.8
Total residents under guardianship	**3,048**	**100.0**

Source: World Bank survey of RCs (2020).

Note: GDSACP= General Directorate for Social Assistance and Child Protection.

Some persons with disabilities under guardianship have no appointed legal guardian, which may cause difficulties with regard to legal and administrative matters that involve persons with disabilities in RCs. Guardianship already has been sanctioned not only by the CRPD Committee but also by the Romanian Constitutional Court as a substituted decision-making system that restricts the exercise of legal capacity. The lack of an appointed guardian, however, for persons with a court decision for placement under guardianship may, in fact, further increase the likelihood of abuse and lack of autonomy concerning decisions about one's life. In situations where no guardian is appointed, guardianship authorities cannot carry out their monitoring activities of guardians and, as a result, some cases of abuse are unlikely to be identified. At the same time, persons under guardianship cannot conclude legal acts, nor exercise their rights and, in the absence of guardians, it is unclear how certain acts are concluded. Currently, almost 2 percent of persons under guardianship in RCs have no appointed legal guardian.

Support in the decision-making process is not only a need of persons with disabilities under guardianship who live in RCs. Ensuring decision-making support as a measure to ensure the exercise of legal capacity is an obligation Romania has assumed as State Party to the CRPD.[181] This type of support is an activity widely carried out in RCs, not only as a service offered to persons under guardianship. In fact, only 18 percent of residents requiring decision-making support are under guardianship. About 90 percent[182] of RCs offer this type of activity, with some variation across types of centers, with smaller proportions at CRRPHs and CITOs (approximately 74 percent and 88 percent, respectively). Close to 59 percent of residents need such activities, almost three times the number of residents under guardianship.

While decision-making support is being offered at large scale in residential institutions, many residents have limited control over aspects of their daily life. Independent living and personal autonomy begin with the ability to make one's own decisions about everyday life tasks, bodily routines, and the management of time, as well as about making choices about personal matters such as appearance and presentation and the personalization of immediate living space. Deciding about these aspects as a resident, however, is in contradiction with the logic of institutions, and

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[181] CRPD Committee (2014a).

[182] Comparatively, approximately 74 percent of all centers house residents placed under guardianship.

they are strong arguments for deinstitutionalization. Still, even in an institutional context, measures can be taken to allow for more autonomy of residents in their everyday lives. The opportunities for making choices relating to everyday life are insignificant and do little to compensate for the depersonalizing and regimenting experience of living in a RC. For instance, residents are consulted about the food menu at least once a day in only 68 percent of centers.

Activities of assistance and support in decision-making are predominantly offered by psychologists and social workers. Specialized staff involved in this type of support mostly comprises psychologists and social workers (approximately 70 percent). The heavy reliance on psychologists and social workers to provide support in making decisions at the expense of other RC specialized and nonspecialized staff may deprive residents of the possibility to make circumstantial decisions regarding aspects of their daily lives, from self-care, sleep schedule, clothing and nutrition, socializing, and social activities to other activities they may be involved in.

Training opportunities in supported decision-making for staff in RCs are limited. Institutional culture and institutionalized service provision may significantly limit access to decision-making support that respects the will and preferences of residents, particularly due to beliefs that persons with disabilities cannot decide for themselves and that there is a lack of accessible communication options. In addition, any support in decision-making must meet certain conditions[183] to ensure that all decisions respect the will and preferences of the person with disabilities and must not be used to limit the exercise of legal capacity and autonomous decision.[184] Thus, offering this type of support is not an easy task, but is one that requires changing old patterns of relating to persons with disabilities and acquiring new specific skills. In 2019, only 31 percent of RCs organized training in supported decision-making[185] for their staff, providing training to only approximately 27 percent of staff in the residential system. Close to 68 percent of centers did not have such training sessions included in the annual plan for professional staff training. These low numbers contrast with the high proportion of centers that reportedly offer this type of support and which house residents who have this need.

2.3.2. Informed consent

The exercise of legal capacity is also restricted whenever any service is provided without the informed consent of residents. Art. 25 of the CRPD stipulates that health

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[183] According to Art. 12 (4) of the CRPD, any measure regarding the exercise of legal capacity, including supported decision-making services, must meet certain conditions to ensure that the support provided (1) respects the will and preferences of the supported person; (2) is free of conflict of interest and undue influence; (3) is proportional and tailored to the person's situation; and (4) is applied for the shortest time possible and subject to review by a competent, independent, and impartial authority or judicial body.

[184] CRPD Committee (2014a, para. 17).

[185] Currently, this type of training is not mandatory for staff in RCs, according to quality standards.

services should be provided only "on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care." Persons with disabilities, especially those with intellectual and psychosocial disabilities, are considered incapable to make decisions and, consequently, to express their informed consent. RCs should make sure that all conditions are in place to ensure the informed consent of residents regarding their health care, treatment, and any form of support provided.

Currently, there is no procedure to ensure the informed consent of beneficiaries for regular care and medical treatments in RCs, or for any other activities. Quality standards for residential social services for adults with disabilities establish the informed consent of beneficiaries, or of their legal guardians, to provide care and medical treatment in exceptional circumstances. The written consent is to be included in the beneficiary personal files.[186] Current standards, however, offer neither guidance as to what these exceptional circumstances may be nor how informed consent is otherwise secured[187] with regard to day-to-day care practices, regular administration of medication, or any other activities beneficiaries may be involved in. While standards have no specific requirement regarding the administration of psychotropic medication, RCs did report that psychotropic medication is administered with the informed consent of beneficiaries in 50 percent of cases, in 26 percent with that of their legal guardians, while for 24 percent of beneficiaries, no written consent is recorded.

2.3.3. Psychotropic medication

Most persons with disabilities in RCs are being administered psychotropic medication, which raises issues about possible overuse for nonmedical reasons. Around 77 percent of residents regularly are being administered psychotropic medication, while in some counties the proportion is as high as 90 percent.[188] Psychotropic medication is generally used as a medical treatment for issues as a result of psychiatric diagnoses. It is not only persons with psychosocial disabilities in RCs who

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[186] Order No. 82/2019. Annex 1. Module I, Standard 4, Minimum Requirement 16.

[187] A clear procedure to ensure informed consent should explain the steps to be taken so that staff make sure that residents are aware of and understand the purpose of administering medicines (including contraception)/medical interventions (including termination of pregnancy and sterilization), their side effects, as well as other short-/medium-/long-term consequences, other (medical or nonmedical) options available, including by provision of information and communication adapted to the type and degree of disability of that person (easy-to-read texts, sign language, Braille, audio-video with subtitles, other alternative and augmentative communication methods) and/or of persons to provide decision-making support. In addition, RCs should implement the practice of advance directives, which are written documents in which persons can specify, in advance, their choices about health care, treatment, and recovery options in the event that they are unable to communicate their choices at some point in the future. Advance directives can also include treatment and recovery options that a person does not want to have and, as such, can help to ensure that they do not receive any intervention against their wishes.

[188] Such as Alba, Bucharest, Covasna, Călărași, and Galați.

are being administered this type of medication in high numbers, but also those with intellectual and physical disabilities (Annex-Table 15). While this high proportion may be explained by similar numbers of residents diagnosed with mental, behavioral, and neurodevelopment disorders, the widespread practice of administering psychotropics raises the possibility of overmedication. Overuse of medication is a practice staff in residential institutions may resort to[189] as a cost-effective way to manage challenging behavior in the elderly with disabilities,[190] persons with intellectual disabilities,[191] or persons with any disabilities in distress[192] and, generally, to decrease engagement for staff convenience. Overmedication of persons with disabilities in closed institutions constitutes ill-treatment and may amount to torture UN (2017b: para. 33).

Psychotropic medication is generally administered by medical staff, while in some centers nonmedical staff is involved. Most staff administering psychotropic medication to residents has medical training, of which 81 percent are medical nurses and 5 percent are medical doctors. Approximately 14 percent of staff responsible for this task, however, has no medical training.[193] On average, in close to one-sixth of RCs, nonmedical staff has this responsibility. The proportion is higher for certain types of centers—nearly half of CRRPHs and around a third of CPVIs have nonmedical staff administering psychotropic medication. Small-size centers under 20 places stand out with the smallest share of medical staff responsible for this task (33 percent medical nurses and only approximately 2 percent medical doctors), while close to 66 percent, nonmedical. While this high proportion of nonmedical staff administering psychotropics may correlate with the significantly high number of residents who need support with drug administration in the residential system (close to 98 percent), this situation further raises questions about the practice of ensuring consent, since this requires staff to communicate to residents appropriate information about the nature of the drugs, diagnoses, potential side-effects, and risks that can endanger their life and health.

High use of psychotropics in the absence of alternative mental health services indicates exclusive reliance on medication as treatment for psychiatric diagnosis. While the percentage of residents who are being administered psychotropics is

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[189] CRPD Committee (2019b, para. 59).

[190] Human Rights Watch (2018, 49).

[191] The practice of prescribing psychotropics off-label to persons with intellectual disabilities without a psychiatric diagnosis has been documented elsewhere. A report by Public Health England shows that over half the number of adults with learning disabilities being prescribed psychotropics did not have a general practitioner's diagnosis of a condition the medications are designed to treat, including psychosis, bipolar disorder, or depression, and that such drugs often are provided to people with learning disabilities to try and manage challenging behaviors (Glover and Williams, 2015).

[192] Overmedication has been used as a response to the increased mental distress of persons in RCs in Europe, caused by restrictions relating to the COVID-19 pandemic (Brennan, 2020: 25).

[193] Some counties have a particularly high percentage of nonmedical staff responsible for administering psychotropic medication; for instance, Maramureș (around 78 percent) and Covasna (around 94 percent).

significantly high, less than a third have been assessed as needing psychotherapy and 80 percent of them have benefited from it. One explanation could be the critical shortage of psychotherapists. The system currently is short of 42 psychotherapists,[194] but only three positions exist on the organizational charts of all centers, out of which only one position is filled.[195] The absence of psychotherapists is mirrored by that of designated spaces for psychotherapy in approximately 78 percent of centers (Annex-Table 16). While psychotherapists and therapy spaces are insufficient, residents receive psychotherapy from other types of staff. At the time of data collection, residents could benefit from psychotherapy in approximately 19 percent of RCs, mostly from psychologists and, in some centers, also from rehabilitation educators or psychologist-educators.

Access to onsite psychiatric medical care is limited. At the time of data collection, there were only 17 psychiatrists employed in RCs, approximately half in CRRNs. They also were concentrated in centers with a capacity below 50 places, leaving residents in bigger centers with no immediate access to psychiatric medical care in case of need. While the number of employed psychiatrists is relatively low, persons with disabilities do have psychiatric consultations. In 2019, more than 80 percent of residents had psychiatric consultations—approximately 83 percent had consultations twice or more per year, and 17 percent only once.

2.4. Freedom from Torture or Cruel, Inhuman, or Degrading Treatment or Punishment, and from Exploitation, Violence and Abuse

Persons with disabilities in residential settings are particularly vulnerable to violence and abuse as an effect of how institutionalized care is organized. CRPD[196] requires that all persons with disabilities should be protected from violence, abuse, and exploitation, as well as any instance of ill-treatment and torture; and that appropriate measures are in place to identify and prevent such situations. While physical forms of abuse are easily identified in residential institutions, other forms are less obvious and sometimes are part and parcel of institutionalized care practices.[197] In fact, violence and abuse in residential settings often is overlooked and excused, when it occurs by the well-meaning perspective of an institutionalization being a means to offer expert care to persons with disabilities.[198] The interpretation of violence as a "service incident" rather than a criminal matter requiring investigation leads to the normalization of violence in institutions.[199] Women and girls with disabilities are particularly vulnerable

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[194] As evaluated by center staff.

[195] The only psychotherapist is employed in a CIA with a capacity below 50 places.

[196] Art. 15: Freedom from torture or cruel, inhuman, or degrading treatment or punishment; and Art. 16: Freedom from exploitation, violence, and abuse.

[197] Bartlett and Schulze (2017).

[198] Especially when violence and abuse are perpetrated by the staff (Bartlett and Schulze, 2017, 2).

[199] Maher et al. (2018, 72).

to violence and abuse from the staff in residential settings who are supposed to care for them.[200]

Violence, exploitation, abuse, or torture and inhuman or degrading treatment of persons with disabilities do occur in Romania's residential institutions. In 2019, at the level of GDSACPs, there were 130 complaints registered for acts of violence, exploitation, and abuse against persons with disabilities in RCs—almost one-third of complaints regarding acts perpetrated against persons with disabilities nationwide.[201] In 2019 and 2020, complaints[202] were registered in almost one in five residential institutions, the majority of which also were confirmed after investigation, pointing to the fact that various forms of violence are still relatively common in the residential system. Complaints against employees were made in 20 institutions, mostly for physical abuse and neglect, while 31 centers registered complaints against beneficiaries, mostly for alleged verbal or physical abuse. In seven centers, complaints were made against employees and residents alike. Only one complaint regarding acts of torture and inhuman and degrading treatment was registered during the same period.

Residential institutions of a certain type, size, and in certain counties, appear to be more affected by violence. While most complaints were registered in CIAs and CRRNs, CITOs also stand out, with 2 out of 10 centers registering complaints. In addition, data collected show that the larger the RC, the higher the likeliness of violent incidents occurring. Complaints were registered in approximately one-third of centers with more than 100 places, one-fifth of centers between 50 and 100 places, and approximately 5 percent of institutions below 20 places. There also are large geographic disparities with regard to the incidence of violence, with some counties registering no complaints, while others, for instance, had complaints in 8 out of the total 10 RCs (Iași) or 4 out of 8 (Constanța).

Adequate measures not always are taken in cases of confirmed instances of violence and abuse. In some cases, measures are limited in scope, and cannot be expected to lead to prevention of violent and abusive behavior of staff toward residents. For instance, in 6 centers out of 9 that registered complaints about verbal and physical abuse by staff against residents, no measures were taken whatsoever, while in 11 centers employees received warnings only for cases of confirmed physical, verbal, and economic abuse, as well as for physical neglect. Wage penalties were applied in 9 centers for similar forms of abuse and neglect, as well as for confirmed cases of torture or cruel, inhuman, or degrading treatment. Cases of physical abuse were addressed through criminal investigations in two centers and termination of employment in

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[200] Shah, Balderston, and Woodin (eds.) (2015, 66).

[201] Data collected by the World Bank (World Bank, 2020) from all GDSACPs at the county level, as well as from the Municipality of Bucharest in 2020 (for the study on the Diagnosis of the Situation of Persons with Disabilities).

[202] Data refer to complaints made by residents or their legal guardians; notifications of incidents by any other persons; and internal inquiries by center staff/GDSACPs or ex-officio investigations by police or public prosecutor's office.

another two. In the only center with confirmed cases of sexual abuse, the measure was mere demotion, with no further possibility for promotion.

Access to justice is particularly limited for persons with disabilities living in institutions, so not all instances of violence and abuse may get reported or adequately remedied. Reporting bad treatment requires specific knowledge on how to identify abuse as such, as well as access to complaint mechanisms.[203] Often, residents may not be aware when they experience such treatment from staff or other residents. In addition, the restrictive nature of an institutional setting makes it difficult for residents to make complaints for fear of reprisal[204]or hopelessness that a prompt course of action may follow.[205] Even though quality standards require RCs to encourage and support residents to notify any instances of violence, abuse neglect, or exploitation,[206] as well as torture or cruel, inhuman, or degrading treatment,[207] there currently are no clear guidelines available as to how to enable residents to identify and notify abuse and violence against them or other residents.[208] Currently, only 3.5 percent of centers have institutional collaborations (e.g., with NGOs, universities, and local authorities) to provide residents with relevant information on intimate relationships and sex that, for instance, may enable them to identify situations of sexual abuse.

Unconfirmed cases suggest the presence of additional barriers in accessing justice. Complaints from persons with disabilities about alleged acts of violence and abuse were not always confirmed in RCs. Allegations for sexual abuse are of particular interest, with only 1 center having confirmed such allegations out of 6 centers that registered complaints. Lack of credibility is sometimes a factor that may lead to dismissing complaints from persons with disabilities, in general; in the case of women and girls with disabilities, in particular, it is a factor that increases their vulnerability to violence.[209] In addition, stereotypes about persons with disabilities and, in particular women and girls' hypersexuality or asexuality, may lead to ineffective investigation, prosecution, and punishment of perpetrators, as well as limited access to adequate redress and reparation.[210] The high prevalence of contraceptive administration in RCs to prevent unwanted pregnancies, often the only sign of sexual abuse[211] also may be a contributing factor to the ineffective identification of abuse and violence. Currently,

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[203] In Romania, this situation is addressed through independent monitoring by the Ombudsman, Monitoring Council for the Protection, Promotion, and Monitoring of CRPD Implementation, as well as NGOs.

[204] Bartlett and Schulze (2017, 9).

[205] As indicated by interviews carried out with persons with disabilities, who were formerly institutionalized, in the study, Diagnosis of the Situation of Persons with Disabilities in Romania (World Bank, 2020: 94).

[206] Order No. 82/2019. Annex 1. Module 1. Standard 4. Minimum Requirement 7.

[207] Order No. 82/2019. Annex 1. Module 1. Standard 5. Minimum Requirement 5.

[208] The provision of information and education on how to avoid, recognize, and report instances of exploitation, violence, and abuse is also a requirement of the CRPD in its Art. 16: Freedom from Exploitation, Violence, and Abuse.

[209] Ozemela, Ortíz, and Urbán (2019, 10-11).

[210] CRPD Committee (2016: para. 26, 47, 52).

[211] Gîrlescu, Obreja, and Tănăsan (2014, 32).

almost 26 percent of women of reproductive age in RCs are being administered hormonal contraceptives.

Staff training as a measure for preventing situations of violence and abuse and facilitating access to justice varies in RCs. Violence, abuse, and any ill-treatment in RCs can be prevented if employees are able to (1) identify and adequately respond to these situations to ensure that residents have access to redress and reparations; and (2) limit the conditions that may facilitate the occurrence of violence and abuse. In some situations, the lack of adequate training on how to appropriately respond to resident needs in situations of crisis may lead staff to resort to abusive interventions, such as physical and chemical restraint, seclusion, or others that might further escalate violence against residents;[212] and it may facilitate involuntary admission to psychiatric hospitals.[213] Current quality standards require mandatory yearly staff training on how to prevent, identify, and report forms of exploitation, violence, and abuse,[214] as well as of torture or cruel, inhuman, or degrading treatment.[215] However, the number of such trainings, as well as other forms of training relevant to the prevention and reporting of abuse, such as de-escalation techniques, remains insufficient, resulting in a large proportion of untrained staff (Annex-Table 13).

Access to legal assistance is essential for any person reporting an unfair situation and obtaining appropriate remedy. The CRPD committee has stressed the obligation of State Parties to ensure free legal assistance to institutionalized persons, since institutionalization often limits access to any resources beyond the institution.[216] Most RCs (85 percent) turn to public service providers—in most cases, GDSACPs—whenever there is a need for counseling and legal assistance for institutionalized persons, and close to 7 percent to a person working in the RC. Legal assistance resources outside the social protection system appear not to be readily available, with only approximately 5 percent of centers able to turn to a local organization and 3 percent to a well-known person in the community.[217] The heavy reliance on GDSACPs, as well as on persons working in RCs, to offer or find legal assistance resources may not always secure

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[212] While restraint and seclusion are no longer practiced in RCs, many centers do have secluded spaces to temporarily isolate those with infectious health conditions; in some centers, residents may be secluded in closed spaces. Recently, a visit by the Center for Legal Resources, a human rights NGO, to a CRRPH in Sighetu Marmației led to the discovery of several residents with psychosocial and intellectual disabilities who had been locked in cages of approximately 2.5 meters high, with metal frames and transparent plexiglass. Some were tied with shirts and strips of cloth (Center for Legal Resources, 2019b).

[213] In 2019, approximately 24 percent of resident admissions into psychiatric hospitals were involuntary.

[214] Order No. 82/2019, Annex 1, Module 1, Standard 1, Minimum Requirement 12; Module V, Standard 4, Minimum Requirement 5.

[215] Idem. Module V, Standard 5, Minimum Requirement 4.

[216] CRPD Committee (2019b, para. 22(b)), CRPD Committee (2014b, para. 26(b)).

[217] Only one center reported no access to legal assistance of any source.

effective access to justice, especially in cases where violence and abuse is being perpetrated by an employee in the social protection system.

2.5. Living Independently and Community Inclusion

In line with the guiding principles of the CRPD, people with disabilities have the right to self-determination, autonomy, to live independently, and to fully participate and be included in the community. This means being able to make one's own decision in terms of life choices (where to live, with whom, and how), everyday activities, and relationships, as well as pursuing educational and employment opportunities if they so wish. It means to not be segregated or geographically and socially isolated, and to be allowed the opportunities and access to social, cultural, religious, and leisure activities. Living independently does not mean being left alone; on the contrary, it means that a person has a right to an independent, self-determined life that is realized by the ability to participate in the community and have the same rights as others.

The Romanian public system of RCs infringes, in many ways, on the international standards Romania has ratified,[218] leading to the continuation of segregation, isolation, and limited opportunities to live independently and to participate in the community. Due to its history and structure, the Romanian system has segregated people with disabilities from the rest of the population and placed them in institutions, often isolated from communities and the public eye, and institutionalizing them for the rest of their lives. Since the socialist era, the residential system has been conceived as a means to contain people who were seen as unfit within the definition of a desirable citizens; that is, those incapable of working and contributing to the state and society.[219] The post-1989 period reflects this same logic and structure, segregating and institutionalizing those with disabilities, often in rural or distant places, for life on the one hand; and on the other, validating the institutionalization model by not providing them with specialized and community support. The dismantling of the institutionalization model must take into consideration the inertia and resistance of the system and its propensity to adopt solutions and alternatives that do not threaten its logic and organization.

2.5.1. The right to be included in the community and to not be segregated and isolated

Institutionalization is defined by measures and conditions that segregate people not only from their socially significant others (family, friends, peers) but also from the community and the opportunities it offers. In order to assess the degree of isolation and segregation, four broad indicators were applied (1) location of centers in broad geographic terms and in the context of the village/town where they are placed; (2) isolation from relevant regional and community services; (3) access to public

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[218] The CRPD (Art. 19), The Charter of Fundamental Rights of the European Union (in particular Art. 26), and the European Social Charter (Art. 15).

[219] T. Mladenov documented the system and its continuing logic and structure in neighboring Bulgaria; it is safe to say that the systems are fairly similar in Romania and Bulgaria (Mladenov, 2017: 1109–1123).

transportation and to transportation offered by centers; and (4) access to forms of communication and intra-institutional forms of sociality (i.e., socialization with other residents, intimate relationships, and the potential for receiving visitors).

Adults with disabilities living in a public residential institution in Romania are geographically and socially isolated, situation compounded by the general lack of support services. For a high number of centers, their location—either in rural areas or in suburbia; far from regional and community services; and with limited access to public transportation or transportation offered by the institution itself—limits their ability to provide residents with opportunities for community inclusion, including support services and other resources they may need. Moreover, such isolation leads to increased dependency on and captivity in institutions that deprive residents of the right to freedom of movement, integration into the community, independence, access to educational and employment opportunities, and other community activities (e.g., cultural, religious, leisure, social) or specialized services. Being institutionalized combines the vulnerability of disability and institutionalization with the vulnerability of being poor and geographically isolated. The vehicles owned by the institutions can only partially address this problem, as they are insufficient, especially in the larger centers. Only for a small number of centers located particularly in urban areas access to regional and community services as well as public transportation are less of a problem.

A. Location of residential centers

A large number of centers are located in rural areas, away from the nearest county seat,[220] and generally away from the center of the town or village where they are located, where most relevant services are found. About half the centers are in rural areas, and half in small towns and cities. In five counties (Bucharest, Caraș-Severin, Covasna, Dâmbovița, and Satu-Mare), all centers are in urban areas which, in principle, should translate into higher access to regional and community services. This is not the case in the rest of the counties, however, where most centers are in considerable isolation. For instance, in three counties situated in the south part of Romania, (i.e., Călărași, Giurgiu, and Ilfov), all centers are located in rural areas. Also, two-thirds of public centers are of some distance from the central areas in their communities. Farther distances generate more difficulties in accessing the community support services and resources that are available. Four centers (i.e., Bacău, Bihor, Prahova, and Sibiu) are located completely outside of the village/town, most likely significantly isolated from such services. A higher-than-average proportion of CITOs (i.e., over 60 percent) are located at the periphery (Table 37) of town. The distribution seems to be relatively even with regard center size, with smaller centers usually situated slightly closer village/city centers and the larger ones, further away (Table 38).

Table 37: Distribution of Residential Centers, by Location within the Town/Village and Type of Center

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[220] The country seat is the administrative center of the county, generally the largest and most important town/city of the county. This is where the most and the best resources are located (i.e., health, education, services).

	In the Center	Between Center and Periphery	At the Periphery	Outside the Town/Village	Total (percent)	Total (number)
CAbR	33.3	33.3	30.6	2.8	100	36
CRRPH	36.0	30.0	32.0	2.0	100	50
CIA	37.5	36.8	25.7	0.0	100	136
CRRN	23.2	48.2	25.0	3.6	100	56
CITO	0.0	37.5	62.5	0.0	100	8
CPVI	33.3	33,3	33.3	0.0	100	3
Total	**32.9**	**37.4**	**28.4**	**1.4**	**100**	**289**

Source: World Bank survey of residential centers (2020).

Table 38: Distribution of Residential Centers, by Location within the Town/Village and Size of Center

	In the Center	Between Center and Periphery	At the Periphery	Outside the Town/Village	Total (percent)	Total (number)
<=20	41.5	22.6	35.8	0.0	100	53
21–50	33.3	36.8	28.5	1.4	100	144
51–100	27.5	47.1	23.5	20	100	51
100+	26.8	46.3	24.4	2.4	100	41
Total	**32.9**	**37.4**	**28.4**	**1.4**	**100**	**289**

Source: World Bank survey of residential centers (2020).

B. Proximity to local community and regional resources and services

A great majority of centers are located away from the regional resources that are needed. Geographic isolation can be an index for the general isolation of an institution and its residents, and for limited access to an array of resources (e.g., cultural, administrative, medical, and social), including collaborative opportunities with other organizations and institutions. The proximity to regional resources for rural centers was evaluated by applying an indicator calculated as the average distance to the nearest town, county seat, local city hall/village administration, and hospital. Centers located further away from the county seat scored higher in terms of average distance. Thus, only 15 out of 133 rural centers are considered close to these resources (i.e., average distance lower than 10 kilometers (km)). The rest are located further away, with 18 centers located at an average distance of over 30 km from these resources. No CRRPH, CITO, or CPVI is located at an average distance of 10 km or under from the resources of interest. The only one rural CPVI is actually located at an average distance of 20–30 km, which raises questions about the degree of community inclusion residents are unable to enjoy (Table 39).

Table 39: Distributions of Residential Centers by Average Distance to the Closest Town, County Seat, City Hall, and Hospital, by Type and Size of Center

		<=10 Km	10–20 Km	20–30 Km	>30 Km	Total (number)
Type of center	CAbR	6	4	6	2	18
	CRRPH	0	4	12	1	17
	CIA	5	32	20	9	66
	CRRN	4	11	8	5	28
	CITO	0	2	0	1	3
	CPVI	0	0	1	0	1
	Total	**15**	**53**	**47**	**18**	**133**
Size of center	<=20	4	6	9	1	20
	21–50	8	29	22	11	70
	51–100	1	10	9	4	24
	100+	2	8	7	2	19

Source: World Bank survey of residential centers (2020).
Note: Km= kilometers.

Proximity to community mainstream services and institutions in the same town/village is essential for community inclusion; however, this does not apply to many centers. About 25 percent of centers are located within an average walking distance from community services (less than 1.5 km) (i.e., local store, post office, bank, train and bus station, park, church, hospital, habilitation/rehabilitation services, and family practice doctor), with about one-fifth at a distance greater than 7.5 km, which makes such services relatively inaccessible for center residents. The distribution is the same in terms of center type and size, with the exception of CPVIs (two out of three are located within walking distance and one is at a distance greater than 7.5 km) (Table 40).

Table 40: Distribution of Residential Centers by Average Proximity to General Services in the Community, by Type and Size of Center

		<=1.5 Km	1.5-4 Km	4-7.5 km	>7.5 km	Total (percent)	Total (number)

Type of center	CAbR	22.2	38.9	30.6	8.3	100	36
	CRRPH	30.0	38.0	18.0	14.0	100	50
	CIA	27.9	22.1	23.5	26.5	100	136
	CRRN	21.4	26.8	33.9	17.9	100	56
	CITO	12.5	37.5	25.0	25.0	100	8
	CPVI	66.7	0.0	0.0	33.3	100	3
	Total	**26.3**	**28.0**	**25.3**	**20.4**	**100**	**289**
Size of center	<=20	30.2	35.8	26.4	7.5	100	53
	21–50	28.5	24.3	25.0	22.2	100	144
	51–100	13.7	35.3	19.6	31.4	100	51
	100+	29.3	22.0	31.7	17.1	100	41

Source: World Bank survey of residential centers (2020).

C. Access to public transportation and institutional resources

Access to public transportation facilitates active engagement with the community, and is particularly essential for residents who live in the more remote RCs. Almost 40 percent of centers in rural areas have limited or no access to public transportation. Forty-six centers have access to buses/trains that come twice a day or every three hours, and six centers have no access at all to public transportation. With the exception of Bihor and Sibiu, the counties where these six centers are located do not necessarily overlap with those located beyond village or town, which suggests that those six are located in isolated villages that have no access to regional resources. Only about one in four centers (the proportion of CITOs and CAbRs is higher than for other centers) have frequent access to public transportation (once an hour or more frequently) (Table 41).

Table 41: Distribution of Residential Centers, by Frequency of Public Transportation and by Type and Size of Center

		Buses/Trains Come Once Every 30 Minutes Or More Often	Once an Hour	Once Every 2–3 Hours	At Least 2 Buses a Day, but at More than 3 Hours Apart	No Buses or Trains	Total (number)
Type of center	CAbR	2	5	6	4	1	18
	CRRPH	0	2	5	9	1	17
	CIA	4	11	26	24	1	66
	CRRN	3	5	10	7	3	28

	CITO	0	2	0	1	0	3
	CPVI	0	0	0	1	0	1
	Total	**9**	**25**	**47**	**46**	**6**	**133**
Size of center	<=20	1	5	4	10	0	20
	21–50	3	12	26	24	5	70
	51–100	1	6	11	6	0	24
	100+	4	2	6	6	1	19

Source: World Bank survey of residential centers (2020).

People with disabilities have less mobility, given that public transportation has not adapted to them. A recent World Bank report[221] shows that in Romania, public transportation has not yet adapted to the mobility of the disabled, particularly in rural areas. Moreover, those with disabilities have difficulties in exercising their right to use public transportation free of charge, as required by law. [222] Some transportation companies have no contract with GDSACPs, or they refuse to provide transportation free of charge; in other cases, the fee reimbursement process is too complicated and limiting. Furthermore, the law is unclear as to the guidelines for public transportation to ensure accessibility for those with disabilities. The numbers presented above, therefore, should be interpreted conservatively; that is, while there may be public transportation, it does not necessarily imply that center residents are able to use it, given it has not been adapted for their use, especially in consideration of those with mobility or sensory impairments, or those with little or no income.

RCs should address not only the lack of public transportation adaptation for the disabled, but also provide their own adapted vehicles. Around 60 percent of centers have a vehicle and about 25 percent own a van/minibus with eight or more seats, averaging 1.3 vehicles per center on a national scale. Larger institutions (i.e., over 50 places) have vehicles at a higher proportion (Table 42). RCs in 16 counties, including some large ones, do not have a van/minibus; in the county of Ialomița, not one RC has any kind of vehicle (Annex-Table 17). Although close to one-fifth of residents use a wheelchair (of which 72 percent are housed in CIAs) and 77 percent of centers have at least one beneficiary with a wheelchair (90 percent of CIAs), only around 10 percent of vehicles have been adapted, with higher proportions (almost 20 percent) in the case of smaller centers. The geographic distribution of adapted vehicles is considerably unbalanced, since about half of the counties fail to own any kind of adapted vehicle, and three counties (i.e., Bucharest, Ilfov, and Constanța) own only adapted vehicles (Figure 25).

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[221] World Bank (2020).

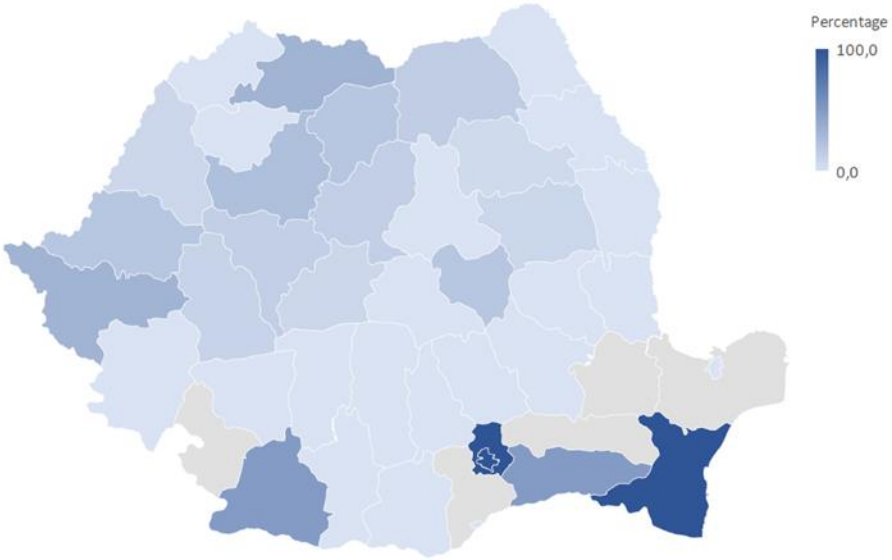
[222] Law No. 488/2006 guarantees public transportation, free of charge, for the seriously disabled, and Government Decision 1017/2018 explains the procedures for reimbursement.

Table 42: Distribution of Number of Vehicles Owned by Residential Centers, by Type and Size of Center

		Small Vehicle (percent)	Van or Vehicle with More than 8 Seats (percent)	Number of Centers
Type of centers	CAbR	58.3	22.2	36
	CRRPH	36.0	30.0	50
	CIA	58.8	19.1	136
	CRRN	75.0	35.7	56
	CITO	75.0	12.5	8
	CPVI	33.3	33.3	3
	Total	**58.1**	**24.6**	**289**
Size of centers	<=20	35.8	24.5	53
	21–50	58.3	18.8	144
	51–100	72.5	29.4	51
	100+	68.3	39.0	41

Source: World Bank survey of residential centers (2020).

Figure 25: Proportion of Adapted Vehicles from Total Vehicles, by County



Source: World Bank survey of residential centers (2020).

2.5.2. The right to participate in social, cultural, religious, and leisure activities

People with disabilities have the right to a full social and cultural life, to participate in the cultural life of the community, and to opportunities for leisure and entertainment. These opportunities should not be limited to the confines of the center. They should be geographically accessible, the residents should have the freedom of movement necessary to access them, and these places and events should be accessible and appropriate for the needs of all people, including those with disabilities.

People in RCs have limited opportunities for a full cultural life, as well as for leisure and recreation. Opportunities for leisure and culture in RCs are usually limited to watching TV, playing games, using a computer, reading books, or accessing the Internet (over 98 percent of centers offer at least one of these options). Beyond the RC, opportunities are limited by the geographic isolation (most likely in a rural area or outside of the town/city center) and the general dearth of cultural and leisure outlets in most of the country. Still, data collected indicate that residents from 76 percent of centers have access to at least four cultural or leisure outlets (e.g., parks, bars, libraries, performance halls, museums), with a much higher proportion (93 percent) in urban areas (compared with 56 percent in rural areas). More than a quarter of beneficiaries, nationwide, do not have sufficient cultural and leisure opportunities in the town or village where the center is located.

Even before the COVID-19 pandemic, only a small proportion of residents participated in activities outside the center, or even left the center of their own accord or accompanied by someone. Limited experience with the world outside the center and with mundane activities, such as shopping or using public transportation, are challenges that need to be addressed during the process of deinstitutionalization. It is likely that the Covid-19 pandemic has brought additional isolation, segregation, and challenge to participating in community life. Despite some opportunities seemingly existent, only a limited number of residents actually enjoyed them (Table 43). During the year before the pandemic, 68 percent of residents never went shopping, 53 percent never went to the park, 90 percent never used public transportation, and 71 percent never participated in cultural or recreational activities beyond the center, either alone or with support from somebody else. Also, in a sample of 820 residents, the park was the most frequented destination, in terms of activities outside the center, as 20 percent of residents visited one in the past month.

Table 43: Participation in Activities beyond Residential Centers

During the 12 months preceding the COVID pandemic, beneficiaries…	Freque ntly	Rarely	Neve r	Not Kno wn	Total
			(percent)		
Went shopping, alone or with someone	10.6	20.8	68,1	0.5	100

Went to the church in the community, alone or with someone	9.9	24.9	64.6	0.6	100
Went to the park, alone or with someone	17.3	28.7	53.4	0.6	100
Used public transportation, alone or with someone	2.1	7.2	89.7	0.9	100
Participated in cultural, sports, or entertainment activities outside the residential center, alone or with someone	6.7	21.9	70.8	0.7	100
Left the residential center alone with permission*	5.7	5.9	87.7	0.7	100
Left the residential center alone, without letting anybody know*	0.4	3.0	96.0	0.6	100

**Question for the sample of 820 residents*

Source: World Bank survey of RCs (2020).

Civic and social participation is a fundamental dimension of a life fully included in the community, but many residents are not supported to enjoy it. Quality standards refer to a wide range of activities to increase residents' level of involvement in community social and civic life, which should be offered in RCs, including support for getting accustomed to the social environment; stimulation/learning of appropriate behaviors for social situations; involvement in sports, cultural, artistic activities carried out in the community; participation in recreation and leisure activities; craft activities; and visits, among others.[223] Despite the wide range of activities that may be offered, approximately 58 percent of residents were evaluated, in 2019, as needing activities relating to civic and social participation, with some variation across different types of centers (96 percent for residents in CPVIs, but 48 percent for CRRPHs and 50 percent for CIAs).[224] Providing these activities may be a challenge in many centers due to (1) limited access to sports, culture, arts, and other recreational and leisure activities in the community (due to their unavailability or inaccessibility); (2) lack of (accessible) transportation; (3) shortage in staff that could accompany residents. However, it is less clear why almost half of residents were not evaluated as having a fundamental need for being part of community life.

Leisure travel is inaccessible for the majority of residents and continues to be institutionalized in the form of organized trips. Although organized trips might be the only opportunity for a resident to leave the town or village where the center is located (other than for nonmedical reasons), only 77 percent of centers have offered them to

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[223] Order No. 82/2019, Annex 1, Module 4, Standard 15, Minimum Requirement 2.

[224] Since 90 percent of RCs do offer these activities, including approximately 88 percent of CRRPHs and CIAs, the difference in the number of residents that benefit from these activities by type of center, as well as the small number, overall warrants further research.

their beneficiaries. The distribution is geographically uneven, with centers in three counties (Dâmbovița, Giurgiu, and Mehedinți) not having organized any trips at all for their residents in 2019. Only 37 percent of institutionalized people in the system went on a leisure trip that year.

2.5.3. The right to access educational and employment opportunities

People with disabilities should have access to mainstream community services and, in particular, to educational and employment opportunities. These are fundamental rights and necessary conditions for the personal development and fulfillment of any individual, as well as being important dimensions for integration into the community. For many, they are steps to independent living and to reducing economic and social dependence on institutions, including RCs.

Beneficiaries of public RCs are limited in their access to educational and employment opportunities by the physical isolation of the centers and the integration of many services within the physical confines of the institution. Access to educational and employment opportunities is dependent on the physical access to areas where these are provided which, in Romania, tend to be urban—especially county seats or large cities. Half of the centers are in rural areas, and the majority of institutions are away from the centers of towns and villages, and at distances from large urban centers that make them practically inaccessible.

Inside the institutions, the majority of educational efforts are directed at basic educational needs, namely reading and writing, setting a low bar and limiting other more tailored educational opportunities for residents. RCs are segregated from the world—boring and limited in terms of intellectual and sensory stimulation. Education in RCs should be approached holistically and adaptively to break through these limitations. It should not be considered as a remedial enterprise but, rather, a constructive approach. Still, about 44 percent of residents have never been to school, so the overall educational needs of the residents were evaluated as needing to learn how to read (19 percent), how to write (19 percent), as well as other needs (13 percent). Centers reported attending to these needs by offering support to 28 percent of residents, not offering support to 16 percent, and stating that for the rest "it was not the case" (56 percent)—an assessment that needs further investigation. In the nationwide sample of 820 residents, the educational support they received was overwhelmingly directed at learning how to read and write (77 percent), and in lower proportions at facilitating participation in support groups (21 percent) and instruction for using assistive technologies for education (6 percent). There is close to zero support in furthering education, either for applying to educational programs or offering support to meet the challenges of any educational program they might be in. The support came mostly from center employees and, to a significantly limited degree, from outside people or institutions (e.g., volunteers, schools, religious or nonreligious organizations).

Work opportunities provided inside the institutions are rather insignificant, taking the form of occupational therapy or resident involvement in RC maintenance activities. Beneficiaries are involved in various activities in RC vegetable gardens, orchards, or animal raising facilities. Also, residents are involved in work that relates to the making and serving of their own meals, including preparation, setting the table, serving the meal, and washing the dishes. Given the nature of the work, these activities should be seen more as ways to compensate for human resource deficits and less as enrichment opportunities. While these may be treated as learning opportunities, they cannot be regarded as genuine employment or education.

A minority of persons with disabilities in RCs need support to maintain or improve their level of education or training necessary for employment. RCs can provide different forms of related support to enable the disabled to (1) meet the requirements of educational institutions; (2) participate in handicraft activities or hobbies; (3) use and strengthen practical and social knowledge and skills; and (4) use their full creative and lucrative potential. They also should be assisted before and after becoming employed, be provided with legal counseling, and have access to support groups, for instance.[225] In 2019, only approximately 16 percent of residents needed support to maintain or improve their level of education or training for employment, out of which 86 percent received it.[226] CPVIs are the centers with the highest proportion of residents needing such activities (80 percent), while in other types of centers the proportion is below 50 percent,[227] with CIAs having as little as 5 percent of residents needing such support. Surprisingly, only 48 percent of residents of Centers for Integration through Occupational Therapy required these activities.[228] While the small proportion of persons receiving such support may be explained by the large numbers of residents who cannot work, either because of an assessed invalidity, a presumed inability to work,[229] or as a result of being placed under guardianship, other variables might factor in, such as the lack of (1) local opportunities for education/training; (2) accessible jobs or jobs that provide reasonable accommodation; and (3) staff that can offer legal counseling before and after residents become employed. This situation further warrants a set of measures to ensure the autonomy and wellbeing of residents who will be living in the community but will not be in the position to access employment and ensure a stable income this way.

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[225] Order No. 82/2019, Annex 1, Module 4, Standard 13, Minimum Requirement 2 and 3.

[226] The estimated percentage based on data collected on the sample of personal files is slightly higher, at 95 percent.

[227] Thirty percent in CAbRs, 17 percent in CRRPHs, 21 percent in CRRNs, and 48 percent in CITOs.

[228] In all types of centers, there is little difference between the percentages of persons who need this type of support and of those who actually received it.

[229] As assessed by center staff, in the case of residents who do not have an official assessment of work capacity.

3

THE TRANSITION FROM INSTITUTIONS TO COMMUNITY LIVING

A DIFFICULT PROCESS

3. Transition from Institutions to Community Living: A Difficult Process

This section offers an analysis of the current deinstitutionalization efforts of persons with disabilities who live in public RCs and, in particular, with regard to the process of restructuring and reorganizing public RCs. The first part outlines recent steps in the direction to reduce the number of persons in the residential system through EU and state-funded projects aimed at setting up alternatives to the residential system, as well as a response to legislative requirements to sizing down large-size institutions. The second part offers an in-depth analysis of the restructuring and reorganization process of RCs with respect to various difficulties relating to the planning and implementation stages.

3.1. Context and Current Situation

Since having ratified the CRPD, the Romanian government has implemented a series of measures for the deinstitutionalization of persons with disabilities living in residential institutions. As State Party to the CRPD since 2011, Romania has assumed the obligation to ensure the right to independent living and inclusion in the community for all persons with disabilities living in residential institutions. To this end, the government has approved a financing line of the EU structural and investment funds for the deinstitutionalization of 516 adults with disabilities within the Regional Operational Program 2014–2020.[230] During the first call, restructuring projects were prepared for 11 institutions. These dedicated funds were complemented by the Human Capital Operational Program 2014–2020 that supported the development of social services at the community level, particularly day centers and sheltered housing.[231]

The Program of National Interest (PNI), initiated by NARPDCA in 2016, has been another source of funding for developing public services for persons with disabilities from large institutions. The PNI, "Developing social services such as day care centers, respite/crisis centers, and sheltered housing for the purpose of deinstitutionalizing persons with disabilities from traditional institutions and for preventing institutionalization of persons with disabilities in the community,"[232] had the objective to ensure the full participation and inclusion of persons with disabilities into society by safeguarding their access to essential social services, especially to those in RCs of less

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[230] Related to the call for project proposals POR/8/8.1/8.3/B/1, Priority Axis 8: Development of Health and Social Infrastructure, Specific Objective 8.3: Increase the coverage of social services.

[231] Specific Objective 4.15: Reducing the number of elderly and disabled people placed in residential institutions by providing social and medical services at the community level, including long-term services (Applicant's guide). Specific conditions for accessing funds. Deinstitutionalization of adults with disabilities—the transition to social services in the community. AP 4/PI 9.iv/OS.4.15. 2018: 5). A call for proposals was specifically launched for the deinstitutionalization of adult persons with disabilities from traditional institutions—social services at the community level.

[232] The PNI was approved through Government Decision No. 798/2016.

than 120 places. So far, the PNI has had seven calls for GDSACP projects, with a budget allocation of approximately €22 million.[233]

Downsizing and reorganizing RCs for persons with disabilities is a priority of the government and NARPDCA as a preferred avenue toward deinstitutionalization. In 2018, the government passed Emergency Ordinance No. 69,[234] limiting the maximum capacity of RCs to 50 places. By December 31, 2018, all GDSACPs, as well as private sector providers, were expected to submit restructuring plans for all centers exceeding a capacity of 50 places, accompanied by action plans with scheduled activities for the period 2019–21. In addition, all RCs with a capacity of less than 50 places had to be reorganized to provide services in response to the individual needs of beneficiaries, in accordance with current quality standards for social services.[235] The Ordinance also sets out a budget cut of 25 percent a year from January 1, 2019, for RCs with over 50 places, along with exclusive financing from local budgets[236] as of January 1, 2022.

Most RCs have begun the process of restructuring or reorganization. After almost two years from the deadline to submit the restructuring plans and reorganization proposals, only a few RCs with more than 50 places yet have to begin the restructuring process. Over 90 percent of RCs with more than 50 places and more than 80 percent of those with more than 100 places are now undergoing restructuring.[237] More than half of the centers with less than 50 places already have been reorganized, while 38 percent are undergoing reorganization.

The process of restructuring and reorganization seems to be driven by RC size. The smaller centers and, in particular those of medium size, are far more advanced in terms of restructure and reorganization than the larger ones (Figure 26). About 58 percent of medium-size centers (21–50 places) have completed the process, 38 percent of small centers (20 places and under), and only around 2 percent of larger centers (over 50 places). The small- and medium-size centers are able to go through the reorganization process faster because the process does not necessarily involve the transfer of beneficiaries or significant material transformation—only a readjustment of the center profile and possibly adding extra services. Larger centers undergoing restructure, however, have to make decisions about the transfer of a good part of their residents to other locations (following complex assessments), seek new living arrangements, and deal with the challenge of a material base that needs to be converted or repurposed. While a small number of centers will carry on with

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[233] This includes funding allocated for the deinstitutionalization of children and youth with disabilities, based on Government Decision No. 193/2018. According to NARPDCA data, there were 27 projects in 2019 that were submitted with regard to the transfer of 622 persons. The projects related to the development of 76 sheltered homes, 25 day care centers, and two respite/crisis centers.

[234] Government Emergency Ordinance No. 69/2018 to modify Law No. 448/2006 regarding the protection and promotion of the rights of persons with disabilities.

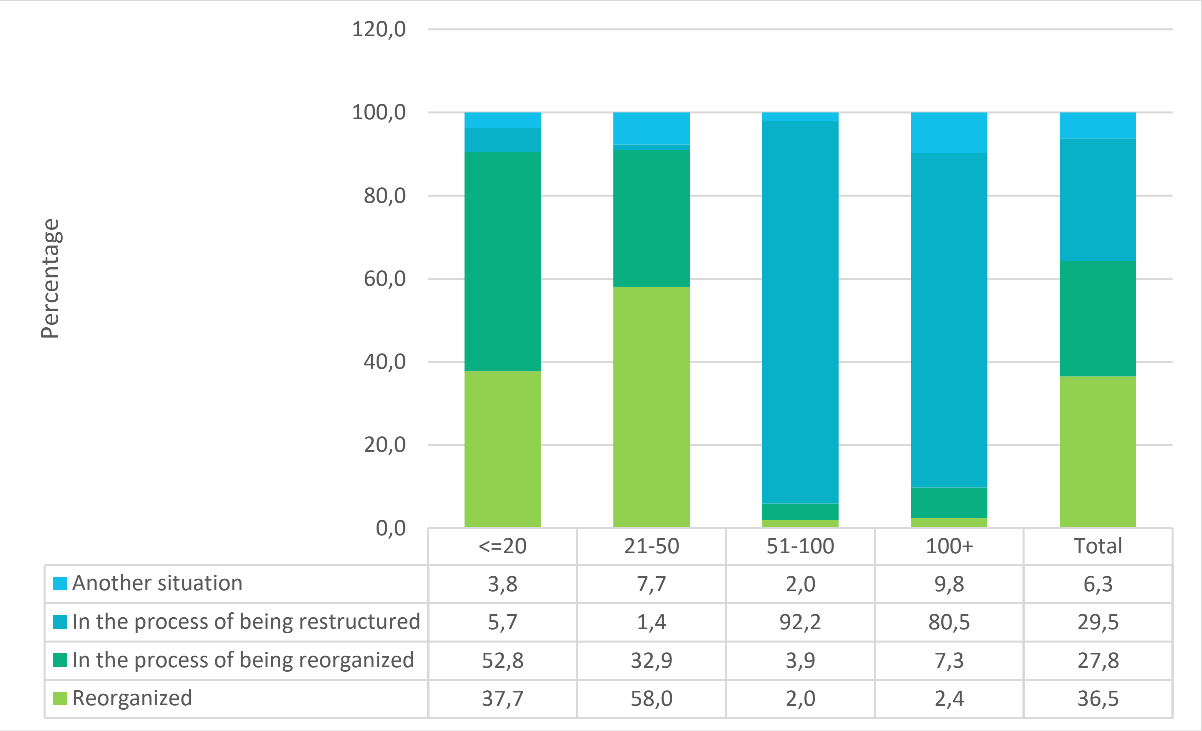
[235] Art. II of Government Emergency Ordinance No. 69/2018.

[236] County or sector budgets for centers located in Bucharest.

[237] The World Bank survey of RCs collected data on 288 residential institutions, of which 51 have a capacity of over 50 places and 41 a capacity of over 100 places.

restructuring activities in 2022 and 2023, the estimated date for completion of the restructuring process for most RCs (88 percent) is 2021.

Figure 26: Distribution of Residential Centers by Stage of Reorganization/Restructuring, by Size of Center on October 30, 2020



	<=20	21-50	51-100	100+	Total
■ Another situation	3,8	7,7	2,0	9,8	6,3
■ In the process of being restructured	5,7	1,4	92,2	80,5	29,5
■ In the process of being reorganized	52,8	32,9	3,9	7,3	27,8
■ Reorganized	37,7	58,0	2,0	2,4	36,5

Source: World Bank survey of residential centers (2020).

Note: * Most restructuring processes of residential centers will be finalized in 2021.

Funding to implement restructuring activities has been secured from a variety of sources. About 83 out of 85 RCs undergoing restructure already have secured funding from one or more sources implementation activities. Local budgets have been the most frequently used by GDSACPs for approximately 84 percent of centers, while the state budget has been used for 50 percent of centers, and EU funds for only 29 percent of centers.

Solutions identified for the transfer of most persons with disabilities living in RCs have been either sheltered housing or other RCs. Almost 47 percent of persons with disabilities living in RCs that are undergoing restructuring will have been transferred by 2021 (3,961 out of 8,485), with 325 persons having already been transferred; 3,636 expected to be transferred within that year, and 921 following 2021 (Annex-Table 18). Most deinstitutionalized persons, so far, have been transferred to other RCs, and this number will further increase in 2021 (Table 44). Approximately 10 percent of residents will be transferred to Professional Personal Assistants (PPAs) or to the community by 2021.

Table 44: Distribution of Persons with Disabilities Who Have Been or Will Be Transferred from Restructured Centers until 2021, by Type of Transfer Solution, on October 30, 2020

	Number of Persons with Disabilities Transferred...				
	… to Sheltered Housing	**… to Professional Personal Assistants**	**… to the Community**	**… to Other Residential Centers**	**Missing Information**
Until 2020	35	1	76	213	
Until 2021	1,239	118	63	2,201	15
Total	**1,274**	**119**	**139**	**2,414**	15

Source: World Bank survey of residential centers (2020).

Sheltered housing not always is a suitable solution to ensure personal autonomy and community inclusion. Even though sheltered housing has been hallmarked as the most suitable transition service from institutions to community living in Romania, as well as in the region,[238] there are concerns that it replicates institutional culture and segregation. The CRPD Committee has emphasized that sheltered housing limits the autonomy of persons with disabilities, inasmuch as their lives most often remain under the control and management of directors and service staff.[239] At the same time, sheltered housing tends to be located in rural areas as part of service hubs/rings that further segregate the beneficiaries from community life and act as a disincentive for local authorities to further develop inclusive community services.[240]

There is a visible trend to reinstitutionalize persons with disabilities in Romania, even though Emergency Ordinance No. 69 requires a speed up of the transition process from institutions to integrated services in the community. In line with Art. 19 of the CRPD, the ordinance highlights stigmatization and marginalization as effects of segregated living and reiterates the need for urgent measures to ensure that the

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[238] Hungary, for instance, has had the same approach to deinstitutionalization. Act III of 1993 on social administration and social benefits (Social Act) limits the size of RCs to 50 places, while the strategy for deinstitutionalization, launched in 2011, establishes the transfer of persons with disabilities living in institutions of more than 50 people to small group homes.

[239] CRPD Committee (2019b, para 66).

[240] CRPD Committee (2019b, para 70).

disabled are able to access community alternatives, including personal assistance. Oftentimes, however, the process of restructuring has led, instead, to the transfer of residents from larger to smaller institutions, as evidenced above, and/or keeping up to 50 residents in the same buildings and relicensing the service (Figure 27), a practice that somewhat extends and perpetuates institutionalization (UN, 2019a: para 101, point f).[241] A report by the UN High Commissioner for Human Rights recommends that the transfer of persons with disabilities from one institution to another should be prevented, and that community living arrangements should not be established and monitored by the institution itself.[242]

Figure 27: Distribution of Residential Centers undergoing Restructuring and Reorganization, by Type of Center that Will Result following the Process on October 30, 2020 (percent)

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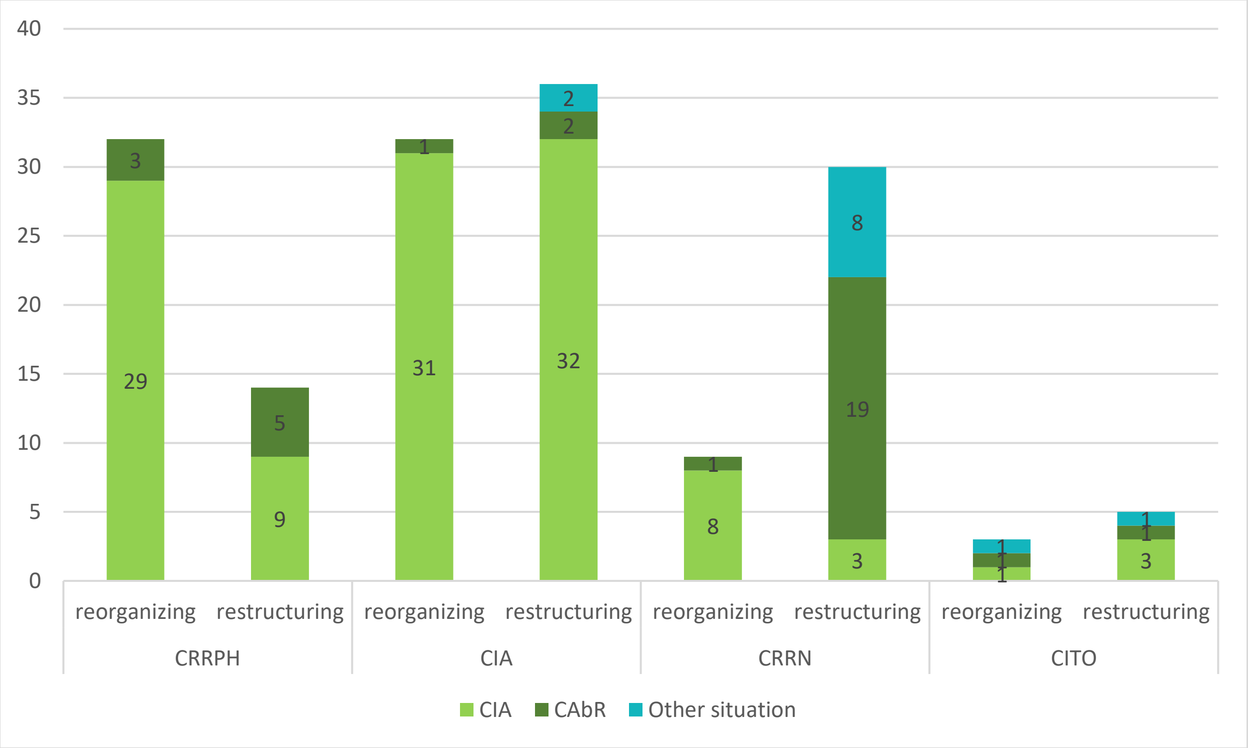
[241] CRPD Committee (2019b, para 101, point f). Only 33 percent of GDSACPs have further plans to transfer community persons with disabilities from reorganized RCs. This may be a consequence of the lack of legislation requiring the deinstitutionalization of persons with disabilities from RCs with a capacity under 50 places, as well as the perception of some GDSACP directors—as qualitative data indicate—that small-size centers are residential services meant to offer services to persons with disabilities with lower support needs and, consequently, are the best option for them in terms of ensuring independent living.

[242] Office of the United Nations High Commissioner for Human Rights (2014, para 26).

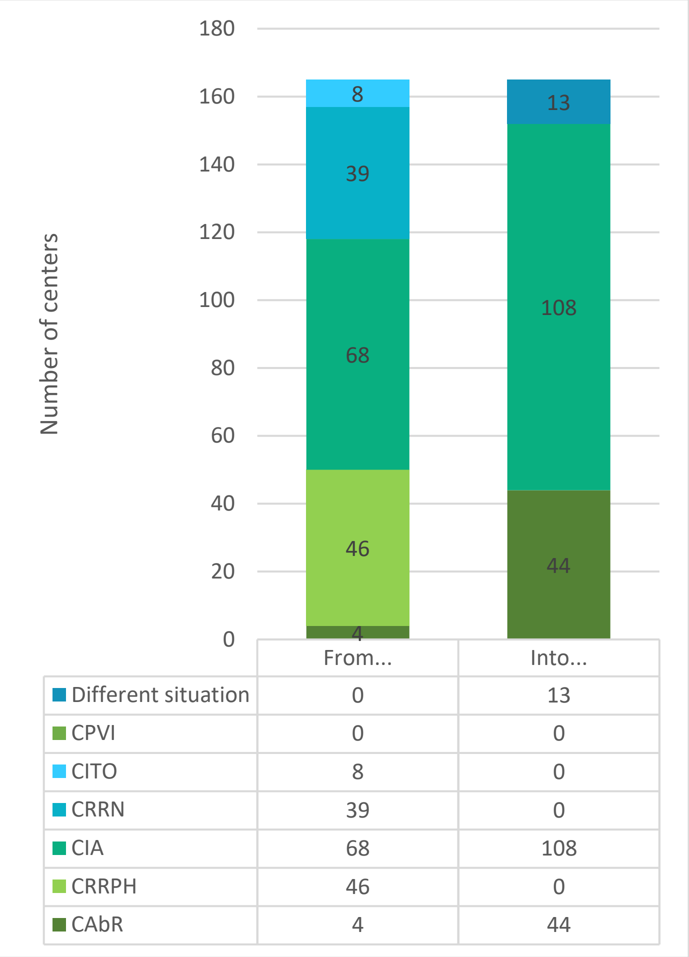


Source: World Bank survey of residential centers (2020).

Notes: CRRPH=recovery and rehabilitation center for adults with disabilities; CIA=care and assistance center for adults with disabilities; CRRN=neuropsychiatric recovery and rehabilitation center; Integration center for occupational therapy.

The main types of RCs undergoing restructure and reorganization are CIAs and CAbRs. In terms of the creation of new centers, CIAs number 108 (including the 63 current CIAs) and CAbRs number 44 (Figure 28). The high number of newly created CIAs suggests, firstly, that creating a CIA require less technical work, given that the activities that make up their profile are less specific within the legislation of quality standards; and secondly, that the traditional profile of a CIA beneficiary (i.e., limited mobility, in need of more intensive and extensive care and assistance) is the very profile of residents who are seen as having “less potential” for independent living and community inclusion, and consequently most likely are to be left in RCs. In fact, according to the GDSACP directors interviewed, as a result of restructuring, the disabled who need continuous or regular support usually end up in CIAs; while those who require regular support end up in in CIAs and CAbRs; and those who need sequential support end up in CAbRs. Furthermore, sheltered housing is considered a solution exclusively for those requiring minimal support. While this transfer criterion is not within the restructuring methodology, the increased number of CIAs can be an ancillary of a larger systemic predisposition to sort beneficiaries and discriminate in the process of deinstitutionalization.

Figure 28: Starting and Ending Points for the Process of Reorganization/Restructuring of Residential Centers on October 30, 2020



	From...	Into...
■ Different situation	0	13
■ CPVI	0	0
■ CITO	8	0
■ CRRN	39	0
■ CIA	68	108
■ CRRPH	46	0
■ CAbR	4	44

Source: World Bank survey of residential centers (2020).

3.2. Difficulties in the Restructuring and Reorganization Process of Residential Centers

The restructure of RCs must be carried in line with a specific framework. Decision No. 878/2018, issued by NARPDCA, establishes the methodology to develop RC restructuring plans that incorporate the characteristics of design, organization, and coordination of activities relevant to the deinstitutionalization process; that is, the (1) transfer of persons with disabilities from the traditional types of institution; (2) development of family-like or residential alternative services; and (3) creation of other measures in the community for preventing institutionalization.[243] The restructuring process is grounded also in a series of principles that emphasizes the creation of local

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[243] Art. 3 of Decision No. 878/2018.

partnerships and integrated planning of activities, with the goal to respect the dignity and autonomy of persons with disabilities and ensure their active involvement in the process, including through their advocates and organizations (Box 6).

Box 6: Principles of the Restructuring Process

- Respect for the dignity, autonomy (including freedom of choice), and independence of persons with disabilities.
- Establishment of local collaborative partnerships in restructuring, capacity building, and coordinating resources; involvement of administrative entities; and protection of civil society.
- Integration of planning activities at all levels to provide an extensive overview of resources and responsibilities.
- Consultation with and involvement of persons with disabilities, their representatives, and organizations, in line with "Nothing about us without us!"

Source: Decision No. 878/2018, Methodology for Elaborating the Plan for Restructuring Residential Centers for Adults with Disabilities.

Many GDSACPs encountered a series of difficulties in the drafting phase of restructure plans. The drafting of plans is a complex and multilayered process requiring the identification and integration of resources to provide the best transfer solutions for persons with disabilities from the traditional types of RCs.[244] Many GDSACP directors interviewed experienced various challenges in drafting the plans due to the (1) short time between receiving the restructuring and reorganization methodologies and submitting the restructuring plans and the substantiation notes relating to the reorganization; (2) unclear requirements and terminology of methodologies; (3) lack of technical capacity at the development phase; and (4) modification of RC minimum quality standards immediately following submission deadline, thus posing further challenges to the implementation process. In addition, GDSACPs had difficulties concerning certain sections of the restructuring plans regarding around 80 percent of the 91 RC to undergo restructure at the national level (Table 45).

Table 45: Difficulties Encountered by GDSACPs* in Drafting Plans for Restructure

Predefined Sections of Restructure Plans, According to the Methodology	Number of Restructure Plans
1. General overview of the current situation of residential centers	1
2. Assessment of beneficiaries from old type of residential centers	29
3. Update of individual plans of intervention to ensure access to person-centered services, as well as transfer to other services	2
4. Planning of restructure stages relating to financial, material, and human resources for the period 2019–21, as well implementation methods correlating to the setting out	66

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[244] Art. 12 of Decision No. 878/2018.

	of service objectives, familial or residential alternatives, of preventive measures newly established/developed in the community	
5.	Proposed actions to ensure a positive and supportive attitude among staff and throughout the community regarding beneficiaries	14
6.	Needs assessment at the community level	12
7.	Measures and actions for preventing (re)institutionalization	30
8.	Internal and external evaluation of restructure process and ways to redress dysfunctionalities	11
9.	Monitoring of restructure process	9
10.	Other aspects (difficulty to comprehend certain concepts, challenges at the community level relating to the deinstitutionalization concept, among others)	15

Source: World Bank interviews with GDSACP directors (June–July 2020). *GDSACP= General Directorate for Social Assistance and Child Protection.
Note: Multiple answers for N=91 restructuring plans.

Consultations with Relevant Stakeholders

Any action plan to deinstitutionalize persons with disabilities requires broad and substantial consultation among relevant stakeholders. The involvement of decision-makers from all state and nonstate sectors (e.g., child protection, health, education, culture, leisure, employment, disability, transport, and finance) is crucial to ensure the representation of diverse interests and the coordinated use of local resources to ensure tailored options for deinstitutionalization for every person with disabilities.[245] During the draft phase, consultations were held with 90 percent of RCs heading for restructure by December 30, 2020, while for 26 percent, consultations took place subsequent to the submission of plans to NARPDCA. For reorganized centers, there were fewer consultations (only 15 percent of all centers). The consultation process before and after the drafting of restructuring plans and reorganization substantiation notes included relevant actors, from staff, NGOs, GDSACP specialists, public local authorities, county council representatives, and the local community, among others. Involvement, however, was uneven across counties; for instance, the presence of NGOs and private sector service providers is often limited at the local level. There was little involvement of mainstream services, such as housing, education, and employment at the local and county levels.

Persons with disabilities were consulted and involved in the restructuring and reorganization process only during the assessment phase. As State Party to the CRPD, Romania assumes the obligation to closely consult and actively involve persons with disabilities and their representative organizations in all decision-making processes concerning issues related to them.[246] Since deinstitutionalization is an issue that

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[245] European Expert Group on the Transition from Institutional to Community-based care (2012, 63).

[246] Art. 4(3) of the CRPD.

directly affects those with disabilities,[247] including those currently living in institutional settings, they should be involved in the planning, implementation, and monitoring of deinstitutionalization strategies.[248] Involvement of RC beneficiaries in public consultations with other local actors is essential for making their voices heard and jointly arriving at appropriate solutions that will eliminate the barriers to living independently and for ways in which they can be included in the community. Still, while GDSACP directors reported a high level of involvement of persons with disabilities in the consultation process (Table 46), their involvement across counties, based on the interview data, appears to have been limited to assessments only, which were carried out by the RC multidisciplinary teams to identify their needs and best options for transfer.

Table 46: Type of Actors Consulted during or after Drafting the Substantiation Notes for Restructure Plans and Reorganization

Type of Actors	Restructuring Plans (percent)	Reorganization Substantiation Notes (percent)
Persons with disabilities in the community	3	0
Persons with disabilities from residential centers	84	85
Families/carers/personal assistants of persons with disabilities from residential centers	86	60
Social service providers	34	15
Nongovernment organizations	53	25
Others	41	40

Source: World Bank interviews with General Directorate for Social Assistance and Child Protection directors (June–July 2020).

Note: Multiple answers for N=91 centers with restructuring plans and 133 centers with reorganization substantiation notes.

Assessment of Beneficiaries

Assessing persons with disabilities as a mandatory phase of the restructuring plans was hampered by a series of obstacles. Restructuring plans must include the results of a complex assessment of persons with disabilities from RCs regarding their support needs and preferences in order to live within the community, so that they can benefit from the best alternatives. Frequently, however, assessment provided difficult, given the (1) high level of support required to help the disabled understand and communicate throughout the assessment in the absence of sign-language interpreters and other communication facilitators, as well as an easy-read version of the assessment tool; (2) limited number of legal guardians able to participate—based on the restructuring

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[247] CRPD Committee (2018, para 20).

[248] CRPD Committee (2018, para 83).

methodology—and make decisions on behalf of persons with disabilities they represent; and (3) short time available to carry out the assessment (Box 7). Approximately 80 percent of GDSACP directors interviewed reported that overall, RC beneficiaries were able to express their opinions during the assessments, and these were further included in the concise assessment reports.

Box 7: Difficulties Relating to the Assessment of Persons with Disabilities from Residential Centers

"The questions [from the assessment fiche] are too long, the beneficiaries' attention span is too short, and they cannot answer every question. The questions are difficult and there is need for translation."

"The only problem is in the case of deaf persons, the assessment and communication are difficult, especially if they never went to school and they cannot write. There is only one person [among GDSACP employees] who was trained a few years back in sign language."

"The methodology had not been approved; everything went very fast, we received a deadline for carrying out the assessments before there was even a methodology approved. Subsequently, once the assessment process had already started, we received a modified fiche, so we had to stop and resume the assessment from the beginning. It was difficult to finish the assessment in 15–30 days, I don't remember exactly now, because the assessment had to be carried out by a multidisciplinary team comprised of the only staff we had: social worker, nurse, psychologist... in case there is only one social worker, psychologist in the center, it is impossible to form more multidisciplinary teams if I only have these two. Ultimately, I could form another team with two nurses, the legal advisor, and an educator, something like that. So, the first obstacle—the tight deadline, the whole process—was not clear from the very beginning, we had to meet up and draw our own conclusions on what had to be done …"

Source: World Bank interviews with General Directorate for Social Assistance and Child Protection directors (2020).

The assessment tool was generally considered useful, albeit with various limitations. The assessment of persons with disabilities living in RCs was carried out by one or several multidisciplinary teams comprising three staff members and one NGO representative, and using an assessment form. Only 33 percent of GDSACP directors considered that the tool was adequately suitable for persons with disabilities with reference to independent living. Interviews with GDSACP directors provided suggestions to improve the tool: (1) more in-depth analysis of certain characteristics (e.g., cognitive skills, psychological counseling); (2) clearer demarcation between self-care skills and those for everyday living; (3) additional items to assess higher levels of support needs and the need for continual assistance; (4) clearer scoring system to correlate assessment results with specific transfer solutions, as well as to ensure assessment accuracy; (5) clearer assessment scale to measure the level of support (e.g., using terms such as "continuously," "sequentially," or "regularly"); (6) fields in which to provide more elaborate conclusions of evaluators; (7) ways in which to reduce discrepancies between the wishes of the person and the needs identified by evaluators; (8) clearer prioritization of beneficiary preferences over those of family and specialists; (9) forms for periodic assessments so as to register changes in resident situations; and (10) easy-to-read version of the tool for persons with intellectual disabilities and high support needs so that they can better understand and communicate.

The will and preferences of persons with disabilities during the assessment not always could be prioritized. On many occasions, the expressed preferences of persons with disabilities for certain transfer options could not be prioritized due to either (1) lack of preferred housing alternatives and services to facilitate independent living in the community or (2) conflict between the personal preferences and the opinion of family members or specialists carrying out the assessment. Often, the source of conflict related to family or the belief of specialist(s) that persons with disabilities with high support needs (e.g., persons with intellectual disabilities or certain psychiatric diagnoses) cannot live independently in the community and that the most suitable services can be offered only in a residential setting. Presently, the restructuring methodology does not offer guidelines to resolving such a conflict, while promoting the right of persons with disabilities to freedom of choice, nevertheless.

Persons with disabilities continue to be considered incapable to decide for themselves. Art. 12 of the CRPD recognizes the full legal capacity of all persons with disabilities and the right to decide for themselves and have their decisions respected.[249] Even though decision-making is a process that requires various types and levels of support for those with or without disabilities, in practice, many persons with disabilities are still considered incapable of making any decision. GDSACP directors often indicate that it is a lack of mental capacity rather than a need for support that prevents the ability of beneficiaries to make decisions, leaving it to the discretion of center staff, families, or authorities to ultimately decide on the transfer options (Box 8). This is becomes an issue when GDSACPs prefer to transfer only those disabled with better decision-making skills and less support needs to sheltered housing and other community services. This is contrary to the CRPD, which recognizes the right of all persons with disabilities to live in the community, regardless of their level of intellectual capacity, self-functioning, or support requirements.[250]

Box 8: Barriers in the Decision-Making Process for Persons with Disabilities from Residential Centers

“[T]he individual choices are respected as long as they do not harm them. [The beneficiary] is advised in his or her best health interest.”

“[T]he capacity for understanding such things is sluggish—decisions regarding the choice of menu, what they intend to do in the future, socio-professional inclusion, or even regarding housing conditions and activities carried out in the center.”

“[I]n cases where the court established that mental capacity was lacking, we requested the director of the center to represent the beneficiaries. And the

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[249] As explained in detail in the section regarding the legal capacity of RC beneficiaries

[250] CRPD Committee (2017b: para 21).

[multidisciplinary] committee respected the solution we had found while carrying out the assessment."

"[T]he persons we assess for the transfer to sheltered housing [are those who] can express themselves independently. It really depends on what kind of disabilities they have."

"[I]n some cases, the beneficiaries' choices for certain type of services could not be respected, since their wish did not coincide with the needs identified during the assessment; for beneficiaries placed under guardianship and who lack mental capacity, the legal representative had to be informed about the possibility to choose from among newly established services."

Source: World Bank interviews with General Directorate for Social Assistance and Child Protection directors (2020).

Some persons with disabilities, who have spent a long time in an RC, are reticent to make the transition to other services. Institutional care can isolate and compel residents to live together in a setting where they have little control over their daily lives, and are forced to prioritize institutional requirements over their own preferences.[251] After long-term exposure to an institutional culture (e.g., perhaps in public care or in centers for children), many of the disabled may find it difficult to imagine life outside their institutional setting, where they have formed habits and relationships; to make autonomous decisions; or to be able to identify what support they may need.[252] In some counties, there was a high incidence of residents preferring to remain in the institution where they found themselves, or who changed their minds had they opted for transfer to other services. The GDSACP directors interviewed emphasized the reticence of long-term beneficiaries to leave their RCs for fear of the unknown, a sudden change, and/or the loss of relationships and friendships they had formed over the period they were institutionalized. The European Expert Group on the Transition from Institutional to Community-based care suggests that access to information, advice, and support on the benefits and challenges of independent living, especially from other persons with disabilities who already live independently (i.e., having experienced institutional care), is crucial for building confidence and enhancing decision-making skills with regard to their living environment.[253]

Accessing Financial, Material, and Human Resources

The process of restructuring and reorganizing RCs requires access to different types of resources and support, which are not always available to GDSACPs. In general, the implementation of restructuring plans and reorganization substantiation notes has been fraught with difficulties in various aspects relevant to ensuring transition to community living. GDSACP directors indicated that additional funding and the hiring/training of staff for new services are pressing needs, as well as the support to analyze, identify,

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[251] European Commission (2009, 9).

[252] European Expert Group on the Transition from Institutional to Community-based care (2012, 122).

[253] Ibid.

and ensure suitable community services to successfully carry out the process (Table 47).

Table 47: Types of Support Required to Implement Current and Future Restructure Plans and Reorganization Substantiation Notes

Types of Support Needed	Centers with Restructuring Plans (percent)	Centers with Reorganization Substantiation (percent)
1. Additional funding	58	26
2. Support for training staff for new services	48	25
3. Support for hiring more case managers	49	2
4. Support for conducting an analysis of community-based services	28	10
5. Support for contacting, informing, and involving families of institutionalized persons in the process of ensuring community inclusion	8	5
6. Support/technical assistance to identify necessary services to ensure independent living and community inclusion	31	5

Source: World Bank interviews with GDSACP directors (June–July 2020).

Note: Multiple answers for N=91 centers with restructuring plans and 133 centers with reorganization substantiation notes.

Accessing material resources necessary for the restructuring process proved difficult for many GDSACPs. In many cases, solutions that imply the transfer of persons with disabilities to the community required access to various material resources in terms of service delivery, such as land, buildings, and other resources required for the set-up and delivery of necessary services. Some Mayoralties tend to be reluctant to transfer land rights to GDSACPs to use existing buildings for community social services, resulting not only in a bureaucratic and laborious exercise to obtain the necessary approvals from various central and local authorities, but also delays beyond funding application deadlines. Furthermore, GDSACPs had their own challenges with regard to procurement in terms of a shortfall of applicants for audits, bids, and construction contracts, also placing pressure on deadlines. With regard to the Covid-19 pandemic, in particular, attempts to mitigate its effects took the place of restructuring activities, thus exacerbating the entire process.

County councils are essential as partners of GDSACPs in providing support to implement restructuring plans. According to the restructuring methodology, once approvals from NARPDCA are received, restructuring plans require endorsement from county councils before GDSACPs are able to act. The partnership between county council and GDSACP is imperative to meet the implementation demands of restructuring and reorganizing centers. Qualitative research indicates that the support provided by county councils to GDSACPs include (1) identifying and allocating lands/buildings which they own; (2) facilitating the identification of lands/buildings owned by other institutions/private stakeholders (e.g., social housing); (3) providing financial resources to develop new services; (4) contracting private social services; and (5) providing technical expertise (e.g., legal assistance or expertise to prepare and implement EU-funded projects), as well as other types of support, as necessary. Support mostly has consisted of funding new services (almost 50 percent of restructuring plans) and technical expertise (38 percent). More than half of those county council representatives interviewed indicated the scarcity of supplementary funding to enable restructuring, as well as the absence of impact analyses of increases to RC budgets and the organizational capacity to support RC restructuring locally.

In some cases, there are limited options to develop new services, leading county councils to resort to concentrating two or more services within the same building or vicinity. As key partners to GDSACPs, county councils are able to ensure access to buildings and land in order to develop the necessary services for restructure. However, buildings and lands are not always locally available. In the context of previous investments in building and renovating residential centers which are now undergoing restructuring, County Directors preferred, in some cases, to organize two residential services with a capacity under 50 places in the same building, rather than finding other solutions for beneficiaries in the community. Facilitated by a procedural loop in the restructuring methodology, this practice further reproduces the institutionalization of persons with disabilities and maintains their concentration in a large building. Another type of solution identified by GDSACP that again favors an agglomeration of services is when an existing service benefits of a large yard which sometimes represents the only identified available space for building a new facility.

Adequately trained staff is essential to prevent the transfer of institutional practice into the community and to provide a person-centered approach to ensure independent living and community inclusion. Ensuring the right to independent living requires a change from an outdated institutional care model to a person-centered service delivery. The Fundamental Rights Agency recommends that all EU Member States should provide compulsory training to all actors involved in the deinstitutionalization process, including frontline staff, on how to ensure choice and control for the persons with disabilities they work with.[254] The retraining of staff for new services in the various sets of skills and knowledge, in line with the philosophy of independent living, has been emphasized by GDSACP directors for approximately half the centers under restructure and a quarter of those that are being reorganized. At the same time, however, they point to the lack of training resources and methodology since, at present, there are no accredited courses that deliver training on independent living and no coordinated activities available for existing and new staff at the national or local levels.

Measures are necessary to address the resistance shown by staff with regard to deinstitutionalization. In addition to training, staff must be empowered to become the

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[254] European Union Agency for Fundamental Rights (2018, 11-12).

agents of change rather than of resistance.[255] GDSACP directors indicated that some RC staff members not only feared job and compensation loss in the face of restructuring and reorganization, but also were somewhat resistant to the concept of restructure and reorganization.[256] In some cases, staff refused transfer to private service providers subcontracted by GDSACPs which would pay lower wages than those in the public system. As a result, the new services being established are resorting to recruiting staff with inadequate professional training and, while they may be eager, have no experience dealing with adults with disabilities, thus potentially decreasing the quality of service provision.

Identifying the Appropriate Social Services to Ensure Independent Living and Inclusion in the Community

Even though the evaluation of existing social services for persons with disabilities is one of the mandatory phases in the process of drafting restructuring plans and reorganization substantiation notes, such analyses were not always included. The methodology for restructure and reorganization mandates an analysis of current social services offered within the community,[257] an essential step to identify solutions to facilitate the transition of persons with disabilities from RCs into community life. While admissions to an RC are approved only if no other services can be provided at home or in the community,[258] not all solutions identified for the transfer of persons with disabilities for restructured centers were based on a thorough analysis of existing social services at the community level. Only approximately 75 percent of restructuring plans and 25 percent of reorganization substantiation provided this kind of analysis, which would lend to tailored solutions for transferring beneficiaries into the community, as well as the services that will be necessary.

Social service mapping should be undertaken by county councils for strategic purposes; however this is not always the case. County councils are responsible for preparing county strategies to enable social service development and relevant annual action plans, which they ultimately manage and finance. Plans should include a mapping of existing social services, including type of service and the number and categories of beneficiary,[259] which would prove useful for GDSACPs to enable them to identify and establish the necessary community services on transfer. However, many council county representatives interviewed consider this exercise to fall under the responsibility of GDSACPs, demonstrating that they had little knowledge of the current status of or the needs for social services at the community level. It appears that in many cases, it is the

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[255] European Expert Group on the Transition from Institutional to Community-based care (2012, 68). GDSACPs directors also emphasized the resistance of staff to the process of restructuring.

[256] In one county, a staff member sued against local council approval of an RC restructuring plan for these reasons.

[257] Art. 23 of Decision No. 878/2018.

[258] Art. 89(1) of Law No. 292/2011, and Art. 51(5) of Law No. 448/2006. The latter defines RCs as being (1) sheltered housing; (2) centers for independent living; (3) centers for habilitation and rehabilitation; and (4) care and assistance centers at the exception of respite and crisis centers.

[259] Art. 112(3)(a) and (b) of Law No. 292/2011 of social assistance.

GDSACP that provides the county council the data collected from the services they coordinate.

In most instances, the analysis of existing community social services necessary for the drafting of restructuring plans has included only an assessment of availability and relevance to persons in RCs. To ensure that persons with disabilities can be effectively included within the community, a social service must meet several criteria. It must be (1) accessible in terms of infrastructure, information, and communication, as well as within reach; (2) affordable to all those with no or with low income; (3) provided with quality and have a person-centered approach; and (4) respect culture, gender, age, disability, life-cycle requirements, and other aspects related to the personal contexts of beneficiary.[260] The assessment of community services focused mostly on availability (44 percent of restructuring plans) and relevance to residents (40 percent), while other aspects were assessed to a lesser extent – price accessibility (27 percent), accessibility (23 percent), and quality of service provision (21 percent).

A comprehensive analysis of the full range of community services was missing from some restructuring plans and reorganization substantiation notes. In addition to the closing down of institutions, an effective deinstitutionalization strategy must ensure the development of adequate community-based services for persons with disabilities as well as the inclusiveness of mainstream services.[261] Access to services for the general population is essential for independent living, as it can decrease as well the demand for disability-specific services.[262] For instance, access to accessible housing in the community as well as to supported employment can substantially decrease the demand for residential care or sheltered employment. Not all restructuring plans and reorganization substantiation notes include a comprehensive analysis of disability-specific and mainstream services, even if available (Table 48).

Table 48: Types of Community Services Assessed for Drafting of Restructuring Plans and Reorganization Substantiation Notes

Types of Community Services	Restructuring Plans (percent)	Reorganization Substantiation Notes (percent)
Health	53	22
Education	48	14
Employment	42	12
Housing	33	15
Personal assistance	41	18
Personal professional assistance	24	3
Decision-making support services	24	5

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[260] Human Rights Council (2017b, para. 35).

[261] European Expert Group on the Transition from Institutional to Community-based care (2012: 64).

[262] CRPD Committee (2017a, para. 33).

Source: World Bank interviews with GDSACP directors (June–July 2020).

Note: Multiple answer for N=91 centers with restructuring plans and 133 centers with reorganization substantiation notes.

The low number and diversity of community-based social services for persons with disabilities is a barrier for the deinstitutionalization process, while plans for service development do not match current needs. While sheltered housing remains the most widespread type of residential service besides RCs for persons with disabilities, the number of other community-based services under NARDPCA coordination remains low. For instance, even though there currently are only one mobile team and two home-based care services, no new such services have been developed within the last five years, and the small number of respite and crisis centers have registered little variation (Annex-Table 19). At the same time, while the number of community-based services has not increased over the last years, the number of their beneficiaries, in fact, has decreased from 1,900 to 1,600 (Annex-Table 19). Professional personal assistance, while not a new service,[263] currently is not functional. In August 2020, there were only 21 PPAs in three counties, even though 16 GDSACPs had included 238 such position on their organizational charts.[264] The lack of adequate community-based services has been identified as a barrier in the deinstitutionalization process at the level of 38 percent of county councils. Plans to develop community-based services at the GDSACP level in the near future, however, do not match the present high demand (Table 49).

Table 49: Availability of Community-Based Services and Future Plans for Developing Services at the County Level

Types of Community-Based Services	Counties that Do Not Offer Services (percent)	Counties that Plan to Develop Services (percent)
Respite/crisis centers	91	40
Home-care services	78	20
Mobile teams	84	27
Day centers	87	64
Centers for outpatient neuromotor recovery	80	20
Assistance and support service for adults with disabilities	78	16
Personal assistance	60	9
Personal professional assistance	98	71

Source: World Bank interviews with GDSACP directors (June–July 2020).

Note: Multiple answers for N=45 counties.

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[263] Pursuant to Law No. 448/2006, the PPA offers services to persons with disabilities, who have no access to housing, have no income, or their income is below the average wage. Other normative acts have subsequently detailed the framework for the organization and functioning of this service: Government Decision No. 548/2017 regarding the approval of criteria for obtaining the certificate, of certification procedures and statute of the personal professional assistant.

[264] Data collected by the World Bank in 2020 for the Diagnosis of the Situation of Persons with Disabilities.

Developing community services requires ensuring adequate and sufficient material, financial, and human resources that are often lacking. Some of the interviewed GDSACP directors pointed to the lack of funding for developing new services—other than those with already approved budgets—within restructuring plans. Mayoralties often have an insufficient budget for services and do not support the development of projects proposed by GDSACPs that they deem would be unsustainable in the long term once funds for the implementation phase have run out. In general, mayoralties expect services to be financed from the state budget. The lack of qualified staff also has been suggested as a barrier that prevents the development and maintenance of services, in addition to a perceived lack of interest of potential beneficiaries for such services, although some GDSACP directors believe that the demand may increase with the supply (Box 9).

Box 9: Barriers Preventing the Development and Maintenance of Community-Based Services

"Lack of funding and lack of qualified specialists. The general problem concerns project funding, and even if funding was available, the sustainability of the project is a challenge for the local community and presumably every Mayoralty takes stock of its financial resources. We regularly have open positions but there are no qualified persons to fill them. In addition, there is a discrepancy between the wages of staff for a permanent job and a short-term job, and since in the centers the positions are short-term, the wages are lower than those for a permanent job in a public institution, and applicants prefer to apply to the latter."

"In the crisis center, people were spending short periods of time until we were transferring them to the other [residential] centers, they were in transit, [the center] did not prove its usefulness, and the other [services] – that provide *care and support* are not suitable for rural areas or for small cities, are not suitable for people's needs, people are not interested in using the service for talking and discussing, they are interested in satisfying their basic needs – food, hygiene."

Source: World Bank interviews with GDSACP directors (June–July 2020).

The lack of community-based services is also an effect of concentrated efforts to establish sheltered housing in previous years to the detriment of other services. While 32 GDSACP directors reported the existence of deinstitutionalization initiatives in their counties previous to the current process of restructuring RCs, most initiatives involved setting up sheltered housing. In addition, GDSACP directors also indicated a few other types of services with uneven distribution across counties, such as (1) sheltered employment exclusively for residents of certain RCs, as well as, in some cases, for persons with disabilities living in the community; (2) transitional housing for youth from the child protection system that offers counseling and support for employment and independent living, as well as other services; (3) day centers for the recovery and rehabilitation of adults with disabilities; (4) home-care services, provided mostly by private organizations; (5) services for assisted employment.[265]

While personal assistance is the most widespread community-based service for independent living, there are difficulties in ensuring the sustainability and quality of services offered. Persons with severe disabilities can benefit from personal assistance or opt for caretaker allowance, according to current legislation.[266] Personal assistants (PA) are employed by mayoralties on a minimum net wage at the level of caretaker allowance (currently RON 1.348) plus additional benefits. In March 2020, 74,186 persons with disabilities were benefitting from personal assistance, amounting to only 32 percent of persons eligible for personal assistance or caretaker allowance, with large disparities between county and towns or villages.[267] GDSACPs directors pointed out a series of situations that lead to the ineffective delivery of personal assistance, such as (1) reluctance on the part of mayoralties to hire PAs or the pressure on PAs to end their employment contract, leading to an increased burden on the families of persons with disabilities, since most PAs are, in fact, family members; (2) lack of access to adequate training for many PAs, as well as lack of data on training provided;[268] (3) inconsistent practice of monitoring PAs by mayoralties[269] and the superficial nature of how it is carried out due to insufficient numbers of social workers at the level of mayoralty; (4) the old age of some PAs, often in a poorer state of health than the person with disabilities.

Were PPAs to be promoted as a key service to support the deinstitutionalization of persons with disabilities, their recruitment would remain a nationwide challenge. Professional personal assistance is a family-type alternative to institutionalized care for persons with disabilities from RCs and would prevent institutionalization.[270] While this may function as a solution for those with severe and accentuated disabilities, who otherwise have no access to housing or have sufficient income to cover living costs, the qualitative research shows that the service is far from being functional at the county level. GDSACP directors emphasized the small number of applicants for PPA openings, the lack of available mandatory training courses, and the intensive training requirements that may discourage potential applicants, as well as the lack of cost

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[265] For example, GDSACP Harghita initiated a project with partners from Austria, funded through the European Commission's Leonardo da Vinci Programme, whereby they trained GDSACP staff and further established, together with various NGOs, a network of offices that offered assisted employment services.

[266] Law No. 448/2006.

[267] Diagnosis of the situation of persons with disabilities in Romania (World Bank, 2020, 184).

[268] In some counties, GDSACPs established their own training department for PAs, although mayoralties showed no interest in making use of such resources.

[269] In some counties, the monitoring activity carried out by mayoralties is doubled by that of the County Authority of Payments and Social Inspection, a salutary interinstitutional collaboration from the perspective of GDSACP directors.

[270] Decision regarding the amendment of Art. 6, Paragraph (1) Point (b) from Annex to Government Decision No. 548/2017 regarding the approval of criteria for obtaining the certificate, of certification procedures, and statute of the PPA, Section 2.

standards[271] and insufficient funding from county councils. In 2020, only around half the number of county councils, nationwide, had allocated funding for PPA, and even fewer had plans to provide any budget allocations in 2021; that is, 14 percent of all county councils and 26 percent of those with an allocated budget in 2020. In a few cases, county councils managed to secure PPA funding from EU-funded projects.

Even though nonprofit service providers also could cover the needs for service provision at the local level, their number and capacity remain low, and their distribution is uneven across counties. The value added of nonprofit service delivery often rests with the capacity of providers to best respond to the diversity of needs of persons with disabilities, as well as with their greater flexibility to adapt to changing local circumstances compared to the public sector.[272] Law No. 350/2005[273] that establishes the framework for financing nonprofit organizations from public funds has allowed some GDSACPs to externalize service delivery to the nonprofit sector as a solution to curb RC admission rates. According to GDSACP directors, however, the limited capacity among nonprofit service providers—especially in rural areas where many RCs are located—and their preference to provide services only to beneficiaries with less severe disabilities and lower support needs reflect additional challenges to ensure access to local services. Currently, only 38 percent of GDSACPs have procured, or are planning to procure, services from private providers in the process of restructuring.

The transfer solutions identified for the implementation of restructure plans may reproduce the same culture as traditional institutions. The restructuring methodology defines traditional institutions as characterized by an institutional culture marked by (1) depersonalization, such as removal of personal belongings; (2) rigidity of routine, as imposed, and fixed timetables for daily activities; (3) block treatment, as maneuvering people in groups with no respect for privacy and individuality; and (4) social distance, as symbolizing the different status of staff and beneficiaries.[274] The objective of restructuring is to transfer persons with disabilities to services that would not replicate such features. While the majority of interviewed GDSACP directors (73 percent) assessed the transfer options identified locally as different from traditional institutions, the qualitative research indicates that there is little concern among GDSACP directors regarding the loss of choice and control of beneficiaries over service-provision that may be reproduced in the new types of services. In general, GDSACP directors only indicated the lack of specialized staff or the large number of beneficiaries accommodated in the new centers or sheltered housing among the challenges that could lead to reproducing institutional care.

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[271] Unlike Government Decision No. 978/2015 regarding the approval of minimum standard costs for social services, latest Government Decision No. 426/2020 regarding the approval of minimum standard costs for social services does not include any standard costs for PPAs.

[272] McDaid, Knapp, and Curran (2005, 14).

[273] Law No. 350/2005, December 2, 2005, regarding the system of nonreimbursable funding from public funds allocated for nonprofit activities of general interest.

[274] Decision No. 878/2018; and King, Raynes, and Tizard (1971) in EC (2009: 09).

Family Needs Assessment

Assessing family and caretaker needs is essential to ensure the best transfer solutions for persons with disabilities in RCs, but not all GDSACPs conducted such assessments. Lack of family support is one of the main causes of institutionalization, due to inadequate income, housing, access to relevant community services, and support skills to respond to the needs of family members with disabilities. Family needs assessment is thus crucial in order to identify the challenges confronting families and the measures required to best support them in the process of deinstitutionalization and to prevent (re)institutionalization. In the case of residents living in centers undergoing restructuring, the needs of their families have been most often evaluated by the center multidisciplinary teams comprising the case manager, social worker, psychologist, and other types of staff. While 82 percent of GDASCPs conducted such assessments for establishing transfer solutions, some consider this to fall under the responsibility of public social assistance services which operate at local level.

Conducting needs assessments and implementing support measures for families are not unitary practices across GDSACPs. Current assessment methods vary, and there is no standardized assessment tool that can ensure consistency in evaluation in line with independent living requirements (Box 10). Most often, assessments cover family income, housing, family ability to adequately offer care and support, and access to general and specific services within the community (e.g., social, medical, employment). In general, support measures offered by GDSACPs include assistance in accessing income or housing for family members, as well as employment for persons with disabilities; counseling; access to services, such as mobile teams; home-based care; and daycare centers or rehabilitation services.

Box 10: Family-Needs Assessment Practices at the Level of the General Directorate for Social Assistance and Child Protection

“**[Our GDSACP]** did not conduct an assessment per se, but a survey. Only one family wanted to take in the family member from RCs (out of approximately 300 beneficiaries). The goal of the survey was to collect information on whether the family approved of deinstitutionalization, of placing the person with a professional personal assistant (in case they refused to take in the person), or whether any family member was willing to become personal assistant. The mayoralty (Social Assistance unit) conducts a home visit to make sure that living conditions are adequate, and the results of the inquiry are sent to the RC. […] The families are provided appropriate counseling for providing care to persons with disabilities and, where appropriate, support from local public authorities. Difficulties arise in the case of persons with mental or psychiatric disabilities, due to lack of round-the-clock medical care, low instruction level of family members, [and] the monitoring activities of the local Social Assistance unit should be more updated and more realistic.”

“**[Our GDSACP]** does not conduct an assessment; however, the [multidisciplinary] team in the center meets up […] with the beneficiary who wishes to leave the center, with carers, the mayoralty is asked to conduct social evaluations, to provide a point of view, the evaluation is conducted, the place where the beneficiary would return is assessed."

Source: World Bank interviews with GDSACP directors (June–July 2020).

Measures for Preventing the (Re)Institutionalization of Persons with Disabilities

Preventing institutionalization and reinstitutionalization is essential to achieve an effective transformation of the residential care system and to prevent new admissions. In the absence of a comprehensive analysis of the factors that lead to the admission or readmission of persons with disabilities to residential institutions, deinstitutionalization efforts are likely to fail. Such an analysis can shed light on the roots of institutionalization and mechanisms needed to prevent the maintenance of a revolving-door system, where the places vacated by the people who have left the institutions will be quickly filled by newcomers.[275] Only 60 percent of GDSACPs conducted an analysis of the risks of reinstitutionalization of persons with disabilities from RCs undergoing restructuring. In some cases, directors pointed out the need for specialists to conduct such an analysis, while in others, this analysis was carried out partly during the assessment of beneficiaries by the multidisciplinary teams in RCs undergoing restructuring or in family needs assessments.

The factors that lead to (re)institutionalization vary, thus calling for integrated preventive measures that cover different areas of intervention. A combination of factors usually leads to (re)institutionalization. GDSACPs directors emphasized the (1) lack of community-services able to adequately respond to persons with disabilities, particularly to those with high support needs; (2) high levels of poverty and inadequate standard of living; (3) low disability indemnity, insufficient to cover living and disability-related expenses; and (4) limited involvement of NGOs and private service providers. In addition, (re)institutionalization appears to be precipitated by a lack of adequate family support, job loss, discriminatory attitudes, and the lack of support for transitioning into community living.

Measures for the prevention of (re)institutionalization are scattered at the level of GDSACPs and are not part of a broad and integrated strategy. While many GDSACPs do take measures to prevent the (re)institutionalization of persons with disabilities at the local level, these measures are rarely integrated to respond to the individual needs of persons with disabilities. The measures implemented by GDSACPs vary greatly and concern (1) the development of community-based services (especially PPAs, PAs, daycare centers, mobile teams, respite centers, and home-based care services); (2) family counseling; (3) interdiction of admissions to RCs; (4) support for accessing the Minimum Guaranteed Income; (5) facilitating access to social services delivered by local authorities and county employment agencies; (6) collaboration with nonprofit and private sector providers to ensure transition to community living; and (7) post-transfer monitoring (six months to one year) of persons with disabilities and their families.

Measures for increasing awareness are highly relevant to address resistance at the community level to the right of persons with disabilities to independent living within

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[275] European Expert Group on the Transition from Institutional to Community-based care (2012, 84).

the community, and they are further needed at the national and local levels. Working with communities and relevant stakeholders is essential to counter stigma and discrimination against persons with disabilities. Negative attitudes and prejudices toward previously institutionalized persons with disabilities, in particular those with intellectual disabilities and psychiatric diagnostics, may hamper the development of community services and may lead to the continuation of traditional residential care methods, as some GDSACP directors suggested (Box 11). The need for awareness-raising campaigns regarding equality of opportunities for independent living is thus crucial; this was pointed out by GDSACPs directors with regard to approximately 50 percent of centers undergoing restructure.

Box 11: Negative Attitudes at the Community Level toward Institutionalized Persons with Disabilities

"[The County Council] has made requests for available lands, and no mayoralty declined; however, in the county capital there are problems in certain districts, especially where family-type houses are located. Neighbors complain since they do not approve that a major NGO [nongovernment organization] bought a house and established a social center—there is noise, the ambulance would sometimes arrive at night, and if a neighbor wants to sell his or her house, the price on the market is lower since the property is in the vicinity of the social center. Certain mayoralties that own lands in metropolitan areas are reluctant to answer [to our requests] due to these reasons, even if a center may bring certain benefits regarding the employment [of beneficiaries]."

"The Neuropsychiatric recovery and rehabilitation center for young adults is in the proximity of a social housing building. The residents consider that a center with youth with dementia in the proximity has a negative psychological impact. A solution would be to move the youth with dementia and separate the center by a hedge. The beneficiaries who are more aggressive could be relocated to a different service, such as a sheltered house."

Source: World Bank interviews with GDSACP directors and county council representatives (June–July 2020).

Collaboration with NARPDCA in the Process of Restructuring

Drafting the restructuring plans has been a process carried out in close collaboration with NARPDCA. The restructuring methodology establishes NARPDCA as the governmental institution responsible for approving and monitoring the implementation of restructuring plans for centers under its methodological coordination. GDSACPs most frequently received technical assistance from NARPDCA for the drafting of plans (73 percent) while, in some cases, NARPDCA facilitated collaboration with local authorities (county councils and mayoralties) by promoting deinstitutionalization and community-based service development. Revising the plans has been, in some instances, an assiduous back-and-forth process between NARPDCA and GDSACPs that, according to some GDSACPs directors, has led to stronger emphasis on the technical aspects to the detriment of content and vision. In general, the technical aspects relate to statistical data and organization of documents to be included in the restructuring plans, implementation-related expenses, concrete plans regarding lands to be used in the process and building maintenance and repairs.

4

THE SITUATION OF ADULTS WITH DISABILITIES FROM OTHER TYPES OF SPECIALIZED INSTITUTIONS

4. Situation of Adults with Disabilities from other Types of Specialized Institutions

This section provides an assessment of people with disabilities who have long been institutionalized in specialized residential institutions, such as psychiatric hospitals and wards, forensic hospitals, and MSAUs. An analysis is made of the (1) profile of specialized institutions; (2) profile of persons with disabilities who have been long term within these institutions; (3) reasons for long-term institutionalization; and (4) difficulties in accessing community-based services necessary for independent living.

Many persons in specialized institutions have a disability, confirmed or not by a disability certificate. Unlike the admission procedure in public RCs for persons with disabilities that requires persons with disabilities to have a valid disability certificate, this is not a requirement for the institutions included in this section.[276] There are, however, many more persons in specialized institutions who may have disabilities understood within the context of the CRPD, where disability is “an evolving concept” resulting “from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.”[277] Often, the current process of evaluating disabilities in Romania is grounded in the medical rather than the social model of disability[278] and has an individual perspective of impairment,[279] which may overlook barriers to participation and full inclusion in the community that persons with disabilities are faced with. These barriers also limit access to the procedure of disability assessments,[280] potentially depriving persons with disabilities from obtaining a certificate that would grant them access to a series of benefits and social services.

Long-term admission to a social care institution on the basis of disability is a violation of human rights. All persons with disabilities have the right to live in the community, with choices equal to others, a right that must be ensured through the provision of a wide range of disability-specific and mainstream services within the community.[281] Long-term social care in an institution is a consequence of limited access to community services and a violation of the right to independent living and community

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[276] For this reason, the sample for administrative data collection on the profile of beneficiaries of specialized institutions included persons with disabilities with and without a disability certificate. The sample included 180 residents who had been in 20 different institutions for longer than six months or were expected to stay longer than six months, as follows: 70 residents of MSAUs (of which 29 with a disability certificate), 90 patients of psychiatric hospitals/wards (of which 66 with a disability certificate) and 20 patients of forensic psychiatric hospitals/wards (of which 9 with a disability certificate).

[277] CRPD, Preamble.

[278] Oliver (2013) and Barnes et al. (2002).

[279] Oliver (1996).

[280] For example, due to limited information on how to access the assessment procedure, there is limited access to transportation or financial resources.

[281] Pursuant to Art. 19 of the CRPD.

inclusion. In addition, any form of institutionalization—including long-term commitments to psychiatric wards and MSAUs on the grounds of disability, is a form of deprivation of liberty and contravenes Art. 14 of the CRPD.

4.1. Profile of Specialized Institutions

MSAUs are public institutions that fall under the responsibility of local or county level public authorities that offer care, medical, and social services in a residential setting.[282] The funding of these institutions is either ensured by the overseeing bodies (i.e., local authorities (councils) or county-level authorities (county councils)), or through various medical health insurances,[283] financial contributions of service users, donations, or other forms of income.[284] According to data from the qualitative research of health authorities at the county level, public health departments cover expenses for medicine and nurses' wages. The heads of these entities, who were interviewed for this report, indicated that units directly subordinated to county level public authorities are generally better funded than those coordinated by local (city, village) authorities.

MSAUs have been designated to take in persons with chronic health and social problems from hospitals for the chronically ill, based on the Health Reform Law.[285] Although the law does not clearly outline the type of illnesses that may justify long-term hospitalization, it does make a distinction between primary medical and social-medical issues. While a chronic illness justifies long-term hospitalization in a specific hospital for the chronically ill, the accompanying social problems may justify care in an MSAU or other social protection unit where a medical assessment can be made. The difference in approach is not restricted to psychiatric conditions; it also applies to all forms of chronic illness and social issues. In the codification standards for the diagnosis of psychiatric illness, there are five different codes associated with social problems, which are difficulties (1) relating to housing and economic conditions; (2) associated with the social environment; (3) associated with the medical environment, including family situation; (4) regarding certain psychosocial reasons; and (5) regarding other psychosocial reasons.[286]

Psychiatric hospitals and psychiatric wards of general hospitals offer inpatient medical assessments and treatment for people with acute and chronic mental illnesses. In accordance with the provisions of Art. 49(1) of Law No. 487/2002 on Mental

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[282] Annex 1 to GD No. 412/2003 on regulations regarding the organization, functioning, and financing of MSAUs.

[283] Through the National Health Insurance House and the Bucharest Municipality Health Insurance House.

[284] The sources of income are regulated by Art. 7–9 of Government Decree No. 412/2003 on regulations regarding the organization, function, and financing of MSAUs. Art. 8 regulates the institution's own budget that may consist of (a) reimbursements of medical treatment provided by county-level health insurance bodies; (b) resident/service user contributions, based on prior decisions regarding the amounts (decision made by overseeing local public authorities or the county council); and (c) sponsorships, donations, and other legally recognized forms of funding.

[285] Law on Health Reform No. 95/2006, Art. 170(g).

[286] Coding Standards for International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) (2010).

Health and the Protection of People with Mental Disorders, admission to a psychiatric unit should be carried out only for medical reasons, such as diagnosis and treatment. Hospitals for patients with chronic illnesses[287] allow for long-term hospitalization on the grounds of the "specifics of medical pathology." The law does not provide clear indications about what these specifics entail, nor the length of time hospitalization can be justified; rather, it provides the potential to redirect a patient to an MSAU in the case of both medical and social reasons. Admissions to psychiatric hospitals can be subdivided into three different categories: (1) short-term acute hospitalization (up to 30 days, according to qualitative interview data; or ≈11.04 days, according to the National Health Insurance House); (2) chronic hospitalizations (up to 90 days, or ≈48.57 days, respectively); and (3) long term hospitalization of chronically ill patients (≈302.19 days).[288] In some cases, as reported by the hospital staff interviewed, the patient is discharged and readmitted in order to prolong the length of hospitalization.

There are 16,073 psychiatric hospital beds at the national level. The number reported by the Ministry of Health[289] includes psychiatric hospitals and wards (acute and chronic) as well as forensic hospitals and wards, as follows: four forensic psychiatric hospitals with 1,805 beds, 36 psychiatric hospitals with 8,841 beds, and 91 psychiatric wards of county-level hospitals with a total of 5,427 beds[290].

Psychiatric hospitals tend to have separate wards for chronic and acute patients. According to the research data, psychiatric wards are separated by medical pathology for acute or chronic patients and are of mixed gender. One of the county hospitals had only one ward for chronic patients at the time of data collection, whereas other hospitals had as many as six wards (two hospitals) and up to 17 wards (one hospital). The number of beds varies greatly between hospitals, from 29 to 1,220, with most hospitals in the sample ranging with between 120 and 330 beds. The transfer of patients between acute and chronic wards is possible and is regulated by Order No. 488/2016 and its corresponding Appendix on Regulations for the implementation of Law No. 487/2002 on Mental Health and the Protection of People with Mental Disorders.

Forensic hospitals and wards offer services in a closed setting to people who have committed criminal offenses. Admission to forensic hospitals is stipulated by Art. 110 of the Criminal Code, stating that "when the offender is mentally ill, is a chronic consumer of psychoactive substances, or suffers from an infectious disease and represents a threat to society, the measure to commit the person to a specialized medical facility may be taken until the person's health is restored or until an improvement that eliminates the danger occurs." There are currently four forensic

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[287] Law on Health Reform No. 95/2006, Art. 170(g).

[288] Data compiled from interviews and from Annex 25 of GOR (2016).

[289] Ministry of Health (2019).

[290] Ibid.

psychiatric hospitals in Romania: Ștei, Săpoca, Pădureni-Grajduri, and Jebel, which have a total of 1,805 approved beds.[291] These hospitals are usually located in rural areas and they receive patients from neighboring counties.

Wards for chronically ill patients, including those for forensic patients, tend to be overcrowded throughout the country. Wards for chronically ill patients everywhere in Romania exceed their occupancy rates, whereas wards for acute psychiatric patients are only at 60 percent capacity.[292] A report by Romania's Ministry of Health recommends redistributing the number of beds to ensure that it reflects actual needs; however, it does not address the possible underlying causes for this situation, including lack of community-based services (mental health care and disability-specific services) that may push chronic psychiatric patients into long-term hospitalization.

4.2. General Profile of Persons from Specialized Institutions

Long-term beneficiaries of specialized institutions have chronic health conditions, but their profile varies according to the profile of the institution. Schizophrenia or other schizotypal or delusional disorders, organic brain disorders, mental retardation, hypertensive disorders, or ischemic heart diseases are the most predominant forms of chronic disease in persons who have been admitted for longer than three months to all three types of specialized institutions, with schizophrenia and mental retardation more present among persons with a disability certificate. Some variations occur depending on the type of institution. For instance, while schizophrenia and associated disorders are more common in psychiatric and forensic institutions (in the case of over 50 percent of persons admitted), this is not the case in MSAUs, where most have been diagnosed with either organic brain or hypertensive disorder, each close to 30 percent of persons admitted.

The most common types of disability in specialized institutions are psychosocial and intellectual. According to data collected on a sample of 104 persons with disabilities admitted to specialized institutions, 64 percent have a psychosocial disability, while 24 percent have an intellectual disability, and the majority having an accentuated degree of disability. The predominance of psychosocial and intellectual disabilities is common in the case of all three types of specialized institution.

Most persons in specialized institutions are middle aged and elderly. About 46 percent of all persons in specialized institutions are aged 45–64, and as high as 55 percent for those with a disability certificate. While the same age group is predominant in psychiatric and forensic hospitals, the majority of people in MSAUs are aged 65–84 (43 percent), with the highest percentage of persons above 85 in all types of institutions (20 percent).

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[291] Ibid.

[292] Ibid.

More than half of persons in specialized institutions are single, unmarried, divorced, or widowed, which contributes to the length of time under hospitalization. The proportion of single persons is higher in the case of those with a disability certificate (60 percent) and almost double the proportion of those with no certificate, while the latter are more often divorced or widowed. The proportion of single/unmarried persons is much higher in the case of persons in psychiatric hospitals, rising to 90 percent for those in forensic hospitals (and 100 percent for those with a disability certificate). MSAUs are significantly different in that most are widowed (47 percent), which is not surprising given the predominant age groups in these institutions. In general, across all types of institutions, persons with a disability certificate are more likely to be single/unmarried than those without one. Qualitative research indicates that most people who reside long term in psychiatric institutions do not have a family or a place to go to, while those who have a support system come only for prescription or for short-term admission of between two to four weeks.

Many persons in specialized institutions have never been to school or generally have a low level of education. Around 20 percent of all persons across all types of specialized institutions have attended school, while the majority has been exposed to only vocational education. In general, the proportion is even lower for persons with disabilities with a certificate for all levels of education, pointing to limited access to education. Forensic hospitals stand out with the highest proportion of persons with higher education degrees (15 percent).

A majority of persons in specialized institutions no longer work or do not have the capacity to do so. Around 70 percent of all persons in specialized institutions are either pensioners based on their age, or have been assessed as invalids, both of which are unable to work. In general, most with a disability certificate are pensioners on the grounds of invalidity. In contrast to those in other types of specialized institutions, close to half of those in forensic hospitals have the capacity to work or already are in various types of employment, which reflects the reason for their admission as a result of committing a criminal offense, and not primarily to receive care services.

Reasons for Long-Term Admissions

Long-term institutionalization affects persons in all types of specialized institutions. One-third of persons in specialized institutions have been institutionalized for longer than five years, with more than 10 percent for more than 10 years. In general, more persons with a disability certificate tend to be institutionalized for this length of time across all types of specialized institutions.

Lack of family support, housing, and community-based services are the main reasons for long-term stays in specialized institutions. The factors causing institutionalization in specialized institutions are also determinants of mental health problems. As a recent report by the United Nations Human Rights Council indicates, overcoming these problems involves structural intervention beyond the healthcare sector.[293] While these are the most common factors that lead to at least six months of institutionalization, their distribution varies across the different types of institution. Lack of family caregivers and community-based services are more common in the case of long-term stays in MSAUs for close to 80 percent and 75 percent of persons, respectively, while in psychiatric hospitals, these characteristics affect around half the persons admitted. Lack of housing predominantly affects persons in psychiatric hospitals, where more than half of those with, and twice of those without, a disability certificate ended up in long-term hospitalization.

Lack of community-based services in the case of criminally charged forensic patients prolongs their hospitalization while, at the same time forces some into those residential centers meant for persons with disabilities. The qualitative research indicates that patients remain in forensic hospitals if their mental health does not improve and if no solutions for their discharge are identified, particularly in cases where family is not willing to take the person under charge, or there are no social protection services, or there is no space available in RCs. The lack of community-based services means that the person either remains hospitalized or, in the case of space availability, falls into the social protection system for persons with disabilities and becomes institutionalized. A high proportion of persons in forensic hospitals, in fact, are reported to have remained hospitalized in the long term, given they have no family, housing, caretaker, or community-based services (ranging between 15 and 25 percent).

Admissions to MSAUs from the community may indicate (1) the absence of community-based services for people with medical and social issues and (2) bureaucratic challenges for the most vulnerable to access MSAUs. Despite the profile of MSAUs as residential institutions for the transfer of people with social and medical problems from hospitals, 75 percent of long-term residents come from their own community. Data from qualitative research also indicate that although MSAUs have been established to relieve the burden of hospitals, many residents originate from the community. This, instead, burdens the social workers or the family of the patient (should the latter be the case) in terms of preparing the necessary documentation to access MSAUs. Access to community services certainly would allow persons to continue with their lives within their community; nevertheless, it also should be made easier for those who are most vulnerable to enter institutions on request.

Rationale for Readmission to Specialized Institutions

Readmission to MSAUs is most often due to a combination of circumstances, including social isolation, lack of family support, and limited access to disability-specific and mainstream services. Periodic readmission often occurs in the absence of preventive interventions, with qualitative data showing that six out of eight MSAUs

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[293] Human Rights Council (2019).

readmitted persons who had already made attempts to reintegrate into family life. Based on interviews with unit employees, readmission also is the result of seasonal recommitment (e.g., lack of adequate heating during winter periods), shortage of specialized community services (especially during crises), inability of the family to provide care, absence of home-based care services, and scarcity of community medical services. Other reasons include the feeling of not being understood by family and community, or the view that the center is the only place with friends, the latter of which points to social marginalization within the person's community, with no other opportunities to socialize outside of these MSAUs.

Pressure is placed on family networks as the providers of care, and to long-term MSAU admission due to the lack of specific community-based services for the elderly. Admission to MSAUs is often the only care option for those who otherwise have no access to care provided by family members. Close to 80 percent of long-term residents have families who no longer can care for them and around 15 percent have no family at all; around one-third do not have access to housing, and in around 80 percent of cases, the person has care and treatment needs that, according to staff, cannot be met within the community. Elderly people make up the group most often admitted to these units, most of whom either have family abroad or at a considerable distance to be able to provide the care needed. Some are estranged from their families or have no family at all, are single or widowed, or have no housing (usually as a result of property transfer to a relative or the loss of property without a period of homelessness). In addition, the high degree of monitoring and specialized care for illnesses associated with aging (e.g., depression, strokes, increased blood pressure, heart failure, diabetes, paralysis, orthopedic fractures and interventions, mobility problems, cancer, and affective disorders) places additional pressure on those families able to provide care but lack the necessary resources or skills to do so.

Regular short-term readmission to psychiatric hospitals is a result of a shortage of community-based services for people with disabilities and respite services for care givers. Reasons for short-term hospitalizations relate to the lack of community-based services, either for persons with a previous psychiatric history or for caregivers who develop mental health conditions, themselves, due to the stress of caring for a child, family member, or other person with mental illness, disability, or age-specific pathology. This situation also may require admission to a psychiatric hospital. According to psychiatric hospital staff, short-term admissions are sometimes related to the caregivers' need for some respite, involving either the admission of the persons receiving the care or of the care giver to a psychiatric hospital.

Short-term admissions to psychiatric hospitals are due to a shortage of social protection institutions and funding for social protection for the population, as a whole. Poverty alleviation measures are a key to tackling mental health problems in adult age populations and in the effort to increase their wellbeing.[294] People who lack adequate housing or have been rejected by social protection institutions, or their families sometimes seek entry into psychiatric hospitals, as do the victims of domestic violence. Similarly, people without subsistence means also are likely to seek admission to psychiatric hospitals, either due to exhaustion and/or depression or as an attempt to claim disability benefits, although this practice is being discouraged.

Caregivers and those with mental disabilities feel pressured to re-enter psychiatric hospitals due to the shortage of PAs as a result of limited funding. Despite the potential to employ PAs for those with disabilities, limited funding makes it difficult, thus placing pressure on family caregivers and members with mental health problems, themselves, to seek short-term admission to a psychiatric hospital as a form of respite.

Denial of Admission

Most MSAUs in the sample do not admit people with severe psychiatric diagnosis. Most MSAUs, at the exception of two in the sample, admit only patients with mild psychiatric illnesses, such as mild and average forms of dementia at the exception of aggressive behavior. Those MSAUs not specialized in psychiatric-related services avoid admitting people with psychiatric illness (schizophrenia or dementia). Nevertheless, there are two such units in our sample that take in social cases of patients that have a schizophrenia or Alzheimer diagnosis and that have previously been admitted to a psychiatric hospital. The reason why people with a diagnosis of schizophrenia or severe mental disability (referred to as “oligophrenia”) are no admitted to medical-social units is that these conditions require specialized staff or could potentially perturb the functioning of daily activities.

Patients with communicable diseases (e.g., hepatitis, HIV, syphilis) and lung disease, or patients in need of palliative care (e.g., Crohn's disease) often are denied admission. Denial of admission constitutes discrimination and is an infringement on the person’s right to health and medical services, since these patients are unlikely to receive the necessary care elsewhere in the system. Community-based services and out-patient medical treatment must be made available to patients in this condition, complemented by the necessary care and social services that will allow them to remain within the community without having to seek entry into a residential institution.

Some MSAUs refuse entry to “social cases”. “Social cases” are those people who have previously lived in RCs for persons with disabilities that have been shut down (i.e., “inherited cases”) or those with a diagnosed psychiatric illness who have no family or support network within the community to provide them the care they need. It also relates to those persons who have been referred to MSAUs by psychiatric hospitals or by way of other forms of transinstitutionalization (referred to as “exchanges of

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[294] World Health Organization & Calouste Gulbenkian Foundation (2014, 25).

patients").[295] These instances of trans-institutional biographies often referred to as "social cases" are either people who come from the residential system or psychiatric hospitals and have no family, personal network, access to housing, identity documentation, income, or are in need of specialized care for their schizophrenia or dementia.

Admission may be refused to those considered social cases due to bureaucratic requirements. Not all MSAUs accept patients who may be described as social cases, given that many of the patients may not have a complete file on them. Added to this is the shortage of MSAU staff to assist in putting together the necessary documents for admission. This suggests double social exclusion; that is, marginalizing those with no support network and denying them care in both residential settings and as in the community.

Persons referred to as social cases often are denied psychiatric treatment because of the fear they will remain in MSAUs for the long term. Denial of psychiatric treatment, on request and as needed, constitutes a violation of the right to health. Some doctors fear accepting people from night shelters or those who have recently been classified as a social case, given their belief that once admitted, these patients may become permanent due to the lack of other alternatives, such as social services. This quote from a staff member illustrates the situation: "Doctors are scared of „social cases" because they know they might get stuck with them. They know that Romanian society has no resources, and you feel pity to put the person out into the street. What do you do with him/her [then]?! The time comes to discharge him/her, and you cannot put him/her into the street and say go. Where should she go? In time, requests from night shelters diminished since doctors avoided taking in such cases." MSAUs also note that those social cases already in their care have no access to psychiatric help. These cases point to a very vulnerable category of people who have no networks outside of the hospital and who risk not receiving treatment or becoming de facto institutionalized in psychiatric hospitals. As such, it is essential to provide an integrated set of community-based services that includes adequate housing, community-based mental health care and rehabilitation.

Transinstitutionalization

Specialized staff facilitates the access to assessments for the disability certificate to ensure the transinstitutionalization of particular beneficiaries. The disability certificate is seen as an administrative possibility for trans-institutionalization by employees of specialized institutions, since it may give access to a place in RCs for persons with disabilities. In general, staff will assist in obtaining the disability

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[295] Generally, these people have been institutionalized or have experienced long-term hospitalization for reasons that are connected to downward economic mobility, as well as the belief of psychiatrists that they are too poor to survive beyond the confines of residential institutions or hospitals (Friedman, 2009).

certificate or coordinate a new assessment in the case of certificate renewal. This is not the case with psychiatric hospitals, where some patients have to wait a long period of time—often without success—to obtain the certificate that will allow them entry into an RC.

Attempts of specialized institutions to transfer persons to other institutions or residential services often prove unsuccessful. The most common reason – lack of available in other services – affects persons in specialized institutions differently depending on the type of institutions. While this is the predominant reason in case those in psychiatric hospitals, it is less so for those in forensic hospitals and MSAUs.

In the past, patient exchange took place between MSAU and psychiatric hospital, as well as between psychiatric hospitals and RCs for persons with disabilities. The practice of "patients exchange" primarily occurred between two institutions at the exclusion of patient involvement. Compared to previous practices, the process now involves consultation of residents and/or their family or legal guardian. In any event, no alternative options are open to the patient to ensure independent living within the community. Staff from six out of eight MSAUs was interviewed with regard to residents they had inherited, who had been accommodated not only in RCs for persons with disabilities (some of which have since been shut down), but also had been cared for in foster homes or private residential institutions. In other cases, persons from residential centers would be admitted to medical-social units after having experienced psychosis or as a result of requiring specialized care. "Patient exchanges" also take place between psychiatric hospitals and RCs. Psychiatric hospital staff indicates that some transfers of persons with disabilities cannot be prevented due to the (1) lack of specialized RC staff to address psychiatric illnesses, (2) low wages of specialized RC employees and (3) underdevelopment of community psychiatric services (including community-based mobile teams). Where psychiatric hospitals have attempted to transfer someone to an RC, there was neither the space nor the will on behalf of the center to take in a patient with a diagnosed psychiatric illness considered to be "problematic". Transfers to a private center for the elderly might be an option, however costs are prohibitive for most.

Despite psychiatric hospital staff noting an improvement in the consent practice for patient exchanges, it continues to infringe on the person's right to live within the community. Staff interviewed note that previously, the exchange between a psychiatric hospital and a RC was easier, whereby a hospital simply would offer a "quiet patient or one who was eligible to be discharged" in exchange for one "who was more violent or has a mental illness." The practice today is carried out with more caution; that is, with the consent of the patient, family, center, and community. Transfer, however, is not considered a steppingstone toward life within the community; rather, it is considered more as a way in which to create the space in psychiatric hospitals for those on the admission waiting list.

Patient exchanges also occur between residential institutions and private philanthropic institutions. The right of residents to decide where they wish to live should, by all means, be respected when developing public-private partnerships with the objective of community inclusion. As the quote below reflects, this type of exchange offers some patients the opportunity for community inclusion; however, the ultimate decision on where the person should remain usually is determined by the philanthropic agency, in collaboration with the public institution: "There were attempts to transfer to the community reintegration center of Mr. […] (it is a large community where there are also other people who are mentally ill). A few patients who could speak and they could manage on their own to some extent. It was an exchange, we received some patients that needed psychiatric treatment (Mr. […] also manages to find some) and whose condition was not really good and we transferred some who could no longer stand our services so to speak, but from our patients only one remained in the community, the others did not adjust (they broke windows, started fights in the community)."

Long-term or decade-long commitment to a psychiatric hospital demonstrates a lack of adequate community-based services. Among the long-term chronically ill patients in one psychiatric hospital, there are people who have lived there for several decades; these people are those who were "inherited" (based on the interviewees) from a mental hospital in the 1970s or became mentally ill in the 1980s, at a time when treatment was unavailable and when family members feared the mentally ill. The long-term commitment continues, as hospital administrators discharge their patients only to regularly readmit them after 48 hours.

Barriers to Returning to the Community

Specialized institutions often are unsuccessful in their attempts to transfer long-term residents back into the community. While few MSAUs have attempted to reintegrate their long-term residents into the community, those that have done so have usually been unsuccessful, given the lack of community-based services. There have been however attempts to facilitate the return to community living for about 50 percent of long-term residents of forensic hospitals and for close to 80 percent of those from psychiatric hospitals. The obstacles that limit the success of these attempts include the shortage of caretakers in the community or of family willing to care for the person, both of which are slightly more common in the case of patients from forensic hospitals compared to those from psychiatric hospitals, thus reflecting lack of care and support services within the community.

Long-term residents of MSAUs seldom return to the community; this occurs more as a result of changes in personal circumstances and networks than of targeted interventions. Re-entry into the community occurs in very few cases and is a result of several factors, such as (1) health improvement of the patient; (ii) family willingness to take care of the person (e.g., return of family from abroad, one family members retires and is able to take care of parent(s)); (iii) family unable to afford the expense of residential care; (iv) patient's maladjustment to an institutional environment and unwillingness to follow agreed rules; or (5) exorbitant boarding expenses for patients with income. In a small number of cases, reintegration is an effect of targeted and repetitive family visits (sometimes with the support of GDSACPs). In other cases, those patients who request MSAU entry due to inadequate living conditions at home (e.g., lack of heating) will seek discharge once the weather becomes warmer, their health improves, or they can better take care of themselves within the community. Leaving the system mostly because of changes in personal circumstances is nevertheless not a solution for persons who neither have a network for support beyond institutional care nor have income or housing.

Lack of available community services is a significant barrier to a return into the community for those residents in long-term care in specialized institutions. MSAU staff notes the lack of specialized community-based services that could benefit those residents who have experienced long-term care, including: (1) mental health services (e.g., psychotherapy, day centers, crisis intervention centers, psychiatric practices, mental health centers); (2) recovery and social integration centers; (3) care and assistance services; (4) family counseling services (including for family caregivers facing depression); (5) occupational therapy; and (6) medical services (e.g., internal medicine, lung medicine, radiology). Psychiatric hospital staff states that there is a dearth of specialized community-based services and that those few available are overcrowded. Staff specifically notes the unavailability of community-based services to accommodate the so-called social cases that cannot reintegrate into the community. What are necessary are, for instance, (1) residential services (for severely mentally ill, homes for the elderly); (2) home-care centers for the elderly who are alone (with or without dementia), the costs of which would be reimbursed by the state; (3) mental health centers that liaise with general medical practitioners; and (4) mobile teams (e.g., community nurses, general practitioners, multidisciplinary mobile teams), day centers, and crises centers.

To prevent readmission into psychiatric hospitals, there is a need for community-based mental health programs to enable gradual reintegration into the family and the community. Romania's public authorities should follow the guidelines developed in 2009 by the National Center for Mental Health on how to improve mental health care services and develop community-based services with the active involvement of mental health service users and their personnel.[296] Romania's psychiatric hospitals of today fail to have measures to prevent the readmission of patients, despite what little prevention takes place on the part of some institutions through specific programs, such as social and family reintegration, addiction counseling, ambulatory medical consultations. The

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[296] Most notably Katschnig et al. (2009).

lack of community-based services is invoked as a cause of readmission, namely, (1) day-care centers for young people diagnosed with schizophrenia to be able to socialize, converse with medical staff, and be offered assistance in their housekeeping and finances, and (2) respite centers for those who care for a family member with dementia, paralysis, or other serious conditions, who, in turn, have to seek hospitalization and rest for conditions such as depression. Other reasons include lack of resources for life in the community, lack of personal networks (i.e., family, friends, people with similar experiences); reassessments; changes in treatment; the need for assessment documentation to be able to access benefits; lack of medical treatment for psychotic episodes caused by refusal to take medication or because of alcohol consumption; and lack of local social workers with adequate skills when at a distance from a local psychiatric hospital.

Community-based mental health services should be developed to prevent readmission into forensic psychiatric hospitals. When a patient has been discharged from a forensic hospital, he/she no longer falls under Art. 110 of the Criminal Code (grounds for admission to a forensic hospital); rather, he/she will fall under Art. 109, which calls for the obligation to treatment. Should the patient refuse to see a doctor, Art 109 will revert to Art. 110, with the court having the right to decide whether or not the person should be readmitted into the forensic hospital. It is common for such patients to remain in these institutions for the long term, given the unavailability of appropriate community solutions. To prevent readmission, a psychiatric mobile team could be established within each community. There are rare examples of this, however, in light of the difficulties to ensure the continuity of service provision (Box 12).

Box 12: A Mobile Team as a Community-Based Mental Health Service: An Example

The concept of a mobile team for persons with psychiatric illnesses was developed in 2009 as part of the Community Alternatives for Psychiatric Assistance project (*Alternative comunitare de asistență psihiatrică*). It is meant for those living within the proximity of Câmpulung Moldovenesc and the surrounding rural areas. The project was partly funded by the European Union through its Poland and Hungary Assistance for the Restructuring of the Economy (PHARE) program and was implemented by the New Horizon Foundation (*Fundatia Noi Orizonturi*) in partnership with the Center for Mental Health at the Câmpulung Moldovenesc Psychiatric Hospital.

The service was established to ensure access to mental health services to persons who otherwise would not be able to access a service of high quality on a regular basis, given the hospital-centric provision of psychiatric and other mental health services in the region and, overall, in Romania. The project's main objective is to increase the quality, accessibility, and friendliness of mental health services within the psychiatric sector of Câmpulung Moldovenesc Psychiatric Hospital.

Designed in collaboration with psychiatric hospital users, project activities include the option of home-based medical-social services based on individualized intervention plans. The service is offered by a multidisciplinary team of psychiatrists, psychologists, social workers, and other professionals. The team is able to inform and communicate with other professionals (e.g., general practitioners and community workers) within the local community.

The project's pilot phase was implemented in 2009 and, albeit on a much more limited scale and with fewer users, the project has continued for several years at the Center for Mental Health. Downscaling of the project was a result of alternative funding challenges to ensure its sustainability once initial project funding had ended.

Although still limited, collaboration between specialized institutions and relevant non-state actors could support transition of their beneficiaries into the community. Significantly few staff from specialized institutions reported any collaboration with other institutions. One example, however, was an MSAU that collaborated with an NGO to ensure a former beneficiary had the necessary support to manage finances, daily meals, and other needs of support within the household in order to live alone. Another example is that of a psychiatric hospital that joined forces with various NGOs to ensure the social reintegration of patients by way of various programs (e.g., Alcoholics Anonymous; an eight-hour program; day centers; centers for the elderly; respite centers; legal and vocational counseling; self-care support; donations of food and clothing).

Services Offered in Specialized Institutions

Services in specialized institutions are offered as a result of needs-based assessment upon admission. MSAU multidisciplinary teams carry out a preliminary and complex assessment of new admissions, with the teams composed of social workers, medical doctors, nurses, and kinesiotherapy specialists. The assessment is repeated every six or 12 months, with results added to an individual intervention plan that outlines the activities of residents, their schedules, and type of staff involved. Patients in psychiatric hospitals are evaluated by medical doctors and a social worker. There are no data regarding this practice taking place in forensic hospitals.

There is no assurance by specialized institutions of continuity with previous services and recommendations. MSAU staff reported difficulties relating to disability assessment committee recommendations at the county level, since they related more to those in community living at the aid of PAs rather than to those in a residential institution. Moreover, psychiatric hospitals have no protocols to continue activities set out in the service plans of people who may have benefitted from other services.

The general profile of MSAUs indicates a focus on basic care and support for day-to-day activities, and less on active leisure activities, occupational therapy, or ways in which to prepare residents for independent living. An overwhelming majority of MSAU residents receive assisted care and support. Approximately 90 percent are assisted with daily hygiene, and a similar proportion receives assistance for getting dressed and taking medicine. One-third of persons have help with feeding and hydration or for changing body position and movement. Other services, to a lesser extent, include the following: (1) more than half, to maintain and develop independent living skills; (2) over one third, occupational therapy; and (3) approximately 20–30 percent, art therapy, involvement in social and civic activities, and decision-making assistance. Notably, no residents have the option of educational activities to prepare them for employment; staff also note the lack of labor market integration services (Annex-Figure 3).

MSAUs organize their space differently to reflect different care needs and monitoring arrangements. Qualitative research indicated that some MSAUs, with a capacity ranging from 30 to 178 beds, organize their space and activities according to the needs of patients. In three MSAUs, there is a difference between the wards. Open wards host patients who do not require constant supervision, while closed wards require the presence of a caretaker and a nurse, with residents able to leave the ward only under supervision so as to prevent any risk of harming themselves or others. One MSAU in the sample administers a mixed-gender rehabilitation ward for those chronic patients with a high level of autonomy. The ward is within a house in the community that offers living conditions similar to a home environment. Any change in a resident's behavior (e.g., window breaking, fighting, or refusing treatment) will result in she/he being sent to an alternative ward, with his/her space being filled by another resident whose health recently has shown improvement. Finally, one MSAU showed that its wards are organized by patient diagnosis (e.g., schizophrenia or Alzheimer's disease) and care needs.

Psychiatric hospitals focus on medical treatment and less on other rehabilitation services or services for maintaining and improving independent living skills. Administration of medication is the most common type of assistance received by residents in all types of specialized institutions, escalating to 91 percent in the case of psychiatric hospitals. Most patients receive assistance in their daily hygiene, feeding, and hydration, although to a lesser extent than in MSAUs, which indicates a higher level of autonomy. Other types of services, such as psycho-sensory-motor stimulation and art therapy, are exclusively provided in psychiatric hospitals to close to one-third of patients. Only around two-thirds of residents benefit from occupational therapy and 10 percent of vocational activities—the smallest proportion in all specialized institutions. Even though patients in psychiatric hospitals are generally perceived by staff as unable to live independently, services to maintain and improve independent living skills are offered to only around half of patients.

Specialized institutions offer activities for improving occupational skills, although labor market integration services are missing. While occupational therapy is offered to 75 percent of residents in forensic hospitals—the largest proportion in all specialized institutions—only 10 percent of residents benefit from employment training, exclusively in forensic hospitals. At the same times, access to jobs is virtually nonexistent for residents from all specialized institutions. Particularly in the case of psychiatric hospitals, staff noted that residents are confronted with the lack of money that they could well use to buy items not available in institutions (e.g., coffee, cigarettes). Access to adaptive employment (e.g., part-time, 2-4 hours/day) also is limited.

Psychological counseling and psychotherapy are not sufficiently provided to persons in specialized institutions. A shortage of psychotherapy and psychological counseling services was indicated by interviewed staff, as well as the necessary funding, staffing, and space. This, however, varies across different types of institutions mirroring the profile of residents. While psychological counseling is offered to around half of residents in each type of institution, psychotherapy as an alternative or a complement to psychotropic medication is offered to only 30 percent of residents in psychiatric hospitals and, to a lesser extent, in forensic hospitals.

Persons admitted to MSAUs and psychiatric hospitals rarely access other services in the community. Only one person in MSAUs received legal counseling and another received help in accessing medical intervention. No one was accessing any legal or medical service beyond the psychiatric hospital at the time of data collection, and staff members remarked that transferring patients to other specialty wards or hospitals is difficult due to funding. In addition, the lack of adequate and adapted transportation in these institutions' limits, considerably, access to other community services, including dental and medical appointments for nonemergency health issues. While staff does recommend certain specialized services outside the institutions for the treatment of certain conditions, residents can rarely access them.

Relations with the Community

MSAU resident relationships with the community exist; however, they are more of a charitable nature. Interaction between residents and the community is limited to attending religious services or visiting shops, as well as receiving visits from family members and people from the community who make donations. These are encouraged by the staff, as this quote shows: "We made a sort of advertisement that they are orphans, adult orphans and no one thinks about them, only about orphan children. You can find help for orphan children but for adult orphans it is harder, especially if they also have a mental illness... they are like children. They are happy if you bring them toys. Others have also learned this, and they bring them toys." It also is clear from the interviews that the pandemic has greatly reduced such interaction.

Long-term patients in psychiatric hospitals have little contact with the community. Interactions with the community are very limited, since community members appear reticent to interact with psychiatric cases. What interaction there is takes place at religious services and traditional practices (e.g., Christmas carols, Easter visits by school children), but other interactions are only possible for individuals (e.g., for instance, in the case of a psychiatric patient that plays the piano and attends choir shows). Holidays, especially religious holidays, also are among the rare occasions when people are allowed to spend time with their families for one or two weeks (except in the case of family reintegration).

Institutions do not facilitate socialization to compensate for limited community interaction. Only a small proportion of residents in specialized institutions is able to experience social and civic integration and participation—30 percent in MSAUs and 20 percent in psychiatric and forensic hospitals, respectively. In some cases, socialization outside the institution may be due to the isolation of the center (e.g., located in rural areas), while in others, it may be indicative of a secluded environment, where long-term patients are forced to socialize only among themselves and with the staff.

Involuntary Admissions

Involuntary admissions remain a practice in specialized institutions. About 10 percent of persons in psychiatric hospitals have been involuntarily committed and the proportion is even higher for those in MSAUs. While the occurrence of involuntary admission in psychiatric hospitals is not surprising, given that the Romanian mental health law provides for this,[297] it is less clear how this type of admission is carried out in MSAUs.

Conventional representatives are personal advocates who may prevent involuntary admission and ensure consent-based treatment; however, this option is either unknown or is considered unhelpful. A conventional representative is designated by a person with full mental and legal capacity, who is about to receive medical treatment, to represent them for the duration of the medical treatment.[298] A convention is signed that includes an explicit written declaration of the represented person, formally designating the conventional representative. The conventional representative may represent the person in all matters relating to admission into hospital, medical treatment, as well as the person's rights during admission. The conventional representative in Romanian legislation is equivalent to the personal representative outlined in key international human rights documents and is central to international human rights practice in the field of mental health.[299] Psychiatric hospitals should respect patient rights to a conventional representative that they, alone, appoint. None of the institutions appears to have gained any experience with conventional representatives. It is sometimes confused with the presumed right of the patient's family to sign instead of the person, despite not being appointed to do so and despite the fact that this practice infringes upon a person's legal capacity.

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[297] Art. 45 of Law No. 487/2002 on Mental Health and the Protection of People with Mental Disorders.

[298] Ibid.

[299] World Health Organization (1996).

Conclusions and Recommendations

A large number of persons with disabilities still live in RCs throughout Romania, contrary to the obligations outlined in the CRPD, as well as in European and national strategic documents. Institutionalization infringes on the right of independent living and community inclusion and deprives persons with disabilities of the potential to exercise many of their civil, political, social, and economic rights. In addition, RCs offer improper living conditions, and cannot meet the requirements for ensuring person-centered service delivery. While there are measures still needed to further ensure the quality of life of and provision of services to persons with disabilities who continue to reside in RCs, all material, human and financial resources must be converted for deinstitutionalization purposes and for establishing support services within the community, essential for independent living and community inclusion.

The RC system is geographically uneven, overcrowded, and still formed out of large and very large institutions. There remain substantial numbers of large and significantly larger institutions (in particular CIAs and CRRNs) with a high proportion of beneficiaries. Many institutions function at close to or full capacity, and many are concentrated in a handful of counties. As such, the system will be faced with considerable inertia in the process of deinstitutionalization. Furthermore, the challenges of deinstitutionalization will differ from county to county and from institution to institution, with some bearing more of the burden than others.

The profile of beneficiaries—in terms of age, type, and degree of disability—reflects historical legacies (national as well as system-wise) and current systemic state, community, and family failures to care for those leaving the child protection system, as well as the elderly population. Younger beneficiaries in RCs tend to have originated in disproportionate numbers from the child public care system and tend to have higher degrees of disabilities, reflecting lack of options and services in the community and a failure and isolation of the child public care system. Elderly residents arrive in RCs in disproportionate numbers from the community and care of their families, whereby the RC system has become more of an end-of-life/palliative care option, again indicating the lack of services and alternative options. The middle-age segment of the resident population is testament to the history of the institutionalized system, as many were institutionalized as children, and are a part of the last generations born during the communist pro-natalist era.

The transfers so far made, the intra-institutional beneficiary assessments and services that have taken place, and the differences in the profile of institutions and residents, suggest that there is a preference for deinstitutionalizing particular types of residents at the exclusion of others. Younger residents and, in particular, those with less severe forms of disabilities, are being given preference compared to those who are older or have more severe forms of disability. This is cause for concern and can result in a parallel system for each profile if not addressed.

The residential system tends to work as a life-long solution for its beneficiaries, with the majority leaving when they die. The institutional mortality rate is of considerable concern, since for the younger age groups, it is 33 times higher than average), and some of the causes of death suggest the possibility of neglect and poor care. Those residents who return to the community tend to have more support from their families and relatives, compared to those who remain within the institution.

Most RC employees have a medical profile, are employed full time, and leave employment at retirement age. The prevalence of medical assistants and nurses among RC specialized staff points to the predominance of care and assistance activities at the expense of those for habilitation and rehabilitation. Labor mobility is low, and most employees leave the system upon retirement. This may be a sign of resistance to change once more systematic plans to deinstitutionalize are implemented, being transferred to newly established services, and being trained in the delivery of person-centric services to provide the skills for independent and community life.

Budgets and expenditures vary across centers and counties. Some budgets and expenditures can be reflective of the specifics and type of center, while others appear somewhat random, correlating neither with the characteristics of the beneficiaries nor with the structure of staffing. The significantly high costs of some centers and counties clearly represent inefficiency in the delivery of what should be similar services of quality across the board. County councils should be held accountable when they set average costs per beneficiary that are significantly higher than the standard cost.

Staff wages and bonuses are the main factors that account for the average cost per beneficiary and, during the last years, there has been a steep increase in both. It is neither unclear whether or not increased staff costs have brought about a significant improvement in the quality of services provided to beneficiaries, nor does it appear that they have made the sector any more attractive for specialized personnel. Efforts should be made to ensure that salaries are in line with performance, and that the sector has a unitary wage policy that compensates and motivates employees without using legal artifices. There also is a great need to invest more in professional training of personnel.

RECOMMENDATIONS

- The process of deinstitutionalization needs to respond to the various challenges and pressures as a result of an uneven RC system that has concentrated on large and significantly larger institutions in certain counties and geographic areas.
- A tailored approach to deinstitutionalization is needed, depending on the profile of residents, their histories, and their locations within the system, whereby residents are provided equal opportunities to benefit from a life outside the institutional system.

- GDSACPs should provide training in line with the principles of independent living, for staff who will be subject to transfer to community-based services.

Dimensions of Care and Support in Residential Centers

An Adequate Standard of Living

For the past 20 years, there has been a massive investment in new institutions, new buildings, and renovations. This indicates (1) the need to improve the living conditions of residents, and (2) a continued commitment to institutionalization as a current solution for persons with disabilities. The renovations and consolidations have improved the living conditions but have not assured a sufficient degree of physical accessibility of spaces. Improving living conditions for individuals housed in residential institutions was understandably a desirable immediate goal, but at the same time it can become a hindrance to the process of deinstitutionalization in the medium and long term. It is an option for pursuing temporary failures in the system, rather than systemic change. Investing in building construction and repairs commits valuable funds to ends that might be of little use to deinstitutionalization, encourages attachment by the authorities and decision makers to existing infrastructure and centers, and provides a justification for resistance to closing them.

While material living conditions have improved in institutions, they remain inadequate and bare the flaws of a system of overcrowding, lack of privacy, depersonalization and de-individuation, and lack of control over one's everyday living conditions. A high number of residents still live in rooms that exceed the legal number of beds. Neither do they have access to ensuite bathrooms or individual pieces of furniture to store their items and help the personalization of their own space. The bulk provision of clothes and toiletry items further contributes to depersonalization and deindividualization. Furthermore, residents have little or no control over their daily program, one-third of whom eat all meals in their own room, and of whom the majority has limited opportunities to socialize.

RCs offer little support for sustaining family life and relationships and are inimical to parenthood. While RCs allow for phone calls and visitation rights, and they consider family relationships to be essential with regard to deinstitutionalization, the geographic isolation, segregation, and stigma associated with institutionalization make sustaining family relationships difficult. Furthermore, intimate relationships and partnerships are almost nonexistent and generally go undetected or are hidden from staff. The occurrence of a pregnancy and birth is considered an anomaly, and no measures are taken to protect and support the mother-child relationship, since a child automatically is placed in the public care system.

RECOMMENDATIONS

- GDSACPs and local public authorities should conduct thorough evaluations of RC buildings and lands in order to assess whether or not they can be used for community-based services, either through concession, as rentals, or by sale.
- GDSACPs should ensure that RC staff respects the autonomy of all persons with disabilities in all aspects of their daily life (e.g., schedules, meals, washing, clothing, shopping).
- While the right to privacy is severely restricted in RCs, some measures must be taken, where possible, to ensure some degree of privacy (e.g., rooms with less beds, private bathrooms, individual bathing, separating screens, access to individual spaces with furniture to keep private belongings)
- RCs should provide the necessary support for residents who became parents, in order to prevent the separation of child from parent(s), including alternative services for both parent(s) and child. RCs also should ensure the right of residents to decide on the options of abortion and sterilization without being coerced or forced and should provide appropriate support in decision-making and of support requested before and after the medical procedure.

Enjoyment of the Highest Attainable Standard of Physical and Mental Health

All services and activities in RCs for persons with disabilities that are meant to ensure the highest standard of physical and mental health are provided according to needs-based assessments and are coordinated and monitored by a case manager. Needs-based assessments of all residents should be carried out by multidisciplinary teams upon admission and on a regular basis thereafter; they must include the recommendations of county disability assessments, as well as those of the case manager in their respective instruments (IRSIP and ISP). These, however, may not always be available or comprehensive, thus jeopardizing continuation of services and activities. Moreover, not all residents have a case manager, some of whom may be confronted with high caseloads that limit them from providing adequate service delivery to many residents.

While access to primary care appears not to be an issue, residents continue to have limited access to specialized care and are exposed to health risk factors. This is evidenced by the high incidence of chronic disease, high rates of hospitalization, and high mortality rates for all age groups, including high rates of cancers. Factors affecting the health status of residents include living an almost captive life within the confines of a center, excessive medication (psychotropic and nonpsychotropic), various addictions, diagnostic and treatment overshadowing, insufficient screening and prevention methods, addressing health problems only when they become acute, scale economy of managing large numbers of residents, power relations within the institution, and so on.

Persons with disabilities in RCs generally are offered a wide range of services and activities tailored to their needs, as well as for future independent living within the community. RCs provide (1) information and counseling about one's rights and social benefits; (2) psychological counseling; (3) habilitation and rehabilitation activities; (4) care and assistance activities; (5) activities to support the development and maintenance of independent living skills; (6) maintenance and improvement of the level of education and employment training; (5) decision-making support; and (6) activities for social and community life. However, given their diversity, most residents are assessed as needing care and assistance services and developing basic self-care skills, rather than the skills to live independently in the community, such as vocational/occupational activities, activities relating to education/preparing for work, or social and civic participation. This may be connected to the predominance of care and assistance staff in RCs; however, more data are needed on the extent to which activities respond or do not respond to the actual needs of beneficiaries.

The majority of residents have been assessed as needing support to develop and maintain independent living skills. In fact, more than half of residents need continuous support to gain the necessary skills for daily-to-day living, communication, mobility, self-care, healthcare, home management, social and interpersonal relationships, and shopping, as well as broad social skills and an interest to take up an occupation. The rest have been assessed as needing a sequential or minimal amount of support. A low level of independent living skills or the lack thereof, however, must not be argument for continued institutionalization, as some people may never develop the necessary skills, nor will they at the level required to live totally independent; in fact, they may need to access personal assistance or other community support services.

There is a continued shortage of specialized staff in RCs, potentially impacting the type and quality of services offered. While vacancies affect positions in RCs at all levels—from management to specialized and administrative—the majority are for specialized, particularly in relation to certain professions. The distribution of vacancies that arise for specialized staff varies, however. Lower rates affect care and assistance staff, which is also the most numerous in RCs (e.g., medical assistants, nurses, medical doctors) and rehabilitation staff. While fewer in number of staff, however, there are more vacancies that arise for psychotherapists, speech therapists, nutritionists/dietitians, and vocational counselors. Certain types of centers are particularly affected, such as the Centers for Reintegration through Occupational Therapy and the Centers for Independent Living, where vacancies for the position of occupational therapist have not been filled. Attempts to hire specialized staff are rare, with only eight out of 10 positions being advertised. Still, as reported by staff, while the number of vacancies may affect the system, organizational charts often fail to reflect the number of specialized staff that is needed, as some professions are overrepresented (e.g., medical assistants, nurses, rehabilitation educators, psychologists, social assistants, social assistance technicians, childcare educators, instructors-educators for resocialization activities, ergotherapy instructors).

Staff training is necessary to ensure the delivery of quality services, but this is not sufficiently provided in RCs. Quality standards require mandatory annual training of staff in specific areas. However, even though most centers do have a yearly training plan, there are still large numbers of employees who do not take the training. In addition, the training necessary for person-centered services are virtually nonexistent, and persons with disabilities are rarely involved in the training sessions as trainers. Despite most staff having been assessed as requiring training, the needs appear to relate more to care and assistance activities, with very little to do with decision-making support, the CRPD, or respect for autonomy and independence of persons with disabilities.

Collaboration with other actors may enhance RC activities and services, provide a wider range of approaches to service delivery, and increase knowledge and experiences regarding independent living within a community. Currently, there is little collaboration between RCs and volunteers or organizations (e.g., NGOs, universities, research institutes, local public institutions, hospitals). Quality standards require such collaboration in order to provide residents with special programs, particularly relating to sexual and reproductive health, safe sex, and vocational training, among others. The fact that is little of this taking place may indicate that residents have limited access to these opportunities.

RECOMMENDATIONS

- NARPDCA should propose amendments to the quality standards of preventive measures that address residents' health needs; this includes increased routine testing, screening, and individualized access to specialist care.
- NARPDCA should develop, in partnership with the Minister of Health, training programs for medical staff and primary care physicians involved with residents, so as to detect and diagnose medical conditions before they become acute.
- Measures should be taken to enable residents to actively communicate with medical providers and take part in medical decisions, thus empowering them rather than allowing them to remain as passive recipients.
- GDSACPs should ensure that RC organizational charts better reflect the staff required, by type and number, in order to respond to the needs of residents.
- Local public authorities should allocate additional budgets for increased staff, particularly for specialized staff.
- GDSACPs should reach out to other organizations and volunteers from the community to provide activities and programs to residents that cannot be provided by RCs.

Legal Capacity and the Right to Personal Liberty and the Security of Person

Many persons with disabilities in RCs are placed under guardianship and thus deprived of legal capacity. The practice of guardianship is contrary to CRPD provisions, since it restricts the exercise of all civil, political, economic, social, and cultural rights. In response to the recent decision of the Romanian Constitutional Court regarding the unconstitutional character of guardianship, the Civil Code will undergo amendments in the near future to ensure that all persons currently under guardianship, including those in RCs, will be able to exercise their legal capacity. This will entail securing access to a variety of measures to support the exercise of legal capacity, including decision-making support.

Exercising legal capacity requires, in some cases, support in the decision-making process. Presently, RCs offer programs for decision-making that include those who are not under guardianship and who have different types and levels of disabilities. While decision-making skills may be profoundly affected by long-term institutionalization, regardless of type and level of disability, it is unclear whether or not this kind of support, in fact, is being offered—as required by the CRPD—in a way that is tailored to respond to individual needs. Quality standards do not clearly specify this requirement, nor is there guidance on how to achieve this. In addition, decision-making support requires adequate training, which is still not provided to staff in the residential system.

Most persons with disabilities in RCs are being administered psychotropics, particularly antipsychotics. This is a common practice in RCs in other countries for persons with disabilities and the elderly that has repeatedly drawn attention, since psychotropics are often administered frequently and off-label for the convenience of staff. In the Romanian residential system, the following issues require further attention: (1) limited access of persons with disabilities to alternative mental health services; (2) absence of clear regulatory standards to ensure an individual's consent for the administration of medical treatment; (3) significantly high percentage of residents who need support with the administration of medical treatment; and (4) administration of psychotropic medication by nonmedical staff, who may not be able to provide the medical information necessary to ensure consent.

RECOMMENDATIONS

- NARPDCA should enhance regulations to include clear standards to ensure consent for the administration of medical treatment, as well as for various levels of decision-making support.
- NARPDCA should develop training materials and coordinate training programs for the management and specialized and administrative staff of RCs in relation to the decision-making of persons with disabilities regarding the administration of their medical treatment.

Freedom from Torture or Cruel, Inhuman, or Degrading Treatment or Punishment and from Exploitation, Violence, and Abuse

Incidents of violence and abuse are likely to occur in RCs, and effective complaint mechanisms must be put into place. The occurrence of violence and abuse in institutions is sometimes overlooked and may become normalized, especially in large institutions. Women and youth with disabilities are particularly vulnerable to institutional violence, particularly sexual violence. Furthermore, fear of reprisal and absence of reporting mechanisms lead to underreporting and the perpetuation of tolerance for violence, abuse, and negligence. The small number of complaints does not necessarily reflect a low incidence of violence and abuse in residential institutions; rather, it reflects underreporting. There are no clear guidelines within quality standards for reporting violence and abuse, especially when members of staff may be the perpetrators. A more robust monitoring and complaints mechanism is needed by public service providers to enable prompt identification and immediate response to any type of violent behavior and negligence.

More preventive measures are needed to deter the occurrence of violence and abuse. Violence can occur due to lack of awareness on the part of staff and residents, lack of adequate knowledge on how to de-escalate violence in its early stages, staff unresponsiveness to the needs of residents, and high tolerance for perpetrators, among others. A number of measures should be implemented in RCs to prevent violence and negligence; these should include (1) training for staff and residents on how to identify and report abuse; (2) training for staff on how to de-escalate violent situations and prevent the use of additional force, seclusion, and physical and chemical restraints on residents, as well as involuntary admission and treatment in psychiatric facilities; and (3) prompt and proportionate measures against perpetrators.

In addition to an effective complaint and monitoring system, legal assistance and counseling is essential to enable access to appropriate treatment in cases of violence and abuse. While it is unclear how persons with disabilities can access legal assistance in case they suffer wrongdoing, RCs currently turn to GDSACPs if need be. The absence of legal resources (e.g., organizations and individuals) beyond the social protection system may prevent institutionalized persons from access to justice, especially in the event that they are harmed, either by violence or negligence from staff or other residents and may want to obtain justice in a cause that is contrary to the interest of the service providers.

RECOMMENDATIONS

- NARPDCA should implement and coordinate a national monitoring system and a complaint mechanism, with clear responsibilities for public service providers at the local level to identify situations of torture or cruel, inhuman, or degrading treatment or punishment, as well as exploitation, violence, and abuse—ones that will facilitate prompt access to justice for persons in RCs.

- NARPDCA should propose amendments to quality standards with regard to training programs for residents to enable them to identify and report cases of torture or cruel, inhuman, or degrading treatment or punishment, as well as exploitation, violence, and abuse.
- NARPDCA should develop training materials and coordinate training programs on the prevention, identification, and reporting of **all instances** of torture or cruel, inhuman, or degrading treatment or punishment, as well as exploitation, violence, and abuse for staff **and** residents, alike, in formats that are easily accessible.
- GDSACPs should ensure access to legal assistance and counseling, including to persons and organizations independent of the social protection system.

Living Independently and Being Included in the Community

The institutional system of RCs perpetuates resident segregation and isolation, and limits opportunities for independent living and participation within the community. Institutionalized people with disabilities continue to live separate from the community in RCs that are geographically isolated in rural or marginal areas, with little access to community and regional services, public transportation, and opportunities for community participation. They rarely leave the center (accompanied or unaccompanied) and have few opportunities to participate in programs outside the center or in those that promote educational or employment opportunities.

Access to education and employment for persons with disabilities in RCs is limited. While almost half the residents have never been to school, the programs available in RCs include only courses in reading and writing. There is little support for residents to apply for further education or to meet the challenges they face in what programs are offered. What assistance there is comes from center employees and, to a much lesser degree, from people outside the institution (e.g., volunteers, schools, religious or non-religious organizations). Support for improving or maintaining the level of education and training for employment is also low and mostly takes place in CPVIs and CITOs. While this may be a reflection of the large number of aged or invalid pensioners in RCs, almost one-third of residents have never had the opportunity to have their capacity for work assessed.

RECOMMENDATIONS

- Deinstitutionalization should not reproduce the issues resulting from RC segregation and isolation. Transitional or more permanent housing solutions for beneficiaries should be located in areas that are not isolated, are not clustered in the same building or area; instead, housing should enable access to community services, and provide realistic opportunities for persons with disabilities to be able to participate in community life.

- GDSACPs should enable access by persons with disabilities to mainstream education programs and employment, as well as opportunities for training in certain skills, with the collaboration with NGOs and other actors. GDSACPs also should ensure accommodations needed by residents to be able to carry out their educational and work tasks.

Transition from Institutions to Community Living

So far, the process of RC restructuring and reorganization has taken place at a slow pace, with mostly small and medium-size centers already having gone through the process. While most centers will have been restructured and reorganized by 2021, the small number of persons with disabilities who have been transferred either to sheltered housing or personal professional assistance, or who have returned to community to live with their families or on their own, reflects the fact that a majority of residents from large centers will continue to reside in restructured and reorganized RCs rather than within their communities.

Restructuring and reorganizing RCs has been a process fraught with multiple difficulties for most GDSACPs. The short time between receiving the restructuring and reorganizing methodology and the request for the submission of the plans has prevented GDSACPs from clearly understanding what was expected of them. This also caused issues in securing the necessary material, human, and financial resources at the implementation stage to ensure that residents were provided with transfer options tailored to their needs. In addition, the restructuring methodology fails to offer the necessary tools (other than for beneficiary assessment) to undertake a comprehensive analysis of what resources are available in the community in the face of deinstitutionalization (e.g., assessment for disability-specific community-based services, family needs, access to mainstream services (housing, health, employment, education)). Community resistance to welcoming persons with disabilities as residents also has constrained the development and implementation of plans and has led to transfer solutions that have reproduced instances of segregation and isolation.

Lack of adequately trained frontline staff for future community-based services remains a challenge to ensure person-centered service delivery. A large part of staff working in traditional RCs are now being transferred or will soon work in newly established services (i.e., sheltered housing, personal professional assistance, and community-based services, in general). Their training, in line with independent living principles, is essential to prevent traditional ways of providing care from being replicated. Services must be delivered in a personalized manner, in respect of the wishes and preferences of each person with disabilities. There are currently no training materials and no methodological requirements to be enable this type of training for staff.

Transfer options do not always respect the preferences of persons with disabilities. For instance, the conflict between the (1) preferences of a beneficiary and the perspective of the assessment team and/or her/his legal representatives on what the latter consider(s) to be the best options for transfer is the most common situation, whereby the opinion of the beneficiary, ultimately, is ignored. In particular, the choices of a beneficiary, who needs a higher level of support to understand and communicate, are often substituted by professionals or a legal guardian, either due to the absence of support during the decision-making process or due to a belief that a person with disabilities is unable to decide for herself/himself. In some situations, the absence of a community transfer option preferred by a beneficiary (e.g., housing, personal assistance) may pressure her/him into accepting alternative options.

There are currently very few plans at the local level to deinstitutionalize persons with disabilities who live in RCs with a capacity below 50 places. An effect of the process of restructuring, traditional RCs simply have been transformed into new RCs with a maximum of 50 places, adding to the number of small and medium-size residential centers that were expected to reorganize their service delivery to better respond to the needs of their residents. There is no legislation requiring this type of center to seek transfer solutions to enable all residents to live in the community. In fact, some of the larger-size centers have been split into two smaller RCs within the same building.

The process of restructuring traditional RCs has facilitated the transfer of persons with disabilities with lower support needs to alternative types of residential services or into the community. Youths with lower support needs, in particular, are most often selected for transfer to sheltered housing or to live within the community, while other persons with disabilities—predominantly youth with severe intellectual disabilities and elderly people—remain institutionalized, often indefinitely despite CRPD requirements to avoid this practice. This is more problematic since these are the largest groups of persons with disabilities living in residential institutions, leading in effect to their indefinite institutionalization. This general practice is not a consequence of a specific requirement in the restructuring methodology; rather, it reflects the fact that clear legal provisions are needed to ensure that all residents, regardless of age or type or level of disabilities, are deinstitutionalized.

Sheltered housing is the preferred transfer solution for persons with disabilities in RCs, and this practice may reinforce the absence of other community-based services. Most residents have, and continue to be, transferred to sheltered housing at the exclusion of other solutions. This practice gained predominance as an effect of financing lines of European Structural and Investment Funds. Additional funding comes from the Program of National Interest, coordinated by NARPDCA, which has had multiple calls in previous years to establish sheltered housing and day centers, as well as of the specific requirement of restructuring methodology to ensure access to family-type or residential alternatives with a capacity of less than 50 places. While sheltered housing are promoted as a transition service providing support for acquiring the skills necessary for independent living, there is concern they may turn into long-term residential services especially in rural areas where there is a shortage of housing and community-based services. Furthermore, there is the chance that sheltered housing may replicate the characteristics of traditional institutions in that they will not deliver person-centric services. Funding should be secured to ensure the development of a variety of community-based services as well as to ensure access to sufficient housing within the community.

Access to housing is essential for the deinstitutionalization process, but it is still limited as an option for persons with disabilities in RCs. This is a situation that affects persons with disabilities, in general, due to (1) a low social housing stock, mostly concentrated in urban areas; (2) inappropriate living conditions and absence of social housing; as well as (3) absence of any other form of financial support (e.g., subsidies, vouchers, personalized budget) for persons with disabilities who could supplement or cover housing rental costs. [300] Since many RCs are located in rural areas, limited access to housing will constitute a significant barrier to ensuring independent living and community inclusion, and this must promptly be addressed in a coordinated manner by all responsible central and local institutions.

RECOMMENDATIONS

- NARPDCA should provide public and private service providers guidelines for the process of deinstitutionalization, including (1) the principles of independent living and community inclusion for persons with disabilities; (2) clear steps and timeframes for deinstitutionalization; (3) instruments for assessing the support needs of persons with disabilities, as well as disability-specific community-based services and access to mainstream services (housing, employment, health, education); (4) instruments for monitoring persons with disabilities following transition to community living.
- NARPDCA should develop training materials for frontline staff, employed in alternative and community services, on how to deliver personalized services to those with disabilities to enable them to live independently and inclusively within the community.
- NARPDCA should develop training materials for staff to provide decision-making support to persons with disabilities during all stages of the deinstitutionalization process.
- NARPDCA should propose amendments to current methodologies for restructuring and reorganizing RCs to ensure that persons with disabilities are not discriminated against in terms of age or type or level of disability during the process of deinstitutionalization

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[300] Diagnosis of the situation of persons with disabilities in Romania (World Bank, 2020, 188-192).

- NARPDCA should propose amendments to current RC restructuring methodology to address the gaps that enable the establishment of two or more residential services below 50 places within one building or complex.
- GDSACPs and local public authorities should develop a wider range of community-based services or subcontract them.
- NARPDCA should carry out national and local awareness-raising campaigns in collaboration with GDSACPs and local public authorities regarding the right to independent living and community inclusion for persons with disabilities.

The Circumstances of Persons with Disabilities in Specialized Institutions

The profile of residents with and without disabilities in specialized institutions, in many respects, is similar to that of persons with disabilities in RCs. While most persons with disabilities in specialized institutions have intellectual and/or psychosocial disabilities, they are more likely to be older than those in RCs. The care provided in the specialized setting is, unfortunately, the same as that in RCs prior to deinstitutionalization; that is, with a greater focus on care and assistance, and less concentration on rehabilitation, socialization, or skills development and maintenance for independent living. Long-term institutionalization and frequent readmission are a result of an absence of family support and social networks in the community; lack of housing; no access to employment; and no access to community services to facilitate independent living. While resident profiles may vary by type of institution (i.e., psychiatric hospital, forensic hospital, MSAU), the fact that there are no mainstream community or disability-specific services continues to be a common issue for all.

There is no coordinated system at the local level to ensure access to benefits and social services for persons with disabilities from specialized institutions. In some situations, those from specialized institutions are able to obtain their disability certificate with the support of staff. Without access to community services, the evaluation committee for adults with disabilities may recommend admission to an RC under the administration of a GDSACP, although the shortage of places at these centers leads to prolonged stays in specialized institutions. A nationwide, integrated deinstitutionalization strategy must include measures that also take into account the situation of long-term residents of specialized institutions, to avoid the perpetuation and reproduction of institutionalization in both RCs and specialized institutions, including by way of trans-institutionalization.

RECOMMENDATIONS

- GDSACPs, together with local public authorities, should implement a coordinated system for collecting data on the status of persons with disabilities from specialized institutions, so as to facilitate their access to the disability assessment procedure, as well as to identify their needs in relation to specific and mainstream community services.
- GDSACPs and local public authorities should take into account the needs of persons with disabilities from specialized institutions, based on their specific

profiles (i.e., age, type and level of disability) when planning the development or subcontracting of community-based services.

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Legislation

1. Charter of Fundamental Rights of the European Union.
2. Civil Code.
3. Criminal Code.
4. Decision No. 155/2011 for the approval of criteria and norms of clinical diagnosis, functional diagnosis, and assessment of work capacity, used for establishing invalidity degrees I, II, and III.
5. Decision No. 878/2018 for the approval of the methodology to develop the restructuring plans of RCs for adults with disabilities.
6. Decision No. 601/2020 regarding the exception of unconstitutionality of the provisions of Art. 164 (1) Civil Code.
7. Decree No. 770/1966 regulating abortion.
8. European Social Charter.
9. Government Decision No. 412/2003 on the norm regarding the organization, functioning, and financing of MSAUs.
10. Government Decision No. 430/2008 for the approval of the methodology regarding the organization and functioning of the committee for the assessment of adults with disabilities.
11. Government Decision No. 978/2015 on the approval of minimum cost standards for social services and the level of monthly income per family member, based on which the monthly maintenance contribution due by the legal supporters of the elderly in RCs is established.
12. Government Decision No. 798/2016 on the approval of the national interest program in the field of protection and promotion of the rights of persons with disabilities, "Establishing social services such as day centers, respite centers/crisis centers and sheltered housing in order to deinstitutionalize people with disabilities who are in traditional institutions and to prevent the institutionalization of people with disabilities in the community.
13. Government Decision No. 548/2017 on the approval of conditions for obtaining the certificate, certification procedures, and status of the professional personal assistant.
14. Government Decision No. 193/2018 on the approval of the national interest program in the field of protection and the promotion of the rights of persons with disabilities, "Establishing social services to ensure the transition of young people with disabilities from the special protection system for children to the protection system for adults with disabilities."
15. Government Decision No. 1017/2018 for the approval of the Methodological Norms regarding the manner of granting the rights to free interurban transport to persons with disabilities.
16. Government Decision No. 426/2020 regarding the approval of cost standards for social services.

17. Government Emergency Ordinance No. 69/2018 for amending and supplementing Law No. 448/2006 regarding the protection and promotion of the rights of persons with disabilities.
18. Law No. 487/2002 on mental health and the protection of people with mental disorders.
19. Law No. 350/2005 regarding the system of nonreimbursable funding from public funds allocated for nonprofit activities of general interest.
20. Law No. 95/2006 on health reform.
21. Law No. 448/2006 regarding the protection and promotion of the rights of persons with disabilities.
22. Law No. 71/2011 for enforcement of Law No. 287/2009 regarding the Civil Code.
23. Law No. 292/2011 of social assistance.
24. Law No. 78/2014 regarding the regulation of volunteer activities in Romania.
25. Order No. 189/2013 for the approval of technical regulation, “Normative regarding the adaptations of civil buildings and urban space to the individual needs of persons with disabilities."
26. Order No. 488/2016 for the approval of the norms for the application of Law No. 487/2002 on mental health and the protection of people with mental disorders.
27. Order No. 82/2019 on the approval of mandatory minimum specific quality standards for social services for adults with disabilities.
28. Order No. 1218/2019 on the approval of mandatory minimum specific quality standards regarding the application of case management methods in the protection of adults with disabilities.
29. Council of Europe. 1952. Protocol to the Convention for the Protection of Human Rights and Fundamental Freedoms
30. United Nations Convention on the Rights of Persons with Disabilities.

ANNEXES

Annex

Annex-Table 1. Distribution of Residential Centers, by Type

	CAbR	CRRPH	CIA	CRRN	CITO	CPVI	Total
Percent	12.5	17.3	47.1	19.4	2.8	1	100
Number	36	50	136	56	8	3	289

Source: World Bank survey of residential centers (2020).

Annex-Table 2. Evolution in the Number of Residential Centers and Number of Beneficiaries in the System between 2015 and 2020

		2015	2016	2017	2018	2019	2020
Residential Services (total)		**260**	**268**	**284**	**290**	**301**	**297**
Residential services by type	CIA	113	115	118	121	124	136
	CAbR	0	0	0	0	0	38
	CITO	17	17	18	19	19	11
	CPRRPH	3	3	2	2	2	1
	CRRN	62	67	74	74	74	56
	CRRPH	62	64	70	71	79	52
	CPVI	3	2	2	3	3	3
Beneficiaries (total)		**16,906**	**17,098**	**17,099**	**16,876**	**16,496**	**16,127**
Beneficiaries by type of residential service	CIA	6,610	6,510	6,535	6,397	6,312	6,558
	CAbR	0	0	0	0	0	1,603
	CITO	1,042	1,112	1,091	1,145	1,139	835
	CPRRPH	219	217	93	88	92	45
	CRRN	5,947	6,004	6,367	6,379	6,121	5,132
	CRRPH	3,064	3,235	2,972	2,838	2,805	1,908
	CPVI	24	20	41	29	27	46

Source: National Authority for the Rights of Persons with Disabilities, Children and Adoptions (available at http://anpd.gov.ro/web/transparenta/statistici/trimestriale).

Annex-Table 3. Distribution of Centers, Total Capacity, Average Capacity/Center, and Number of Institutions with over 50 Residents

		Total Number of Places	Total Number of Centers	Average Number of Places/Center	Number of Centers with Capacity > 50
Total		**18,075**	**289**	**62.5**	**92**
County	Alba	364	4	91.0	1
	Arad	203	6	33.8	0
	Argeș	561	5	112.2	3
	Bacău	1,117	15	74.5	7
	Bihor	491	18	27.3	0
	Bistrița-Năsăud	240	4	60.0	2
	Botoșani	409	8	51.1	3
	Brașov	197	4	49.3	0
	Brăila	86	3	28.7	2
	Bucharest	493	12	41.1	2
	Buzău	258	3	86.0	1
	Caraș-Severin	142	3	47.3	0
	Călărași	310	2	155.0	2
	Cluj	390	6	65.0	2
	Constanța	528	8	66.0	5
	Covasna	38	2	19.0	0
	Dâmbovița	170	2	85.0	1

Dolj	233	6	38.8	0
Galați	804	3	268.0	1
Giurgiu	114	5	22.8	0
Gorj	362	7	51.7	3
Harghita	172	4	43.0	0
Hunedoara	343	9	38.1	0
Ialomița	215	3	71.7	1
Iași	566	10	56.6	1
Ilfov	238	4	59.5	1
Maramureș	393	15	26.2	2
Mehedinți	189	5	37.8	0
Mureș	1,041	13	80.1	5
Neamț	628	6	104.7	6
Olt	497	8	62.1	5
Prahova	1,147	12	95.6	7
Satu Mare	425	7	60.7	3
Sălaj	385	7	55.0	1
Sibiu	785	11	71.4	4
Suceava	866	8	108.3	4
Teleorman	116	3	38.7	0
Timiș	700	9	77.8	4
Tulcea	638	7	91.1	5
Vaslui	348	7	49.7	1
Vâlcea	493	7	70.4	5
Vrancea	380	8	47.5	2

Source: World Bank survey of RCs (2020).

Annex-Table 4. Occupancy Rate by Type of Center and by County (percent)

		CAbR	CRRPH	CIA	CRRN	CITO	CPVI	Total Number of Centers
Total		**92.6**	**91.7**	**83.7**	**90.8**	**89.4**	**109.3**	**288**
County	Alba			100.0	83.2			4
	Arad	99.1		92.9			95.0	6
	Argeș	96.9		87.8		94.4		5
	Bacău	68.8	65.2	67.1	61.9			15
	Bihor		99.5	98.0		97.0		18
	Bistrița-Năsăud			100.0	83.7			4
	Botoșani	100.0	94	92.2				8
	Brașov	100.0		90.5				4
	Brăila			106.1			125.0	2
	Bucharest	98.6		88.7	92.5			12
	Buzău		98.0			74.7		3
	Caraș-Severin			99				3
	Călărași			89.0	55.7			2
	Cluj	100.0		77.6				6
	Constanța	101.3		103.5	129.8			8
	Covasna			108.3			107.1	2
	Dâmbovița		95.8	98.0				2
	Dolj			90				6
	Galați			13				3
	Giurgiu	91.0		97.2				5
	Gorj	98.7	100.0	90.4	100.0			7
	Harghita			99.2	100.0			4

Hunedoara			90			9
Ialomița	100.0		87.7			3
Iași			110.7	100.0		10
Ilfov		97.6	85.5	118.3		4
Maramureș		89.4	112.2			15
Mehedinți			87.2		96.0	5
Mureș	100.0		87.5	96.4		13
Neamț			99.5	103.8		6
Olt	88.9	80.0	81.6			8
Prahova	78.2	102.2	81.4	89.8	83.6	12
Satu Mare		100.0	85.9	100.0		7
Sălaj			101.8	97.5		7
Sibiu	97.6	87.0	66.3	94.5		11
Suceava		80.8		90.0		8
Teleorman			103.1	125.0		3
Timiș			89.1	97.6		9
Tulcea			102.3	102.9		7
Vaslui		160.1	97.9	100.0		7
Vâlcea			93.4	98.3		7
Vrancea		100.0	81.5	106.1	105.1	8

Source: World Bank survey of residential centers (2020).

Annex-Table 5. Distribution by Type of Disability and Age Group (absolute numbers and percentages)

	Type of Disability According to Certificate (number)											
	Physical	Somatic	Hearing	Visual	Intellectual	Psychosocial	Associated	HIV/AIDS	Rare diseases	Deafblindness	No disabilitv	**Total**

18–19 years	0	0	0	0	45	9	34	0	0	0	0	**88**
20–24 years	19	3	1	2	513	87	200	0	0	0	0	**825**
25–29 years	11	3	1	1	799	111	231	3	0	0	0	**1,160**
30–34 years	16	4	1	7	1,562	156	197	44	0	0	0	**1,987**
35–39 years	13	8	2	4	1,009	170	185	3	1	1	0	**1,396**
40–44 years	27	1	1	9	763	263	170	3	0	0	2	**1,239**
45–49 years	36	5	6	7	629	241	109	0	0	0	0	**1,033**
50–54 years	77	10	6	11	503	305	125	0	0	0	1	**1,038**
55–59 years	95	6	7	6	286	201	74	0	1	0	1	**677**
60–64 years	137	12	3	12	341	224	100	0	0	0	3	**832**
65–69 years	182	16	3	20	310	178	118	0	0	0	3	**830**
70–74 years	132	14	8	32	264	131	80	0	1	0	3	**665**
75–79 years	87	13	5	22	182	68	51	0	0	0	3	**431**
80–84 years	74	11	5	29	205	73	52	0	0	0	2	**451**
85 years and over	62	14	5	38	195	56	53	0	0	0	0	**423**
Total	**968**	**120**	**54**	**200**	**,606**	**,273**	**,779**	**53**	**3**	**1**	**18**	**3,075**

Source: World Bank survey of residential centers (2020).

	Type of Disability According to Certificate (percentage)											
	Physical	Somatic	Hearing	Visual	Intellectual	Psychosocial	Associated	HIV/AIDS	Rare diseases	Deafblindness	No disability	**Total**
18–19 years	0.0	0.0	0.0	0.0	51.1	10.2	38.6	0.0	0.0	0.0	0.0	**100.0**
20–24 years	2.3	0.4	0.1	0.2	62.2	10.5	24.2	0.0	0.0	0.0	0.0	**100.0**
25–29 years	0.9	0.3	0.1	0.1	68.9	9.6	19.9	0.3	0.0	0.0	0.0	**100.0**
30–34 years	0.8	0.2	0.1	0.4	78.6	7.9	9.9	2.2	0.0	0.0	0.0	**100.0**
35–39 years	0.9	0.6	0.1	0.3	72.3	12.2	13.3	0.2	0.1	0.1	0.0	**100.0**
40–44 years	2.2	0.1	0.1	0.7	61.6	21.2	13.7	0.2	0.0	0.0	0.2	**100.0**
45–49 years	3.5	0.5	0.6	0.7	60.9	23.3	10.6	0.0	0.0	0.0	0.0	**100.0**
50–54 years	7.4	1.0	0.6	1.1	48.5	29.4	12.0	0.0	0.0	0.0	0.1	**100.0**
55–59 years	14.0	0.9	1.0	0.9	42.2	29.7	10.9	0.0	0.1	0.0	0.1	**100.0**
60–64 years	16.5	1.4	0.4	1.4	41.0	26.9	12.0	0.0	0.0	0.0	0.4	**100.0**
65–69 years	21.9	1.9	0.4	2.4	37.3	21.4	14.2	0.0	0.0	0.0	0.4	**100.0**
70–74 years	19.8	2.1	1.2	4.8	39.7	19.7	12.0	0.0	0.2	0.0	0.5	**100.0**

75–79 years	20.2	3.0	1.2	5.1	42.2	15.8	11.8	0.0	0.0	0.0	0.7	**100.0**
80–84 years	16.4	2.4	1.1	6.4	45.5	16.2	11.5	0.0	0.0	0.0	0.4	**100.0**
85 years and over	14.7	3.3	1.2	9.0	46.1	13.2	12.5	0.0	0.0	0.0	0.0	**100.0**
Total	7.4	0.9	0.4	1.5	58.2	17.4	13.6	0.4	0.0	0.0	0.1	**100.0**

Source: World Bank survey of residential centers (2020).

Annex-Table 6. Number of Staff by Type of Employment Contract in Residential Centers

		Number of Persons Employed in Residential Centers			
		Total	Staff on Full-Time Employment Contracts	Staff on Part-Time Employment Contract	Persons Who Are Collaborators or on a Different Type of Contract
Total		**3,439**	**13,061**	**212**	**166**
Type of center	CAbR	1,190	1,147	33	10
	CRRPH	1,575	1,480	60	35
	CIA	6,198	6,080	71	47
	CRRN	4,018	3,933	29	56
	CITO	419	382	19	18
	CPVI	39	39	0	0
Size of center	<=20	789	742	34	13
	21-50	5,355	5,144	128	83
	51-100	3,254	3,196	20	38
	100+	4,041	3,979	30	32

Source: World Bank survey of residential centers (2020).

Annex-Table 7. Current Staff Distribution by Gender, Age, and Education

		Total (number)	Total (percent)
Gender	Male	2,479	21.2
	Female	9,239	78.8
	Total	11,718	100
Age	<35	892	7.6
	35–44	2,995	25.6
	45–54	5,643	48.2

	55–64	2,142	18.3
	65+	45	0.4
	No information	1	0.0
	Total	**11,718**	**100**
Education level	1 - Maximum 8 grades	743	6.3
	2 - Trade/apprentice/complementary school	1,910	16.3
	3 - Highschool grades 9–11 (unfinished high school)	1,219	10.4
	4 - Finished high school, no baccalaureate diploma	688	5.9
	5 - Finished high school, baccalaureate diploma	3,321	28.3
	6 - Postsecondary school	2,079	17.7
	7 - University undergraduate	1,267	10.8
	8 - University postgraduate (master's, doctorate)	491	4.2
	Total	**11,718**	**100**

Source: World Bank survey of residential centers: Human Resources (2020).

Annex-Table 8. Time Length of Vacancies in Residential Centers for Specialized Staff

	Vacancies		**Length of vacancies**					
	No.		**<=6 months**	**(6 months–1 year]**	**(1–2 years]**	**Over 2 years**	**No.**	**Total**
Total staff vacancies	**,485**	**100**	**12.5**	**16.2**	**19.9**	**50.7**	**0.8**	**100.0**
Total specialized staff vacancies	,343	67.2	11.5	16.2	17.6	54.2	0.5	100.0
Physician (any type)	141	4.0	5.0	14.9	25.5	54.6	0.0	100.0
Medical assistant	290	8.3	12.4	12.1	13.1	62.4	0.0	100.0
"Soră medicală"	2	0.1	0.0	50.0	0.0	50.0	0.0	100.0
Nurse	,027	29.5	11.0	14.7	19.8	54.5	0.0	100.0
Physical and kinesio-therapist	12	0.3	0.0	16.7	41.7	41.7	0.0	100.0
Kinesiotherapist	83	2.4	13.3	16.9	16.9	53.0	0.0	100.0
Massage therapist	44	1.3	2.3	15.9	27.3	54.5	0.0	100.0
Rehabilitation pedagogue	85	2.4	17.6	27.1	4.7	49.4	1.2	100.0
Social pedagogue	1	0.0	0.0	100.0	0.0	0.0	0.0	100.0
Psychologist	106	3.0	8.5	14.2	22.6	51.9	2.8	100.0
Psychotherapist	1	0.0	0.0	100.0	0.0	0.0	0.0	100.0
Psychopedagogue	19	0.5	15.8	36.8	0.0	42.1	5.3	100.0

Speech therapist/speech therapy instructor	15	0.4	26.7	13.3	0.0	60.0	0.0	100.0
Social assistant	116	3.3	17.2	11.2	19.0	51.7	0.9	100.0
Social assistance technician	5	0.1	20.0	20.0	60.0	0.0	0.0	100.0
Social worker	56	1.6	10.7	75.0	8.9	0.0	5.4	100.0
Nutritionist	15	0.4	20.0	13.3	13.3	53.3	0.0	100.0
Educator	40	1.1	5.0	2.5	15.0	77.5	0.0	100.0
Instructor/educator for re-socialization activities	62	1.8	14.5	6.5	6.5	72.6	0.0	100.0
Educational animator	6	0.2	33.3	0.0	0.0	66.7	0.0	100.0
Ergotherapy instructor	151	4.3	13.2	14.6	11.3	59.6	1.3	100.0
Occupational therapist	27	0.8	3.7	18.5	40.7	37.0	0.0	100.0
Vocational counselor	1	0.0	0.0	0.0	0.0	100.0	0.0	100.0
Art therapist	3	0.1	33.3	33.3	33.3	0.0	0.0	100.0
Addiction counselor	12	0.3	25.0	8.3	16.7	50.0	0.0	100.0
Other specialists	23	0.7	13.0	34.8	17.4	34.8	0.0	100.0

Source: World Bank survey of residential centers: Human Resources (2020).

Annex-Table 9. Number of Organized Job Competitions for Advertised Positions (Specialized Staff)

	Number of Job Competitions Organized for Vacancies					
	0	**1**	**2**	**3+**	**Number**	**Total**
Total staff vacancies	**83.0**	**8.9**	**4.7**	**2.1**	**1.3**	**100.0**
Total specialized staff vacancies	**79.7**	**10.4**	**6.0**	**2.8**	**1.1**	**100.0**
Physician (any type)	73.0	10.6	5.0	9.2	2.1	100.0
Medical assistant	85.5	10.3	3.4	0.3	0.3	100.0
“Soră medicală”	100.0	0.0	0.0	0.0	0.0	100.0
Nurse	73.7	12.6	9.9	3.3	0.5	100.0
Physical and kinesio-therapist	91.7	8.3	0.0	0.0	0.0	100.0
Kinesiotherapist	94.0	3.6	1.2	0.0	1.2	100.0
Massage therapist	86.4	11.4	2.3	0.0	0.0	100.0

Rehabilitation pedagogue	98.8	0.0	0.0	0.0	1.2	100.0
Social pedagogue	100.0	0.0	0.0	0.0	0.0	100.0
Psychologist	81.1	5.7	2.8	6.6	3.8	100.0
Psychotherapist	100.0	0.0	0.0	0.0	0.0	100.0
Psychopedagogue	89.5	5.3	5.3	0.0	0.0	100.0
Speech therapist/speech therapy instructor	93.3	0.0	0.0	0.0	6.7	100.0
Social assistant	78.4	11.2	3.4	5.2	1.7	100.0
Social assistance technician	100.0	0.0	0.0	0.0	0.0	100.0
Social worker	100.0	0.0	0.0	0.0	0.0	100.0
Nutritionist	93.3	0.0	0.0	0.0	6.7	100.0
Educator	82.5	7.5	10.0	0.0	0.0	100.0
Instructor/educator for re-socialization activities	66.1	27.4	0.0	0.0	6.5	100.0
Educational animator	66.7	16.7	0.0	0.0	16.7	100.0
Ergotherapy instructor	78.8	11.9	4.6	3.3	1.3	100.0
Occupational therapist	100.0	0.0	0.0	0.0	0.0	100.0
Vocational counselor	100.0	0.0	0.0	0.0	0.0	100.0
Art therapist	100.0	0.0	0.0	0.0	0.0	100.0
Addiction counselor	100.0	0.0	0.0	0.0	0.0	100.0
Other specialists	95.7	4.3	0.0	0.0	0.0	100.0

Source: World Bank survey of residential centers: Human Resources (2020).

Annex-Table 10. Average Monthly Costs for Providing Care to a Person with Disabilities Hosted by a Public Residential Service, as Set by Decisions of the County Councils in 2018 and 2019, per Type of Center—Average Amounts (RON)

		CAbR		CRRPH		CIA		CRRN		CITO		CPVI		Total		2019-2018 increase
		2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	
Total		5,476	6,502	4,384	5,415	4,374	5,336	4,937	5,724	3,302	4,198	3,092	4,499	**4,581**	**5,526**	**20.6%**
County	Alba	-	-	-	-	4,595	4,595	4,322	4,322	-	-	-	-	4,527	4,527	0.0%
	Arad	4,986	5,437	-	-	3,789	3,660	-	-	-	-	3,241	5,523	4,296	4,859	13.1%
	Argeș	6,083	7,299	-	-	5,786	6,808	-	-	3,531	4,210	-	-	5,454	6,485	18.9%
	Bacău	4,904	5,217	4,821	6,434	6,257	6,621	8,440	8,052	-	-	-	-	6,753	7,062	4.6%
	Bihor	-	-	4,396	5,712	3,846	5,372	-	-	3,984	5,185	-	-	4,290	5,605	30.6%
	Bistrița-Năsăud	-	-	-	-	5,958	5,991	3,988	5,135	-	-	-	-	4,481	5,349	19.4%
	Botoșani	3,471	4,858	2,694	4,456	3,282	4,742	-	-	-	-	-	-	3,232	4,721	46.1%
	Brașov	-	-	-	-	4,156	4,156	-	-	-	-	-	-	4,156	4,156	0.0%
	Brăila	-	-	-	-	3,288	4,120	-	-	-	-	-	4163	3,288	4,134	25.7%
	Bucharest	9,900	9,900	-	-	5,681	6,482	4,339	6,084	-	-	-	-	6,752	7,522	11.4%
	Buzău	-	-	3,957	4,666	-	-	-	-	3,123	3,600	-	-	3,679	4,310	17.2%
	Caraș-Severin	-	-	-	-	3,372	3,778	-	-	-	-	-	-	3,372	3,778	12.0%
	Călărași	-	-	-	-	3,564	3,801	3,237	3,861	-	-	-	-	3,401	3,831	12.7%
	Cluj	4,248	5,078	-	-	3,440	4,203	-	-	-	-	-	-	3,709	4,494	21.2%
	Constanța	5,735	5,361	-	-	4,495	4,708	5,734	5,857	-	-	-	-	5,115	5,158	0.9%
	Covasna	-	-	-	-	3,272	4,048	-	-	-	-	2,943	3,811	3,108	3,930	26.5%
	Dâmbovița	-	-	2,993	5,075	2,818	2,818	-	-	-	-	-	-	2,906	3,947	35.8%
	Dolj	-	-	-	-	6,113	7,740	-	-	-	-	-	-	6,113	7,740	26.6%
	Galați	-	-	-	-	4,971	6,065	-	-	-	-	-	-	4,971	6,065	22.0%
	Giurgiu	6,346	11,841	-	-	6,471	12,552	-	-	-	-	-	-	6,421	12,267	91.1%
	Gorj	4,138	5,570	5,200	5,979	4,827	5,784	5,219	6,037	-	-	-	-	4,641	5,756	24.0%
	Harghita	-	-	-	-	4,425	5,457	4,170	4,876	-	-	-	-	4,362	5,312	21.8%
	Hunedoara	-	-	-	-	2,819	2,819	-	-	-	-	-	-	2,819	2,819	0.0%
	Ialomița	4,094	4,661	-	-	3,434	5,670	-	-	-	-	-	-	3,874	4,998	29.0%

	CAbR		**CRRPH**		**CIA**		**CRRN**		**CITO**		**CPVI**		**Total**		**2019-2018 increase**
	2018	**2019**	**2018**	**2019**	**2018**	**2019**	**2018**	**2019**	**2018**	**2019**	**2018**	**2019**	**2018**	**2019**	
Iași	-	-	-	-	5,517	6,499	4,364	4,567	-	-	-	-	5,402	6306	16.7%
Ilfov	-	-	-	-	-	-	-	-	-	-	-	-	-	-	NA
Maramureș	-	-	4,201	4,881	3,391	4,377	-	-	-	-	-	-	4,143	4,847	17.0%
Mehedinți	-	-	-	-	5,150	7,334	-	-	2,642	3,993	-	-	4,649	6,666	43.4%
Mureș	6,819	7,749	-	-	3,905	4,674	4,671	5,402	-	-	-	-	5,068	5,881	16.0%
Neamț	-	-	-	-	5,132	5,308	5,421	5,421	-	-	-	-	5,277	5,376	1.9%
Olt	4,418	5,758	5,264	6,451	4,501	5,959	-	-	-	-	-	-	4,576	5,970	30.5%
Prahova	3,944	6,080	4,794	6,255	4,173	5,285	4,121	5166	3,053	3,910	-	-	3,991	5,163	29.4%
Satu Mare	-	-	6,807	7,685	3,752	4,514	3,496	4,263	-	-	-	-	4,588	5,384	17.3%
Sălaj	-	-	-	-	4,012	4,693	3,721	4,320	-	-	-	-	3,929	4,587	16.7%
Sibiu	3,555	4,261	3,800	5,070	3,836	4,996	3,967	5,084	-	-	-	-	3,729	4,685	25.6%
Suceava	-	-	5,086	6,282	-	-	4,108	4,743	-	-	-	-	4,475	5,320	18.9%
Teleorman	-	-	-	-	4,491	5902	4,749	14,412	-	-	-	-	4,577	8,738	90.9%
Timiș	-	-	-	-	3,900	5,329	5,001	5,816	-	-	-	-	4,634	5,654	22.0%
Tulcea	-	-	-	-	4,262	4,390	3,978	4,098	-	-	-	-	4,140	4,264	3.0%
Vaslui	-	-	3,243	3,861	3,083	3,847	4,747	5,804	-	-	-	-	3,389	4,133	21.9%
Vâlcea	-	-	-	-	3,705	5,400	5,071	6,679	-	-	-	-	3,933	5,613	42.7%
Vrancea	-	-	4,210	5,088	4194	4,947	4,898	5,731	3,046	3,595	-	-	4,317	5,090	17.9%

Source: World Bank survey of residential centers: Financial resources (2020).

Annex-Table 11. Evolution of the Running Costs of Residential Centers 2019-2018 (percent)

		Running Costs	Staff Costs	Goods and Service Costs
Total		**20.30**	**24.75**	**6.26**
Type of RC	CAbR	29.39	35.91	7.99
	CRRPH	19.48	23.05	7.62
	CIA	23.67	28.71	8.33
	CRRN	14.01	17.61	2.14
	CITO	19.84	24.75	7.42
	CPVI	39.51	40.83	35.84
Size of the center	<= 20	22.03	27.88	0.25
	21-50	24.06	29.43	8.30
	51-100	18.68	21.83	8.37
	> 100	16.95	21.26	2.98
County	Alba	18.53	21.01	11.58
	Arad	20.31	23.78	12.04
	Argeș	14.07	14.43	12.49
	Bacău	13.46	14.71	7.43
	Bihor	23.78	29.22	6.84
	Bistrița-Năsăud	5.79	9.55	-2.58
	Botoșani	37.90	43.90	14.00
	Brăila	25.96	32.09	10.89
	Brașov	58.96	78.10	8.32
	Bucharest	22.70	31.11	-0.15
	Buzău	18.23	20.51	10.37
	Călărași	8.54	16.39	-7.68
	Caraș-Severin	38.20	47.99	14.22
	Cluj	28.95	38.26	-4.57
	Constanța	14.25	14.50	13.36
	Covasna	28.02	33.95	14.00
	Dâmbovița	16.53	21.25	3.28
	Dolj	27.85	33.91	0.40
	Galați	21.73	26.78	3.92
	Giurgiu	56.49	85.83	-51.40
	Gorj	14.11	17.38	0.22
	Harghita	11.72	17.27	-4.93
	Hunedoara	19.32	23.69	7.12
	Ialomița	17.97	18.35	16.57
	Iași	12.81	12.53	16.13

	Running Costs	Staff Costs	Goods and Service Costs
Maramureș	19.38	21.74	12.34
Mehedinți	56.51	84.23	9.69
Mureș	17.58	20.10	9.51
Neamț	4.52	5.85	0.06
Olt	29.00	35.94	5.33
Prahova	29.82	38.61	5.83
Sălaj	21.21	31.34	2.55
Satu Mare	20.78	21.83	17.31
Sibiu	27.45	39.48	-1.29
Suceava	9.73	12.15	0.54
Teleorman	27.57	32.17	13.57
Timiș	17.02	21.31	4.80
Tulcea	16.94	19.11	9.25
Vâlcea	27.69	30.46	16.42
Vaslui	33.02	37.09	22.06
Vrancea	18.87	20.93	14.22

Source: World Bank survey of residential centers – Financial resources (2020).

Annex-Table 12. Percentage of Residents Benefiting from Specific Activities/Services, by Degree of Disability

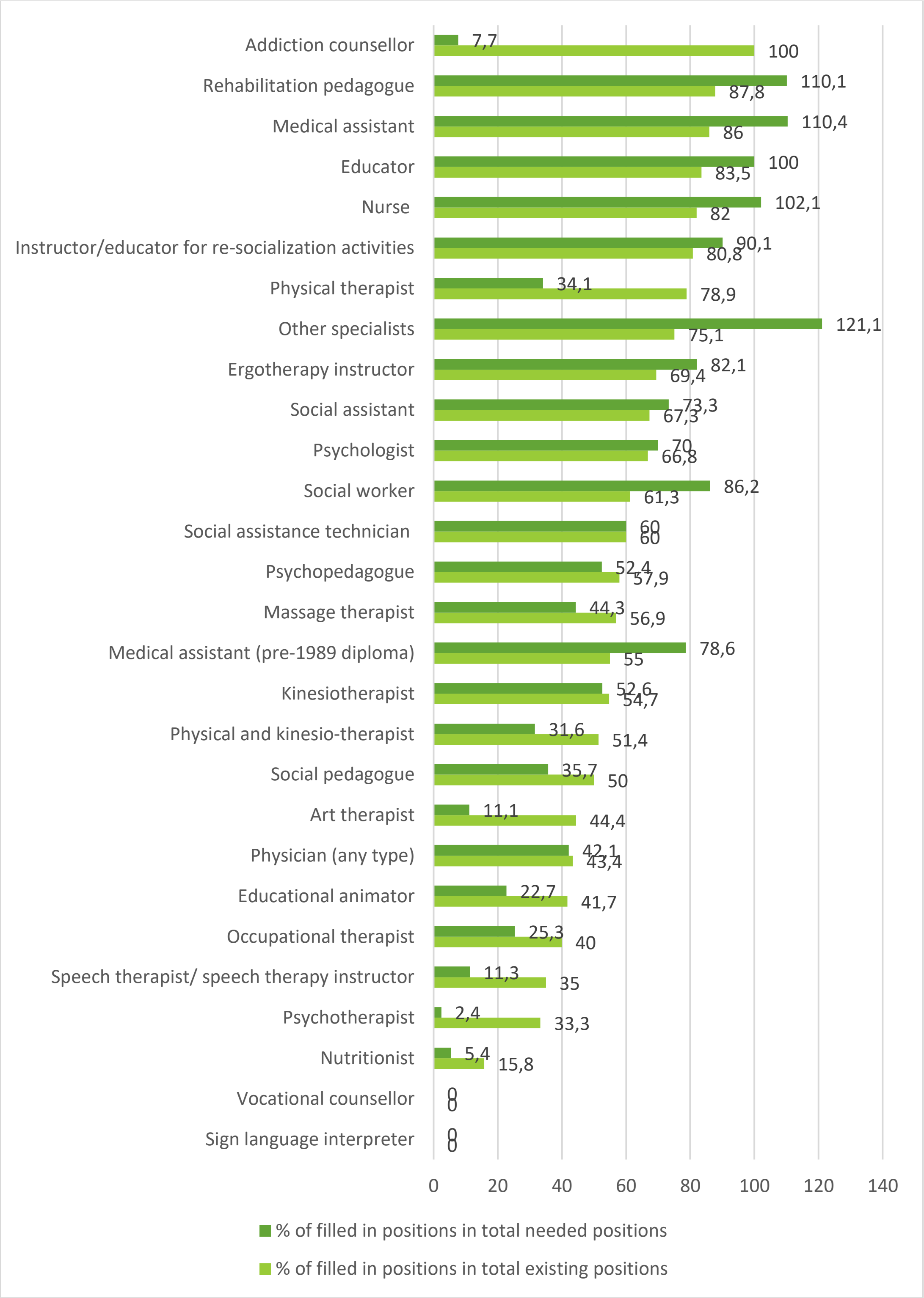
Activities/services	Low	Mild	High	Severe	Severe with Personal Assistant	No Degree Assigned
Information and social assistance	98.1	96	93.5	83.2	77.2	100
Psychological counseling	88.7	92	84.5	68.2	58.3	88.9
Speech therapy	3.8	3.8	4	9.4	7.5	
Psychological counseling: Psychotherapy	15.1	16.3	20.5	16.1	13.8	
Habilitation/rehabilitation: Massage, kinesiotherapy, physical therapy	45.3	43.2	47.7	52.6	49.2	44.4
Habilitation/rehabilitation: Hydrotherapy, thermotherapy, balneotherapy	11.3	2.9	2.1	3	2.4	
Habilitation/rehabilitation: Art therapy, music therapy	42.5	66.3	71.2	72.6	73.9	27.8

Habilitation/rehabilitation: Psycho-sensory-motion stimulation	21.7	31.3	35.8	50.2	64.5	16.7
Habilitation/rehabilitation: Occupational therapy	66	74.9	75.6	56.8	52.3	72.2
Habilitation/rehabilitation: Vocational/occupational activities	29.2	42.1	31.1	17.6	15.9	27.8
Care and assistance: Support for getting dressed/undressed, putting on/taking off shoes, choosing appropriate clothing	33	35.3	48	80.2	88.1	22.2
Care and assistance: support for daily hygiene	60.4	55.5	69.2	90.4	94.5	38.9
Care and assistance: support for administering medication	96.2	93.7	96.8	98.7	99.1	83.3
Care and assistance: support for specific problems: catheters, prevention of decubitus sores (treating eschars), and others	11.3	6.2	7.1	14.7	20.1	5.6
Care and assistance: support for changing body position, moving the body from a horizontal position into a different position, moving the body into another side position	10.4	7	8	19.4	26.1	5.6
Care and assistance: support for transfer and mobilization, moving indoors and outdoors, including shopping	20.8	17	18.6	38.3	49	22.2
Care and assistance: support for feeding and hydration	26.4	18.7	25.8	49.4	62.8	16.7
Maintenance and development of independent living skills: cognitive skills	67.9	79.9	81.5	78.6	81.2	44.4
Maintenance and development of independent living skills: daily living skills	71.7	83.7	83.4	83.4	82.2	44.4

Maintenance and development of independent living skills: communication skills	65.1	72.4	72	75.4	77.3	38.9
Maintenance and development of independent living skills: mobility skills	47.2	43.8	49.1	61.5	71.1	38.9
Maintenance and development of independent living skills: self-care skills	71.7	78.8	83.2	86	84.9	55.6
Maintenance and development of independent living skills: self-health skills	88.7	93.4	92.2	87	85.8	61.1
Maintenance and development of independent living skills self-management	67.9	81.6	79.5	66.3	69	44.4
Maintenance and development of independent living skills: interaction skills	66	81.9	80.9	77.9	77.5	44.4
Education, preparation for work	11.3	30.1	18.4	6.3	6	5.6
Assistance and support for decision making	67.9	71.9	63.4	50.5	44.7	50
Integration and social and civic participation	61.3	65.5	61.7	46.4	42.7	33.3
Total	**100**	**100**	**100**	**100**	**100**	**100**

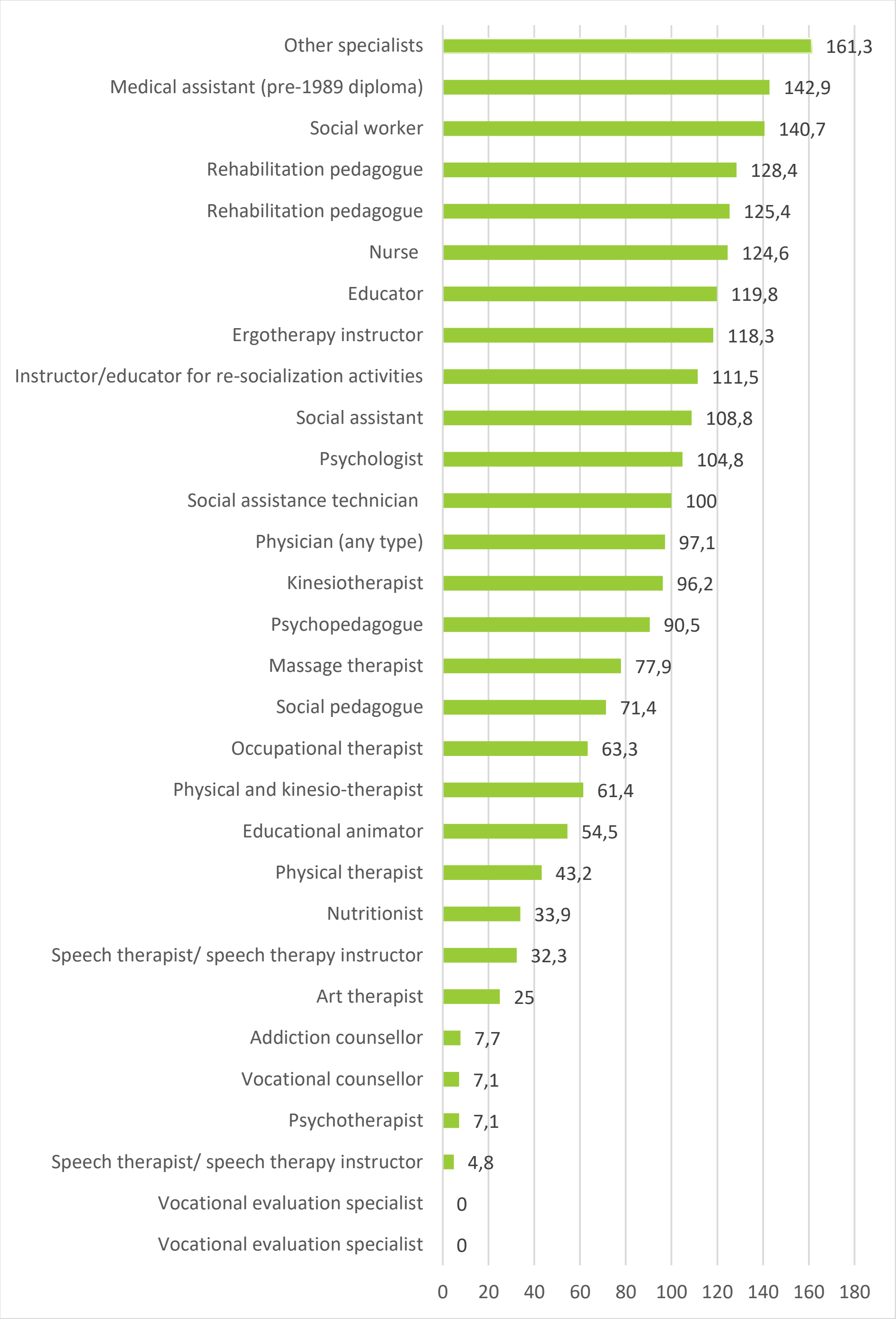
Source: World Bank survey of RCs (2020).

Annex-Figure 1. Percentage of Filled Positions from Necessary Positions and Positions on Organizational Charts



Source: World Bank survey of residential centers: Human resources (2020).

Annex-Figure 2. Percentage of Positions in Organizational Charts from Necessary Positions



Source: World Bank survey of residential centers: Human resources (2020).

Annex-Table 13. Percentage of Centers that Planned and Organized Planning Sessions and Percentage of Staff Trained

	Percentage of Centers with Sessions		Percentage of Trained Staff in Total Staff (Full and Part Time)	Average Number of Session in Centers that Organized Training Sessions
	Included in the 2019 Plan	Organized in 2019		
Equal opportunity	43.0	42.0	31.6	1.6
Prevention, recognition, and reporting of forms of exploitation, violence, and abuse	65.4	65.4	57.5	2.0
Respect for diversity	28.0	28.0	21.1	1.8
Respect and encouragement for individual autonomy and independence of persons with disabilities	42.7	44.1	32.4	1.7
Respect for the dignity and privacy of the beneficiary	55.9	54.9	47.1	1.9
Use of assistive technologies and devices and access technologies for the maintenance/development of cognitive skills	17.1	17.1	11.8	2.1
Recognition of situations/forms of torture, cruel, inhuman, or degrading treatment	58.4	59.4	51.9	1.8
United Nations Convention on the Rights of Persons with Disabilities	46.2	45.8	38.7	1.5
Respect for beneficiaries' rights	68.9	68.2	60.8	2.1
Training for the Ethics Code provisions	67.1	69.2	65.9	1.8
Assistance and support in decision-making	32.2	31.1	26.5	1.7
De-escalading techniques in crisis situations	25.9	24.1	21.4	2.0
First aid	56.6	52.4	34.0	2.1
Assistance and care for people with reduced mobility (including the maintenance/development of mobility skills)	37.4	35.0	23.5	1.9

Communication with persons with disabilities and activities for maintenance/development of communication skills	47.9	47.9	35.8	2.4
Others	45.8	44.8	44.5	1.8
No information on topic	3.5	12.2		

Source: World Bank survey of residential centers: Human resources (2020).

Annex-Table 14. Distribution of Residents under Guardianship, by Type and Level of Disability

		Person Is Placed under Guardianship (N)		Total	Person Is Placed under Guardianship (percent)		Tota l (%)
		No	Yes		No	Yes	
Sex	Male	5,001	1,497	6,498	77	23	100%
	Female	5,027	1,551	6,578	76	24	100
Age	18–19 years	85	3	88	97	3	100
	20–24 years	603	222	825	73	27	100
	25–29 years	793	367	1,160	68	32	100
	30–34 years	1,281	706	1,987	64	36	100
	35–39 years	974	422	1,396	70	30	100
	40–44 years	949	290	1,239	77	23	100
	45–49 years	821	212	1,033	79	21	100
	50–54 years	822	216	1,038	79	21	100
	55–59 years	552	125	677	82	18	100
	60–64 years	687	145	832	83	17	100
	65–69 years	695	135	830	84	16	100
	70–74 years	594	71	665	89	11	100
	75–79 years	388	43	431	90	10	100
	80–84 years	403	48	451	89	11	100
	85 years and over	380	43	423	90	10	100
Degree of Disability	Mild	104	2	106	98	2	100
	Medium	958	78	1,036	92	8	100
	Accentuated	4,848	1,009	5,857	83	17	100
	Severe	1,547	721	2,268	68	32	100
	Sever with personal assistant	2,553	1,238	3,791	67	33	100
	Does not have a disability certificate	18	0	18	100	0	100
Type of disability	Physical	936	32	968	97	3	100
	Somatic	113	8	121	93	7	100
	Auditory	49	5	54	91	9	100
	Visual	183	17	200	92	9	100
	Intellectual	5,579	2,027	7,606	73	27	100
	Psychosocial	1,770	503	2,273	78	22	100
	Associated	1,344	435	1,779	76	24	100
	HIV/SIDA	32	21	53	60	40	100

	Rare illnesses	3	0	3	100	0	100
	Deaf blindness	1	0	1	100	0	100

Source: World Bank survey of residential centers: Beneficiary files (2020).

Annex-Table 15. Distribution of Residents on Psychotropic Medication, by Type and Level of Disability

At this time, is the beneficiary taking psychotropic medication?		**Number**			**Percentage**	
		No	**Yes**	**Total**	**No**	**Yes**
Total beneficiaries		**2,949**	**10,126**	**13,076**	**22.60**	**77.40**
Degree of disability	Low	55	51	106	51.90	48.10
	Mild	392	643	1036	37.80	62.10
	High	1,338	4,519	5,857	22.80	77.20
	Severe	389	1,879	2,268	17.20	82.80
	Severe with personal assistant	767	3,024	3,791	20.20	79.80
	No degree of disability assigned	8	10	18	44.40	55.60
Type of disability	Physical	538	430	968	55.60	44.40
	Somatic	69	52	121	57.00	43.00
	Auditory	24	30	54	44.40	55.60
	Visual	104	96	200	52.00	48.00
	Intellectual	1,433	6,172	7,606	18.80	81.10
	Psychosocial	311	1,962	2,273	13.70	86.30
	Associated	445	1,334	1,779	25.00	75.00
	HIV/AIDS	15	38	53	28.30	71.70
	Rare diseases	1	2	3	33.30	66.70

	Deaf blindness	1	0	1	100.00	0.00

Source: World Bank survey of residential centers: Beneficiary files (2020).

Annex-Table 16. Offices for Specific Activities (percentage of centers)

Type of Office	Yes, in a Space Used Exclusively for This	Yes, In a Space with Multiple Uses	No, It Does Not Exist	Total	Total Number
Medical examination room	83.0	8.3	8.7	100	288
Information and social counseling office	49.3	43.4	7.3	100	288
Psychological counseling office	53.1	38.5	8.3	100	288
Speech therapy office	3.5	7.3	89.2	100	287
Psychotherapy office	7.0	14.6	78.4	100	287
Massage room	20.6	23.7	55.7	100	287
Kinesiotherapy room	34.7	22.6	42.7	100	288
Physical therapy room	10.5	8.0	81.5	100	287
Hydrotherapy/thermotherapy/balneotherapy room	4.5	2.1	93.4	100	287
Multisensory room (for psycho-sensory-motor stimulation)	6.6	8.4	85.0	100	287
Occupational therapy office	38.5	38.2	23.3	100	288
Art therapy or other special therapies office	18.5	36.2	45.3	100	287
Information and vocational counseling office	3.8	26.1	70.0	100	287
Vocational training room	3.5	11.1	85.4	100	287
Gym	15.7	23.3	61.0	100	287

Source: World Bank survey of residential centers (2020).

Annex-Table 17. Number of Vehicles Owned by Residential Centers, by County

	Number of Vehicles	Total Number of Centers that Own Vehicles	Total Number of Centers
Alba	7	**4**	**4**
Arad	7	**4**	**6**
Argeș	7	**5**	**5**
Bacău	26	**15**	**15**
Bihor	12	**10**	**18**
Bistrița-Năsăud	5	**4**	**4**
Botoșani	1	**1**	**1**
Brașov			
Brăila	2	**1**	**0**
Bucharest	1	**3**	**0**
Buzău	0	**5**	**1**
Caraș-Severin	0	**4**	**0**
Călărași	0	**2**	**1**
Cluj	0	**1**	**0**
Constanța	0	**1**	**0**
Covasna	1	**3**	**2**
Dâmbovița	0	**1**	**0**
Dolj	0	**1**	**0**
Galați	0	**1**	**0**
Giurgiu	1	**0**	**0**
Gorj	0	**5**	**1**
Harghita	0	**2**	**2**
Hunedoara			
Ialomița	0	**4**	**1**

Iași	0	1	0
Ilfov			
Maramureș	0	6	0
Mehedinți	0	0	0
Mureș	0	3	0
Neamț	0	2	2
Olt	2	6	2
Prahova	1	0	0
Satu Mare	0	1	0
Sălaj	0	1	0
Sibiu	2	2	0
Suceava	0	0	0
Teleorman	0	1	1
Timiș	0	2	0
Tulcea	0	3	1
Vaslui	2	3	0
Vâlcea	0	1	1
Vrancea	1	0	2

Source: World Bank survey of residential centers (2020).

Annex-Table 18. Distribution of Persons with Disabilities to Be Transferred from Restructured Residential Centers, by County

	Persons Already Transferred to Other Services/Community	Persons to Be Transferred until 2021		Persons to Be Transferred after 2021		Beneficiaries of RCs Undergoing Restructuring	RCs undergoing Restructuring
	Number	No.	Percent from Current Beneficiaries	No.	Percent from Current Beneficiaries	Number	Number

Total		**325**	**3,636**	**42.9**	**921**	**10.9**	**8485**	**85**
Type of RC	CRRPH	18	464	52.6	9	1.0	882	13
	CIA	36	647	24.7	449	17.1	2622	36
	CRRN	249	2,188	50.6	355	8.2	4320	31
	CITO	22	337	51.0	108	16.3	661	5
County	Alba	77	60	32.8	73	39.9	183	1
	Argeș	4	280	66.4	0	0.0	422	3
	Bacău	43	197	36.3	73	13.5	542	7
	Bihor	1	5	16.1	0	0.0	31	3
	Bistrița-Năsăud	0	30	38.5	0	0.0	78	1
	Botoșani	5	40	19.5	6	2.9	205	3
	Brăila	21	22	18.0	0	0.0	122	2
	Bucharest	0	44	30.6	0	0.0	144	2
	Buzău	5	63	53.4	0	0.0	118	1
	Călărași	25	70	34.0	73	35.4	206	2
	Cluj	0	58	38.2	21	13.8	152	2
	Constanța	5	75	15.6	129	26.8	481	5
	Gorj	0	85	37.0	0	0.0	230	3
	Hunedoara	0	12	36.4	0	0.0	33	1
	Ialomița	0	50	41.3	71	58.7	121	1
	Iași	3	245	84.5	4	1.4	290	2
	Ilfov	17	73	51.4	0	0.0	142	1
	Maramureș	0	40	20.5	66	33.8	195	2
	Mureș	24	328	42.7	0	0.0	768	5
	Neamț	2	421	65.4	103	16.0	644	6
	Olt	0	105	33.1	8	2.5	317	5
	Prahova	38	239	41.9	7	1.2	570	5
	Satu Mare	0	19	11.7	44	27.0	163	2

Sălaj	4	10	9.3	0	0.0	108	1
Sibiu	7	202	50.2	5	1.2	402	4
Suceava	28	279	44.1	1	0.2	633	4
Timiș	9	113	45.4	38	15.3	249	2
Tulcea	0	122	72.2	0	0.0	169	1
Vaslui	2	189	99.0	0	0.0	191	1
Vâlcea	3	118	29.0	74	18.2	407	5
Vrancea	2	42	24.9	125	74.0	169	2

Source: World Bank survey of residential centers (2020).

Notes: RC=residential center; CRRPH=recovery and rehabilitation center for adults with disabilities; CIA=care and assistance center for adults with disabilities; CRRN=neuropsychiatric recovery and rehabilitation center; CITO=integration center for occupational therapy.

Annex-Table 19. Number of Public Social Services between 2015 and June 30, 2020

	2015	2016	2017	2018	2019	2020
Residential Services (excluding CIA, CRRN, CITO)	**110**	**120**	**122**	**143**	**146**	**153**
Sheltered housing	100	113	116	133	137	144
Training centers for independent living	3	2	1	3	3	3
Respite centers	3	3	3	4	4	4
Crisis centers	4	2	2	3	2	2
Nonresidential services	**56**	**60**	**61**	**63**	**64**	**58**
Daycare centers	19	20	23	24	25	26
Centers with occupational profile	2	2	1	2	2	2
Centers with services for outpatient neuromotor recovery	28	29	28	29	29	25
Mobile teams	1	1	1	1	1	1
Home-care services	2	2	2	2	2	2

Centers for psychosocial counseling for persons with disabilities	4	6	6	5	5	2
Centers for recovery and social inclusion – neuromotor recovery	0	0	0	0	0	0
TOTAL (excluding CIA, CITO, CRR)	**166**	**180**	**183**	**206**	**210**	**211**

Source: National Authority for the Rights of Persons with Disabilities, Children and Adoptions.

Notes: CIA=care and assistance center for adults with disabilities; CRRN=neuropsychiatric recovery and rehabilitation center; CITO=integration center for occupational therapy.

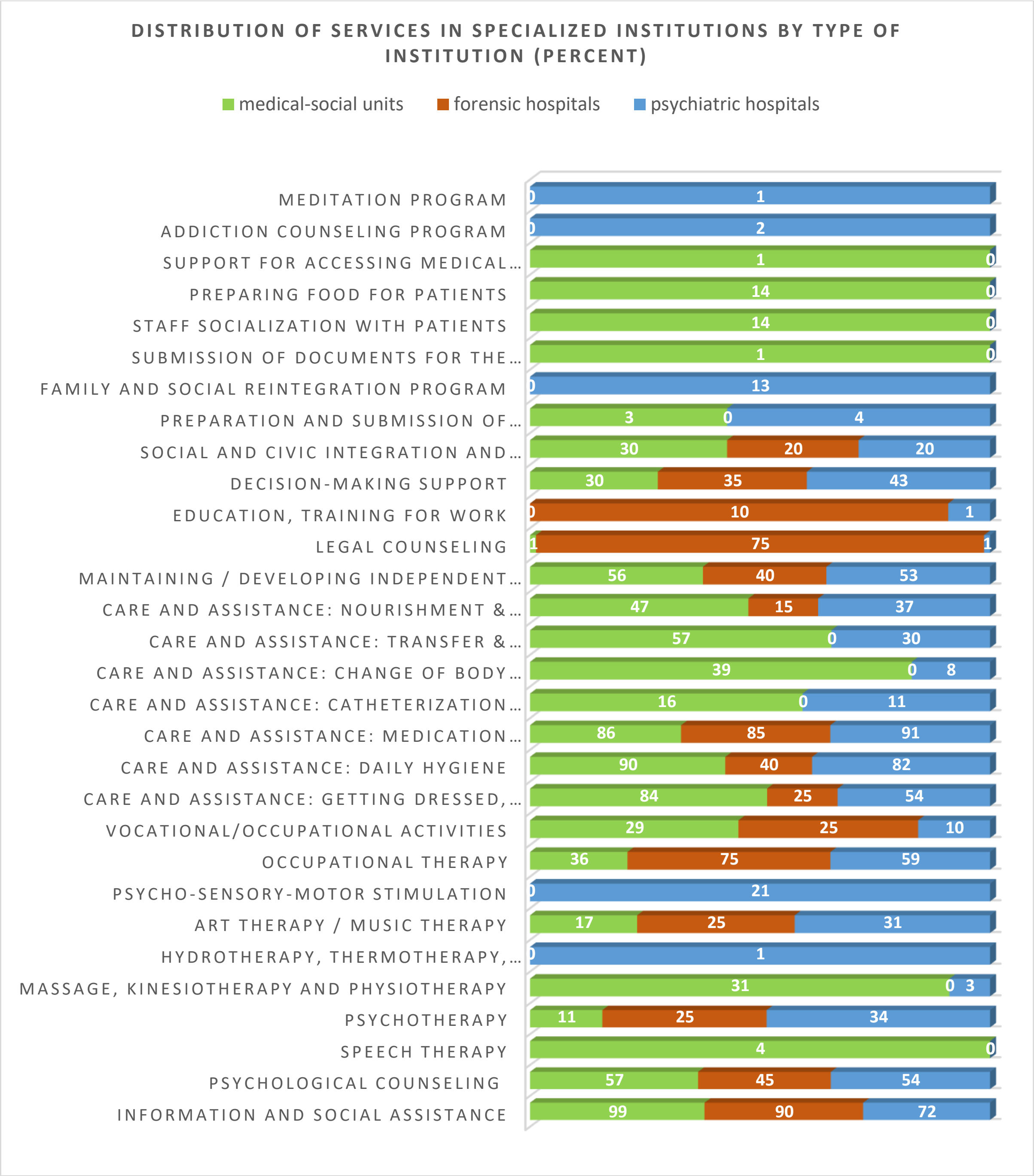
Annex-Table 19. Number of Beneficiaries of Public Social Services between 2015 and June 30, 2020

	2015	2016	2017	2018	2019	2020
Residential services (excluding CIA, CITO, CRR)	**893**	**938**	**977**	**980**	**1,044**	**1,107**
Sheltered housing	851	882	909	919	983	1,038
Training centers for independent living	25	21	10	35	29	40
Respite centers	7	16	3	4	8	7
Crisis centers	10	19	55	22	24	22
Non-residential services	**1,889**	**2,183**	**2,192**	**2,184**	**1,971**	**1,634**
Daycare centers	710	752	667	568	525	569
Centers with occupational profile	49	51	29	64	66	61
Centers with services for outpatient neuromotor recovery	1,008	1,269	1,314	1,329	1,258	878
Mobile teams	0	0	0	22	23	20
Home-care services	42	43	52	67	85	88
Centers for psychosocial counseling for persons with disabilities	80	68	130	134	13	18
Centers for recovery and social inclusion: neuromotor recovery	0	0	0	0	0	0
TOTAL (excluding CIA, CITO, CRR)	**2,782**	**3,121**	**3,169**	**3,164**	**3,015**	**2,741**

Source: National Authority for the Rights of Persons with Disabilities, Children and Adoptions.

Notes: CIA=care and assistance center for adults with disabilities; CRRN=neuropsychiatric recovery and rehabilitation center; CITO=integration center for occupational therapy

Annex-Figure 3. Distribution of Services in Specialized Institutions, by type of institution (percent)


DISTRIBUTION OF SERVICES IN SPECIALIZED INSTITUTIONS BY TYPE OF INSTITUTION (PERCENT)
🟩 medical-social units
🟥 forensic hospitals
🟦 psychiatric hospitals
MEDITATION PROGRAM 0 1
ADDICTION COUNSELING PROGRAM 0 2
SUPPORT FOR ACCESSING MEDICAL… 1 0
PREPARING FOOD FOR PATIENTS 14 0
STAFF SOCIALIZATION WITH PATIENTS 14 0
SUBMISSION OF DOCUMENTS FOR THE… 1 0
FAMILY AND SOCIAL REINTEGRATION PROGRAM 0 13
PREPARATION AND SUBMISSION OF… 3 0 4
SOCIAL AND CIVIC INTEGRATION AND… 30 20 20
DECISION-MAKING SUPPORT 30 35 43
EDUCATION, TRAINING FOR WORK 0 10 1
LEGAL COUNSELING 1 75 1
MAINTAINING / DEVELOPING INDEPENDENT… 56 40 53
CARE AND ASSISTANCE: NOURISHMENT &… 47 15 37
CARE AND ASSISTANCE: TRANSFER &… 57 0 30
CARE AND ASSISTANCE: CHANGE OF BODY… 39 0 8
CARE AND ASSISTANCE: CATHETERIZATION… 16 0 11
CARE AND ASSISTANCE: MEDICATION… 86 85 91
CARE AND ASSISTANCE: DAILY HYGIENE 90 40 82
CARE AND ASSISTANCE: GETTING DRESSED,… 84 25 54
VOCATIONAL/OCCUPATIONAL ACTIVITIES 29 25 10
OCCUPATIONAL THERAPY 36 75 59
PSYCHO-SENSORY-MOTOR STIMULATION 0 21
ART THERAPY / MUSIC THERAPY 17 25 31
HYDROTHERAPY, THERMOTHERAPY,… 0 1
MASSAGE, KINESIOTHERAPY AND PHYSIOTHERAPY 31 0 3
PSYCHOTHERAPY 11 25 34
SPEECH THERAPY 4 0
PSYCHOLOGICAL COUNSELING 57 45 54
INFORMATION AND SOCIAL ASSISTANCE 99 90 72

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