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DIAGNOSIS REPORT ON THE CURRENT DISABILITY ASSESSMENT SYSTEM

MINISTERUL MUNCII
ȘI PROTECȚIEI SOCIALE

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Diagnosis Report on the Current Disability Assessment System

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1 The project, initially implemented by the National Authority for Persons with Disabilities, has been taken over by the National Authority for the Rights of Persons with Disabilities, Children and Adoption – institution established through the Emergency Government Ordinance no. 68 of November 6, 2019, by taking over of activities, attributions, and structures of the National Authority for Persons with Disabilities (and of the National Authority for the Protection of Children Rights and Adoption), which was discontinued.

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Equal opportunities and equity

All project activities were designed and implemented for the equal benefit of boys and girls, men and women. The project team and experts received equal treatment, regardless of gender, ethnic origin, or other characteristics.

Sustainable development

During project implementation, the World Bank team aimed for a wise and effective use of resources to protect the environment and ensure social cohesion. Every citizen and institution should bear in mind that sustainable development is the only way to meet human needs without undermining the integrity of natural systems and the future of humanity.

Anna Maria Neagoe, Rest in Peace!

We fondly remember Anna Maria Neagoe, director of the Directorate for the Protection of the Rights of Persons with Disabilities in ANDPDCA.

With Anna's passing, Romania's disability sector has lost a pillar of stability. Anna was a consummate professional; she was deeply committed to her work to improve policies that have a direct impact on the lives of people with disabilities.

This project was initiated by Anna, and the team dedicates its efforts and results to her lasting memory.

Content

Acronyms and Abbreviations

ADL	activity of daily living
AJOFM	The County Agency for Employment
ALOFM	The Local Agency for Employment
ANDPDCA	National Authority for the Rights of Persons with Disabilities, Children and Adoption
ANOFM	The National Agency for Employment
ANPD	National Authority for Persons with Disabilities [2]
CEPAH	Commission for Assessing Adults with Disabilities
CJRAE	County Center for Educational Resources and Assistance
CPC	Commission for Child Protection
CSEPAH	Higher Commission for Assessing Adults with Disabilities
DAS	Direction for Social Assistance
DGASPC	General Directorate for Social Assistance and Child Protection
EGO	Emergency Government Ordinance
GD	Government Decision
IADL	instrumental activity of daily living
ICD	International Classification of Diseases
ICF	International Classification of Functioning, Disability and Health
ICF-CY	International Classification of Functioning, Disability and Health for Children and Youth
IML	Forensic Medicine Institute
ISJ	County School Inspectorate
M&E	monitoring and evaluation
MMPS	Ministry of Labor and Social Protection
NGO	nongovernmental organization
PAR	Plan for the Empowerment and Rehabilitation of Children with Disabilities
PIRIS	Individual Rehabilitation and Social Integration Program
PIS	Individual Service Plan
PRM	physical and rehabilitation medicine
PwD	person with disabilities
RAS	Reimbursable Advisory Services
SECC	Service for Comprehensive Assessment of Children with Disabilities
SECPAH	Service for Comprehensive Assessment of Adults with Disabilities
SEN	special educational needs
SPAS	Public Service for Social Assistance[3]
UN	United Nations Organization
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WB	World Bank
WHO	World Health Organization
WHODAS 2.0	WHO Disability Assessment Schedule 2.0

2 ANPD has been taken over by the ANDPDCA, through EGO no. 68 of November 6, 2019.

3 In this report, SPAS is used generically for all forms of public social assistance services set up in municipalities, cities, and communes in Romania (DAS, Direction for Social Assistance; SPAS, Public Service for Social Assistance or Compartment, as per GD no. 797/2017).

Executive summary

Background and objectives

The International Classification of Functioning, Disability and Health (ICF) provides a globally recognized framework for classifying and measuring disability. There is broad recognition among experts that Romania should reform its disability assessment and determination process, and align it with the ICF standards. The country has attempted to do so over the past decade, though largely without success. Therefore, the Government of Romania, and specifically the National Authority for the Rights of Persons with Disabilities, Children and Adoption (ANDPDCA), has engaged the World Bank through a Reimbursable Advisory Services (RAS) Agreement to support the modernization of the country's disability assessment system.

The objective of this RAS is to enhance the capacity of the ANDPDCA to develop, adopt, and implement a new disability assessment system. The project aims to provide the necessary support to (i) systematize legislation in the field of disability assessment in Romania by revising it according to modern approaches for evaluating disabilities (those that follow the ICF framework); and (ii) foster a change in the paradigm (going from an impairment to a disability approach)[5] by building the capacity of public servants involved in the disability assessment process at all levels.[6]

This diagnosis report aims to take stock of the existing disability assessment mechanism and processes in Romania. It identifies challenges and successes and determines how to adjust the system going forward in the ICF framework, considering international best practices and lessons learned. Specifically, the analysis provides an in-depth understanding of how the disability assessment system currently works in Romania and its role in referring persons with disabilities to services and benefits that can meet their needs.

The existing legislation suggests that disability assessment and determination should be based on a medico-psychosocial model. Existing legislation stipulates that persons with disabilities shall enjoy rights based on their degree of disability. Following the ICF model, it states that disability level is determined based on medico-psychosocial criteria that cover three dimensions: (i) Functional Parameters (medical criteria); (ii) Activities—Limitations; and (iii) Participation—Needs. Recent legislative updates are almost exclusively focused on the medical criteria.

However, many disability experts in Romania share an understanding that the country's disability assessment process remains predominantly based on medical criteria. The analysis presented in this report validates this assumption by systematically analyzing all aspects of the existing disability assessment system from the ICF perspective. The assessment analyses the processes and instruments used to conduct the assessment, related protocols and procedures, and the link between the disability assessment and the social protection system. The analysis provides an in-depth understanding of how Romania's disability assessment system currently works and its role in referring persons with disabilities to services and benefits that can meet their needs. Finally, the report proposes changes to modernize the disability system and align it to the ICF standards.

4 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.

5 Bickenbach et al. (2015).

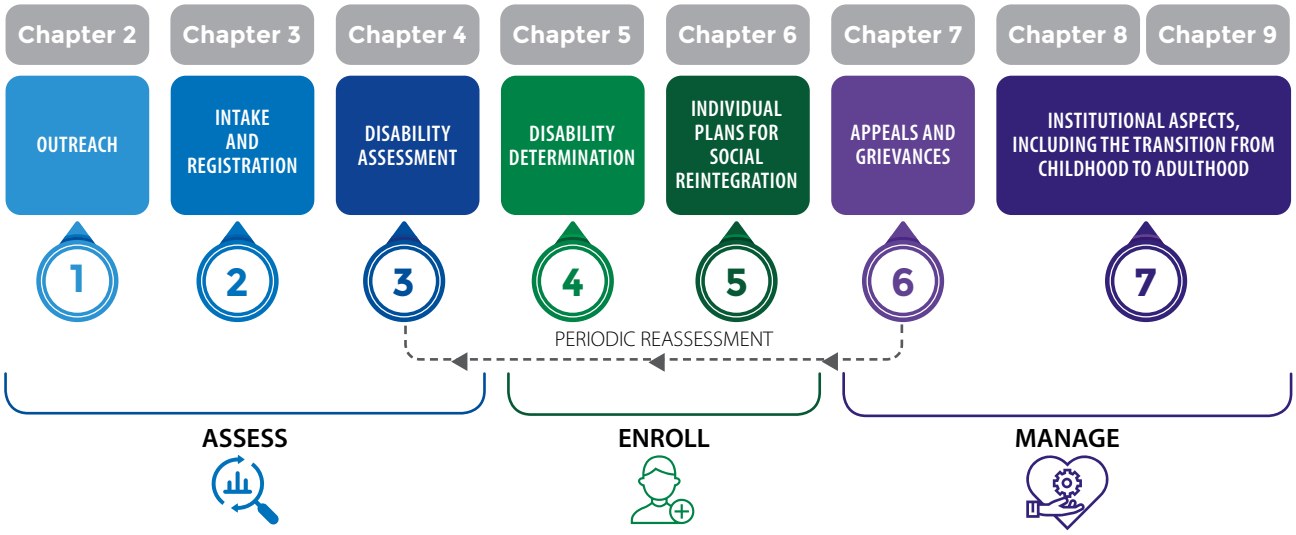
6 This RAS involves activities that will result in analytical outputs and ongoing technical assistance, as well as capacity building. The seven outputs include (i) diagnosis report on the current disability assessment mechanism; (ii) proposed set of medico-psycho-social criteria for disability assessment; (iii) proposed working instruments for a modernized disability assessment; (iv) report on the recommendation of a comprehensive assessment procedure of people with disabilities; (v) mid-pilot report on recommendations on disability determination and needs assessment; (vi) technical recommendations to facilitate specific expertise in disability assessment for court cases; and (vii) final report on recommendations on disability determination and needs assessment.

Methodological framework and data collection

Many high-resource countries have developed advanced, modern disability systems based on ICF principles. Countries such as Taiwan, South Korea, France, England, Canada, and the Nordic countries have created complex, multistage disability assessment procedures with instrumentation based on the ICF conceptualization of disability that fully record information on medical condition and history, impairments of body function and structure, performance of activities of daily living and instrumentational activities of daily living,[7] documentation of significant life areas such as education, work, and community life, extensive documentation of socio-demographic and environmental audits of home, neighborhood, and community, as well as other dimensions. Instrumentation includes either standardized international tools or ICF-based tools that have been thoroughly tested and have good psychometric properties. Romania is currently transitioning towards introducing the ICF principles, and the ICF framework should be utilized as a governing principle at all stages of the assessment.

The disability assessment system is approached in this report using the framework of social protection delivery systems as defined in the World Bank's *Sourcebook on the Foundations of the Social Protection Delivery Systems* alongside the ICF principles.[8] Therefore, the framework of analysis is anchored in the delivery chain's core implementation phases, which include outreach, intake and registration, disability assessment, disability determination, individual plans of intervention (determination of benefits and service packages), and person with disabilities' access to the benefit-service package associated with the disability certificate in Romania, as well as beneficiary operations management, including their compliance, data updates, and grievances. Compliance with ICF is analyzed at every stage.

Core implementation phases of disability assessment in Romania



Source: Adapted to the Romanian context after Lindert et al. (eds.), World Bank (2020: 11).

7 Activities of daily living (ADLs) are basic self-care tasks. The six basic ADLs are eating, bathing, dressing, toileting, mobility, and grooming. Instrumentational activities of daily living (IADLs) include managing finances, handling transportation, shopping, preparing meals, using the telephone or other communication devices, managing medications, doing laundry, doing housework, and undertaking basic home maintenance. Together, these skills represent what a person needs to successfully live independently.

8 Lindert et al. (eds.) (2020).

In tracing the delivery chain of Romania's disability assessment system, the chapters of this report are devoted to individual phases of the delivery chain, as shown above. However, within each chapter, the more detailed levels and aspects of implementation are described and analyzed, including the linkages with other stages, and the enabling factors (such as information systems, communications, and technology). Also, the opinions and beliefs of the various stakeholders are presented, in order to understand changes that should be made to facilitate the paradigm shift from a medical to a holistic approach.

This report presents an evidence-based analysis supported by comprehensive data collection. It brings together findings based on data collection between October 2020 and April 2021.[9] The data collection was structured according to the core phases of the delivery chain presented above.

The research combined quantitative and qualitative techniques and included institutional surveys, opinion surveys, interviews, and group discussions. Over 740 specialists took part in data collection activities; 570 responded to the surveys, and around 170 were involved in interviews and focus groups. The following surveys and interviews were conducted to inform the study:

- **The SPAS survey.** This survey collected data and opinions from practitioners within communities about three core phases of obtaining a disability certificate, namely outreach, intake and registration (the beginning of the process), as well as case management and persons with disabilities' access to benefits and services (the end of the process).
- **SECPAH and CEPAH surveys.** At the county level, two surveys collected factual data and opinions from specialists who work on the comprehensive evaluation services for adults (SECPAH) and children (SECC) with disabilities. Another two surveys collected factual data and opinions from members of CEPAH, its secretariat, and members of the Commission for Child Protection (CPC), which assesses children with disabilities. SECC and CPC opinions were related to persons with disabilities' transition from childhood to adulthood, respectively, for youth aged 16–17.[10]
- **Legal survey and interviews.** Regarding appeals and grievances, seven interviews with judges and lawyers were conducted. In addition, the factual data were collected from an institutional survey. Structured interviews were carried out with judges and lawyers from administrative and fiscal litigation divisions in tribunals, who were involved in appeals against the disability certificate between 2017 and 2020.
- **Focus groups analysis.** Regional focus groups with SECPAH, SECC, and CEPAH representatives were organized to understand the extent to which the ICF's view is integrated into SECPAH work procedures and assessment instruments, as well as to what extent the professionals in this field understand and promote a paradigm shift regarding disability assessment.
- **Interviews with nongovernmental organizations (NGOs).** A total of 20 in-depth interviews were carried out with NGOs that represent persons with disabilities in Romania and are actively and directly involved in that population's protection, representation, and inclusion in the community.
- **Interviews of people with disabilities.** Semi-structured interviews were conducted with 61 people with disabilities.

9 The entire methodological package, including the research tools and description of the data collection process, is presented in a separate document, Output #1: Volume 2.

10 The 16–17 age group includes young people up to 18 years old.

Challenges of disability assessment and determination

A. Key challenges of alignment to the ICF

The process and instrumentation of the SECPAH complex disability assessment do not align with the ICF principles. According to the ICF approach, physicians should evaluate an applicant's impairments at the level of body functions and structures according to items related to ICF categories. Ideally, a group of qualified practitioners should work together to establish and adopt the ICF principles. This is not the case in Romania, however. Nearly 75 percent of counties report that the recommendations from the comprehensive assessment report are predominantly based on the medical criteria. Similarly, more than three-quarters of respondents gave priority to the medical criteria in the formal classification or non-classification into a degree of disability.

The disability assessment for adults in Romania is predominantly medical. In particular:

- The medico-psychosocial criteria purports to assess selected domains of activities and participation from the ICF, but this information is not quantifiable and is insufficiently used in determining the disability degree.
- The social inquiry is supposed to collect some information about the applicant's functioning/autonomy degree and environment. Still, this information is not systematically collected, nor is there a clear procedure on how to use this information in the evaluation process, i.e., in the six mandatory assessment areas.[11]
- Valid psychological instruments are sometimes used, but information about vocation, education, and social integration is sporadically and inconsistently collected.
- None of the functioning information that is collected has any meaningful impact on the final assessment.

The decision of the CEPAH commission is not different from the SECPAH comprehensive evaluation. The determination is solely based on the document review, and the commissions rarely see the applicants. The duration of the commissions' decision-making process per case is approximately 5 minutes, which does not allow for proper deliberation or comprehensive, evidence-based decision making.[12] Under these conditions, CEPAH decisions are the same as SECPAH recommendations for over 90 percent of cases. Therefore, the process can be considered redundant. In addition, in Romania, unlike other countries, over 90 percent of applicants are classified into a disability degree. It is generally sufficient to have a relevant medical condition and submit an application to get certified

The country has no unified approach to determining disability. Significant differences are found across counties regarding disability assessment and determination processes. In only very few counties, SECPAH, and especially CEPAH, benefit from specific, well-designed work procedures. In most counties, work procedures are severely underdeveloped in terms of how to treat discrepancies between the assessments done by specialists outside the SECPAH versus the SECPAH practitioners, how to identify and correct cases suspected of fraud, how to develop training and working methods for multidisciplinary teams, how to ensure effective transition from childhood to adulthood, and how to draft individualized plans for intervention, the Individual Rehabilitation and Social Integration Program (PIRIS) and the Individual Service Plan (PIS).

The decisional process within SECPAH and CEPAH lacks transparency. The absence of procedures or guiding rules is accompanied by a lack of records about how or why decisions are made, without providing applicants with a clear explanation for why a disability degree was conferred (or not conferred). From the ICF perspective, most of the tools used in Romania for both assessing and determining disability, and for assessing service needs, are still too focused on medical aspects, are insufficiently participatory, and based on models that need to be revised to include the person's resources, the way he/she wants to live, and environmental factors, in addition to needs identified by the assessment.

11 GD no. 268/2007, Art. 48.

12 The average time of about 6 minutes per case is the average amount of time taken to resolve a case reported by CEPAH presidents in the Q3A questionnaires (see chapter 5). An estimate of the research team obtained from dividing the available time per month of CEPAH members by the number of cases dealt with per month indicates an even lower average time per case, below 5 minutes (see section 9.3.1).

B. Key challenges of institutions and human capital

Generally, there is insufficient professional staff in SPAS and SECPAH, while the size of CEPAH does not correspond to the size of the population of persons with disabilities officially registered in the county. The main problem related to human resources is the need for additional personnel. Only about a third of the local authorities have a SPAS at the local level that is accredited according to the law. The highest deficit is in persons responsible for providing social services and case managers responsible for children and adults with disabilities living in the family. Only a few SECPAH comply with requirements regarding staff specializations provisioned by law. Specialists such as psycho-pedagogues, physiotherapists, education instructors, and rehabilitation therapists account for a very small proportion of the total SECPAH staff and are found only in a few counties.

Regarding a paradigm shift from a medical to a holistic approach, the current combination of technical expertise is not aligned with the ICF, either at the CEPAH and SECPAH level. Family doctors and general physicians predominate, while specialists with medical expertise in work capacity or in physical and rehabilitation medicine (PRM) are very rare.[13] More such specialists would improve the use of the comprehensive assessment tools and improve recommendations for better services/benefits for persons with disabilities.

Staff who serve persons with disabilities have a very high workload, which varies considerably across specialization, county, and locality. The workload per SECPAH member differs considerably according to the member's specialization, with specialized doctors registering the highest workload. While SECPAH staff workload declined during the pandemic, it still remained relatively high. Generally, the workload is very high in CEPAH, especially since commission members have at least one full-time job in addition to their responsibilities with CEPAH. Discrepancies between counties are significant and depend both on the number of persons with disabilities in the county and on the size and composition of SECPAH/CEPAH. Similarly, the workload in this field varies considerably across localities.

ICF competence and training are lacking. SPAS, SECPAH, and CEPAH all have minimal staff training, and ICF-related training is particularly limited. At the SPAS level, out of the 478 employees of the surveyed SPAS, only 5 persons have ever attended a training related to the ICF. Among CEPAH, out of 120 members, only 8 (from 8 counties) have ever participated in ICF training. Similarly, out of the 346 specialists of the surveyed SECPAH, only 12 (from 3 counties) participated in ICF training in the last 12 months (in 2020).

C. Challenges of information management

A management information system for the disability-related system is nonexistent, and processes are not automated along the entire delivery chain. Most activities connected with the disability assessment and determination are paper-based.[14] Software applications that automate key functions and processes have limited functionalities or are nonexistent. Therefore, most activities—such as cross-checks, validation and verification, administration of benefits, administration of payments, and beneficiary data management—are manual. Counties have substantial differences regarding the kind of recorded data in the existing assessment software applications. In many counties, rigorous data about the registration and initial verification of the application files are recorded in paper registries, and are not available in electronic format. Data about dropout and exits from the system are not available. The quality of data in the existing databases is relatively poor. At the SECPAH/CEPAH level, no IT/data management/data analysis specialist is provided, nor are there data operators. As such, poor data management, poor data quality, and poor use of data are predictable in the absence of these human resources and under very high workload conditions.

In Romania, the uptake and registration phase is much more burdensome than in many other countries. International experience shows that most countries have implemented various measures to minimize the number of papers an applicant should submit. In more advanced administrative systems, a person can register electronically for the disability assessment and medical documents are pooled

13 The legislation (Art. 49 of GD no. 268/2007) mentions "specialized doctor" without any other specific requirement or restriction.

14 To address the gap, the ANDPDCA is currently implementing an EU-funded project to develop the National Disability Management System.

from an e-health system, while a social inquiry (if needed) is obtained through institutional protocols with no involvement, cost, or effort required on the part of the applicant. Romania should strive for this by rethinking the administrative processes to simplify access while avoiding duplication and rent-seeking opportunities.

Collected data are used for internal reporting and less often to document public policies relevant to persons with disabilities, especially for preparing local strategies and identifying social service needs. At the local level, some SPAS do not have data, but make policies regardless. In contrast, others have solid data but do not use them to formulate policies that target people with disabilities. Still, most SPAS report using a participatory approach that involves representatives of persons with disabilities in the analysis of collected data and to define policies.

At the county level, the monitoring and evaluation (M&E) reports of both SECPAH and CEPAH are rarely publicly disseminated. Less than half of SECPAH and less than a fifth of CEPAH use data to document relevant public policies for persons with disabilities, and very few use a participatory approach.

D. Challenges of outreach

Lack of proper disability outreach programs limits the resources available for people with disabilities. Many people with disabilities in Romania do not have access to the same educational and labor market opportunities as their peers without disabilities. The outreach programs fail to facilitate the inclusion of persons with disabilities into society, and do not provide them with more options or offer proper assistance. For many persons with disabilities, the stigma associated with the disability is critical to their participation.

The existing outreach programs provide incomplete information and are poorly adapted to the various types of disabilities and the vulnerable groups that face social risks. The information and communication provided by DGASPC (SECPAH), both online and offline, is only partially adapted for the specific access barriers by type of disability. Inclusive outreach is available only in some counties, and mainly in the larger cities. A deaf individual living in Romania who applies for a disability certificate has a chance of being assisted by a sign language interpreter in just 1 in every 10 SPAS offices, and only in about half of the country's DGASPC offices. For people using a wheelchair, physical access is also very limited, as most of these offices lack a ramp, do not have special parking, or do not provide wheelchair-adapted toilets. There are financial and geographical accessibility obstacles to obtaining medical documents. Further reasons for blockages during the intake phase relate to the lack of support provided by authorities, age when the disease was officially ascertained, lack of adapted communication, and lack of awareness about the existence of and ability to apply for a disability certificate-associated benefit-service package.

E. Challenges of needs assessment and case management

There is no transparent methodology for drafting, implementing, or monitoring the individualized plans of intervention. In Romania, the persons with disabilities' needs assessment is not done with adequate evaluation tools or according to a specific methodology. According to the regulations in force, the PIRIS and PIS are the only instruments that draw conclusions on the service needs of persons with disabilities. Even though these instruments are essential to ensure consistency between what a person needs, how he or she wants to live, and the type of support he or she receives, the legal framework does not include any methodology for filling in the instruments, or implementing and monitoring the actions provided for them. The PIRIS and PIS are only used in some counties; practices regarding drafting them vary significantly across counties, they are sometimes filled in superficially, and social workers and case managers do not use them as much as they should.

The existing PIS and PIRIS are of poor quality, and their content is not entered into the SECPAH/CEPAH database(s), while case management for adults with disabilities is still in an early stage of development. From the ICF perspective, both PIRIS and PIS are still overly focused on needs, especially the medical ones. They are also insufficiently participatory and based on templates that need to be revised to include the person's resources, the way he/she wants to live, and environmental factors, in addition to the needs identified through assessment. Thus, PIRIS, as it exists now, is weakly linked to the assessment conclusions and does not represent anything in terms of an intervention plan. Also, the existing PIS is just lists of general recommendations that do not comply even with the basic standards of proper information, let alone orienting or referring persons with disabilities to the necessary services. In addition, there is no M&E mechanism connected to PIS and PIRIS. Consequently, data from PIRIS are not recorded or analyzed to identify the social service needs of persons with disabilities at the county level.

F. Challenges of transition from childhood to adulthood

In Romania, the process of transitioning from childhood to adulthood for people with disabilities is poor in terms of information, support, and counseling. When young people with disabilities turn 18 years old, they often find themselves cut off from their current support and services, and fall through the cracks of an inefficient adult care system. The lack of information on the transition process, lack of understanding of changes in the assessment system, and absence of general counseling make the process especially difficult for many families.

The transition is abrupt and disorientating for many young people with disabilities. The law defines the support that young persons with disability are entitled to during the transition to adult life period, but such support is almost nonexistent in practice, leaving youth with disabilities and their families struggling with their new reality. Reforms are needed to streamline the transition process and develop appropriate services that support the child and their family during the difficult transition period.

G. Challenges of appealing the disability certificate

The process of appealing the disability certificate is flawed. There currently is legislation in force to facilitate this process, so that a person with disabilities can challenge a disability certificate directly in court. However, the courts lack the necessary knowledge and specialty support to make a decision based on objective criteria. On the contrary, court judgments regarding appeals against disability certificates tend to be highly subjective. Also, the administrative litigation departments do not currently process appeals against the disability certificate with urgency, as required by law. Free public legal assistance is available, but there is no awareness of it or how to get it—hence it is very rarely used. The process of appealing the disability certificate is characterized by a lack of homogeneous procedures regarding the treatment of evidence at the level of courts, concerning issues such as admissibility of the objection on grounds of late filing, admissibility of testimonial evidence or evidence by independent experts, differences in whether the court session is declared non-public, availability of support services during the trial, short periods between the court hearings, and court substantiations. Overall, the judicial procedures are poorly adapted to a person with disabilities' specific needs, as per UNCRPD (Art. 13). Also, DGASPCs lack a complaint and appeal redress mechanism as an alternative route for people who are not satisfied with the disability degree assigned to them.

Key challenges and recommendations: An overview

ICF-related challenges	General challenges
Disability assessment and determination	
• The process and instrumentation of the SECPAH comprehensive disability assessment do not align with ICF principles. • The final decision is predominantly taken by the medical specialist, while the medico-psychosocial criteria are not aligned with the ICF concept of disability. • The Deficiency/Disability ratings in the medico-psychosocial criteria are not supported by sound scientific methodology, either evidence or a stronger form of methodological consensus.	• The decision of the CEPAH is not different from the SECPAH comprehensive evaluation. • There is no unified approach to determining disability across the country. • The decisional process within SECPAH and CEPAH lacks transparency, as standard procedures are missing.
Institutions and human capital	
• ICF training is minimal. • In terms of a paradigm shift (from a medical to a holistic approach), the current combination of technical expertise is not aligned with the ICF, at the level of both CEPAH and SECPAH.	• Generally, there is insufficient professional staff in SPAS and SECPAH, while the size of CEPAH does not correspond to the size of the population of persons with disability registered in the county. • The workload of staff who serve people with disabilities is very high, and varies considerably across counties and by specialization. • Staff training is minimal at all levels: SPAS, SECPAH, and CEPAH.

ICF-related challenges	General challenges
Information management and outreach	
• Data management is highly fragmented between and within counties (among SECPAH, CEPAH, and its secretariat), impeding proper comprehensive assessment. • The provided information is incomplete and poorly adapted to the various types of disabilities and for the vulnerable groups facing social risks. • Lack of proper disability outreach programs limits the resources available for people with disabilities.	• Automation of processes is minimal along the entire delivery chain. • Most activities connected with disability assessment are paper-based. • The quality of data in the existing databases is relatively poor. • Collected data are used for internal reporting and less often to document the public policies relevant to persons with disabilities. • Financial and geographical accessibility obstacles are reported concerning obtaining medical documents. • Improvements are needed to reduce barriers for vulnerable groups. The existing interface between people and institutions is a weak link of the disability system.
Needs assessment and case management	
• Case management for adults with disabilities is in an early stage of development, especially for persons with disabilities living with the family.	• There is no specific methodology or adequate evaluation tools for persons with disabilities' needs assessment. • There is no clear methodology or uniform procedure for filling in, implementing, and monitoring the PIS and PIRIS, as well as the actions provided for therein.
Transition of young with disabilities to adult life	
• Disability in children is not assessed based on similar principles as adults, leading to differences in the assessments.	• Transition to adulthood results, in some cases, in changes to the degree of disability, and even the denial of a new certificate. So, a young person suddenly faces a situation in which his/her adaptive and self-determination resources are insufficiently developed (for example, if the change in disability degree leads to the loss of the right to a personal assistant). • There is a lack of information on the transition process. • The absence of counseling makes the transition process especially difficult for many families. • The transition is abrupt and disorientating for many young people with disabilities. • The law defines support during the transition period, but it is almost nonexistent in practice.
Appealing the disability certificate	
• The disability determination contestation process is resolved with a high level of subjectivity. • Judges and lawyers lack ICF training, and ICF is not considered.	• The process of appealing the disability certificate is flawed. • Detailed information on how to make an appeal, accessible to all persons with disabilities, in accordance with the UNCRPD (Art. 9), is not available in all counties. • The disability certificate appeal mechanism does not include a continuous learning dimension and does not follow the transparency principle. • Courts lack the knowledge and access to expert opinion to provide a result based on objective criteria.

Key policy recommendations

Romania's disability assessment, determination, and needs assessment processes can be modified to be more effectively aligned with the ICF principles. The reform process should include three key pillars, introduced consecutively:

Pillar A. Improve disability assessment and determination by introducing the ICF framework

- **Introduce ICF-based instruments.** The new instrumentation should include a proper psychometric tool that is quick to use, efficient, and fully aligned with the ICF.
- **Design clear procedures that respect ICF principles,** which should streamline the process, improve administrative efficiency, and comply with the principles of the UN Convention on the Rights of Persons with Disabilities (UNCRPD).
- **Invest in skills development on ICF at all levels**, SPAS, SECPAH and CEPAH, including judges, lawyers, and other relevant personnel.
- **Enhance interaction with applicants and improve data management.** Digitizing and enhancing the interoperability of the databases will increase transparency at all levels of the disability determination process, streamline and improve workflows, and significantly improve the system's performance.

Pillar B. Improve access to services tailored to persons with disabilities' specific needs

- **Make disability outreach a priority.**
- **Improve needs assessment and develop case management for adults with disabilities.** Rethinking the role of case management in the service needs assessment and rehabilitation process is an important priority in Romania.
- **Make the transition process from childhood to adulthood gradual, and improve counseling.** The process of transitioning from childhood to adulthood should be streamlined, and clearly articulated in new laws and procedures.
- Facilitate persons with disabilities' access to address the courts directly, and develop a complaint and appeal redress mechanism

Pillar C. Integrate all disability-related systems.

The integration of all disability-related systems in Romania is outside of the scope of this report and these advisory services. Nonetheless, the current marked fragmentation of Romania's disability system represents a factor that must be considered when designing the new set of instruments and procedures to change the paradigm in the field of disability.

Pillar A. Improve disability assessment and determination by introducing the ICF framework

Introduce ICF-based instruments: Integrate functioning into disability assessment

Modernizing Romania's disability assessment system requires integrating information into the assessment process in a meaningful and scientifically sound way. The first and essential reform needed is to collect functioning information in a consistent manner that is standardized across all counties and is scientifically sound. Second, this information must have a genuine, transparent, and measurable impact on the final disability assessment in all cases and for all counties, in the same manner.

Instead of six areas of "comprehensive assessment," the system should consistently collect functioning information using a single, standardized, psychometrically sound instrument. The current six-part, comprehensive assessment of disability should be replaced by a medical assessment augmented by a functioning-based assessment score from a psychometrically sound instrument, one that is fully aligned with the ICF model of functioning and disability; this should be standardly and consistently used in every county. This instrument must be scientifically appropriate for creating a summary or "whole person" disability score, preferably on an integral scale. This change in instrumentation will require changes in the responsibilities and procedures used by both the SECPAH and CEPAH.

The current medico-psychosocial criteria should be revised by updating and modifying medical information to allow for joint evaluation of multiple health conditions and multimorbidity, as well as alignment with the International Classification of Diseases (ICD)-11.

Design and develop clear procedures that respect ICF principles

New procedures urgently need to be redesigned and implemented based on the ICF principles. The new procedures should be developed in a collaborative process featuring practitioners, social workers, international ICF experts, policy makers, and disability advocates. This will provide a unique opportunity to redesign and introduce a modern functional approach to more efficiently determine disability. Ensuring cross-county consistency—both in instrumentation and procedures—is fundamentally a matter of human rights and should be a key focus for policy reforms.

The procedures should be created separately in SPAS, SECPAH, and CEPAH. Procedures should include key aspects of the disability assessment, including coordination between agencies, procedures dealing with discrepancies and fraud, procedures on how the multidisciplinary teams should work and make decisions in the ICF framework, procedures that effectively insure transition from childhood to adulthood, and individualized plans for intervention—the PIS and PIRIS. The interaction with the applicant while conducting the social inquiry should be based on well-established guidance and procedures.

The role and responsibilities of CEPAH, in relation to SECPAH, should be clarified and standardized across counties. We suggest a general review of the roles and responsibilities of CEPAH and SECPAH in the context of disability assessment, keeping in mind that it is ideal to have a single institutional location for disability assessment that should be, to every extent possible, standardized in instrumentation and procedure across all counties in Romania. In this review, the focus should be on the potential added value of the CEPAH commission and avoid duplication or redundancy with SECPAH. Improving the working procedures and instruments will enhance the system's performance.

Invest in skills development

It is crucial to invest in skills enhancement and develop ICF training courses for relevant staff to explain and adopt the correct use of the ICF as a classification, as well as to show its impact and usefulness on daily practice, particularly in multidisciplinary teams. When a jurisdiction moves from the medical approach to a holistic, multidimensional, ICF functioning approach, there is also a change in requirements for the qualification and expertise of assessors. Training on ICF should be carried out for all staff, and opportunities to exchange experience and teambuilding should be multiplied. Staff training should be extended to all SPAS, SECPAH, and CEPAH. Judges and other relevant personnel should also know the ICF practices and methodologies. For some groups of

specialists (e.g., occupational therapists), training on the ICF should be aligned with the curricular content of their licensure.

Alignment with the ICF implies that the assessment process, while benefiting from medical expertise, should not be solely determined by medical expertise alone. All assessors, or members of assessment teams or committees, should be fully aware of and trained in the ICF understanding of functioning and the need to address disability as a global, summary experience, shaped by both health and environmental determinants. Physical and rehabilitation medicine professionals have both the conceptual and clinical expertise to assess functioning based on appropriate and sufficient documentation and evidence. Other rehabilitation professionals—physiotherapists, occupational therapists, educational and vocational therapists—are equally well-versed in the ICF notion of functioning and disability, whether or not they have the clinical experience and expertise to assess disability as a summary measure, rather than in terms of specific functioning domains, such as mobility, independent living, or employment.

The reform should be accompanied by improvements at the staff level. Additional personnel should be ensured, including enough specialized doctors, especially in physical medicine and rehabilitation, as far as possible. Raising awareness and training of SECPAH and CEPAH practitioners could be a game-changer. The specialists' workload should be reduced and balanced.

Enhance interaction with applicants and improve data management

Digitizing and improving the interoperability of the databases will increase transparency at all levels of the disability determination process, as well as streamline workflows and significantly improve the system's performance. The ICF provides the appropriate platform to electronically collect and store health and functioning information in a manner that guarantees semantic interoperability across other existing platforms. Extensive work should be done to ensure that all commonly used health and rehabilitation data collection tools correspond to ICF classifications, so that new ICF-based data are compatible with previously collected clinical data and other legacy databases.

A management information system for the disability-related system should be developed. It is vital to connect several database registries and make data available. Data validation software should be developed. Software applications that automate key functions and processes—such as cross-checks, validation and verification, administration of benefits, administration of payments, and beneficiary data management—should be improved or created. Clear guidance should be given to counties on what data must be collected, and software for data capturing should be developed.

Pillar B. Improve access to services tailored to specific needs

People with disabilities face widespread barriers in accessing health and related services. The origin of these barriers lies in a lack of policies and strategies, service provision and delivery, and awareness and knowledge about disability programs and services. Improving key services and ensuring access to effective promotion, prevention, planning, treatment, rehabilitation, and palliative health services are important areas of improvement.

Make disability outreach a priority

Romania should clearly articulate the main themes for the information and communication programs to be created for people with disabilities. Equal representation and better coverage for people with disabilities can be enhanced by reaching out to specific population groups in culturally sensitive ways and considering the adaptations necessary for vulnerable groups. While more analysis is needed in this area, some key measures could be summarized as follows:

- **Further research is needed to design specific strategies, including comprehensive outreach, to improve services and access.** Some countries have introduced a standardized form, such as a "green form" that must be completed by any specialized physician once he/she establishes a medical diagnosis connected with the disability criteria. It may be accompanied by a brochure with the core information that the medical unit must deliver to those persons receiving a green form.
- **It is crucial to evaluate the effectiveness of existing efforts systematically**. A comprehensive

assessment of outreach programs and practices should be undertaken to gauge future training and development needs, as well as to share best practices in this area.

- **The persistent core message of "handicap" needs to be changed to "disability" to support reforms**. This involves changes to both legislation and public policy documents. However, sustained information, education, and communication campaigns are equally needed to change the perception of current beneficiaries, as well as the general perception of disability as a "handicap," and of the disability certificate as compensation for medical conditions.
- **Joint programs at SPAS, CEPAH, and SECPAH on further development and outreach should be encouraged.** A technical expert panel comprised of interagency representatives should be formed to develop and pilot outreach guidelines. It is essential for people with disabilities to participate in the development of such programs and strategies.

Improve needs assessment and develop case management for adults with disabilities

Improving case management is an important reform that should be undertaken to ensure that it is an integral part of the disability assessment and determination system. Case managers engage with persons with disabilities and assess, plan, implement, coordinate, monitor, and evaluate options and appropriate services to satisfy their needs. Case managers must focus not only on a person's impairment of function or activity limitation, but also on the barriers and challenges created by the external environment. Thus, case managers use the ICF framework, which is integrated and multidisciplinary, to develop person-centered intervention plans.

The individualized plans, PIS and PIRIS, should be made compulsory and improved. The instruments must be standardized and harmonized to ensure a rigorous assessment of the needs of the person with disabilitiess, based on a specific methodology, which is to be aligned with the UNCRPD and ICF. A mechanism to monitor PIRIS/PIS implementation should be put in place and frequently evaluated.

The service package connected to disability assessment should be extended. The services should become available countrywide, including in remote and rural areas. ANDPDCA should also explore the possibility of introducing new support measures, such as grant programs for adapting a house or car to meet the individual needs of a person with disabilities. Developing an integrative platform with information about lifelong benefits and services available to persons with disabilities, coordinated by the ANDPDCA, could add considerable value in this respect.

Developing ICF-based rehabilitation services, both medical and vocational, represents a top priority for reforming the disability system and making effective individualized plans (PIS, PIRIS). Improving the access of people with disabilities to existing services is equally important. More efforts should be made at the county level to develop partnerships, communication, and collaboration between the General Directorate for Social Assistance and Child Protection (DGASPC)/SECPAH and the other service providers (public and private) to create a functional network instead of the existing clusters of isolated services.

Make the transition process from childhood to adulthood gradual

The process of transitioning from childhood to adulthood should be improved. Procedures should be introduced that benefit youth and their families involved in the transition process. New guidance and procedures should be adopted to improve collaboration between agencies. The SECPAH and SECC, as well as CEPAH and CPC, should hold regular consultative meetings and share all the assessment documents to facilitate the transition process. Joint meetings should be held between youth with disabilities and their families and the representatives of SECPAH/CEPAH.

Increase the formal transition period from childhood to adulthood, tentatively from 16 to 20 years old. For young people enrolled in education, the period should be further extended until they receive their degree or turn 26 years old. Maintain the degree of disability as long as the child is in school, so they continue to receive the same benefits.

From age 16, in addition to regular evaluations, the young person and their family should benefit from counseling in order to understand the effects of the transition from childhood to adulthood, in relation to a possible reduction in benefits and services. In addition to information and counseling, efforts should be increased to provide adult life training programs carried out in cooperation or partnership with legal entities, public and private.

These programs should focus on increasing the participation of young people with disabilities in both education and the labor market. The transition to adult life should be coupled with a program to assess the development of independent living skills. Such a program should be applied consistently across the country for all young people with disabilities, especially those who live with family. In addition, programs to facilitate the transition of young people with disabilities to independent living should be developed.

Support measures for young people with disabilities do not ensure a coherent and smooth transition to adult life. Most measures are available only in a few counties and for a small number of youth. The development of support measures is seen as key, but at the same time, is not possible under current conditions and resources available to both evaluation services and commissions for children and adults. Policy makers, disability evaluation structures, and NGOs need to work together to identify the main difficulties of the transition to adult life for young people with disabilities and to advocate for solutions and the subsequent adoption of new legislation.

Facilitate persons with disabilities' access to address the courts directly, and develop a complaint and appeal redress mechanism

It would be useful to develop, at the national level, a guide (potentially titled "How to challenge the certificate of disability") to be made available to all DGASPCs in the country and distributed to all people with disabilities along with the certificate. The CEPAH secretariats should continue to receive and register appeals to the certificates, even under the terms of the new legal framework. In addition, they should collect data based on which statistics, case studies, or more detailed information about how certain cases are dealt with could be published, which is important for proving the mechanism's legitimacy and improving confidence about its efficiency.

It would also be useful to develop a standardized template to substantiate the decision regarding classification/non-classification or degree of disability. This should be completed by SECPAH or CEPAH in a format that can be used by the courts. To reduce subjectivity in court judgments regarding appeals to the disability certificates, support in terms of information or specialty support regarding disabilities and medico-psychosocial criteria should be made available to the courts. Additionally, training on these topics should be provided both to judges and lawyers. ANDPDCA could also identify and train experts who can provide assistance to the courts.

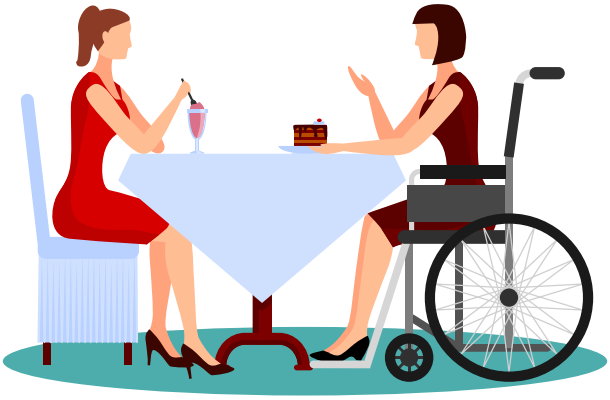
It is recommended to develop, at the DGASPC level, an actual complaint and appeal redress mechanism that respects the principles of accessibility, equity, predictability, transparency, and continuous learning, which could be a way to support those who disagree with the assigned disability degree and reduce the number of appeals filed in court. This new redress mechanism should not be a return to the pre-2017 situation, with a sole commission at the national level working with insufficient resources; rather, it should be based on a network of county and regional institutional structures. Furthermore, the new mechanism should not prevent citizens from pursuing their rights and interests using any other route (administrative law proceedings or other official litigation mechanisms), at the national or local level, neither are they meant to replace the judicial system or any other form of legal action.

Pillar C. Integrate all disability-related systems

Romania's disability system is characterized by marked fragmentation. Parallel systems of invalidity pensions and disability, as well as the separate disability system for children and adults, exist separately with minimal integration. Many other program-specific delivery systems for most of the benefit-service package are attached to the disability certificate, further deepening the fragmentation. This is costly and inefficient for people who must navigate each program separately, provide the same information and documentation over and over, and wait in long lines at different offices. This is also inefficient for administrators, resulting in duplications or gaps in coverage, overlapping processes, wasted resources, and an inability to keep track of how social protection money is spent. The integration of all disability-related systems in Romania is out of

the scope of this report and these advisory services. Nonetheless, it remains an important area of reform that must be considered when designing the new set of instruments and procedures to change the paradigm in the field of disability.

Moving forward, Romania needs to stay the course on disability reform implementation aimed at introducing ICF principles, improving access and quality of services to persons with disabilities, and fostering the system's integration. The first step of this comprehensive reform should focus on ICF introduction. Modernizing Romania's disability assessment system requires a meaningful and scientifically sound integration of functioning information into the assessment process. The first and most essential reform is therefore to introduce new instruments and procedures. Aligning the disability assessment's procedures, instrumentation, and criteria to the ICF and UNCRPD has implications for human capital requirements. ICF training should be introduced at all levels. Once this part of reform is introduced, the quality and access to services should be improved and integration of the disability systems should be considered.



Introduction

The International Classification of Functioning, Disability and Health (ICF) provides a globally recognized framework for classifying and measuring disability. ICF recognizes disability as a multidimensional and universal phenomenon. Use of the ICF leads to more integrated approaches to gathering and sharing information and to policy making. Such an approach could be developed and implemented following the International Classification of Functioning, Disability and Health (ICF) and aligned with UN Convention on the Rights of Persons with Disabilities (UNCRPD). "The assessment should be based on a human rights approach to disability, focus on the requirements of the person because of barriers within society rather than the impairment, take into account, and follow a person's will and preferences, and ensure the full involvement of persons with disabilities in the decision-making process."[15]

There is broad recognition among experts that Romania should reform its disability assessment and determination process and align it with the ICF standards. The country has attempted to do so over the past decade, though largely without success.

Currently, in Romania, the National Authority for the Rights of Persons with Disabilities, Children and Adoption (ANDPDCA) has initiated an extensive reform of the system, focused on the application of the ICF framework in disability assessment for adults, in addition to the existing one for children. Through the current Reimbursable Advisory Services (RAS) Agreement on Modernizing the Disability Assessment System in Romania the World Bank provides assistance to the ANDPDCA in order to improve the legislation governing the country's disability assessment system for adult persons.

The project aims to provide the necessary support to: (i) systematize legislation in the field of disability assessment in Romania by revising it according to modern approaches for evaluating disabilities (those that follow the ICF framework); and (ii) foster a change in the paradigm (going from an impairment to a disability approach)[16] by

15 UNCRPD Committee, General Comment Art. 19.

16 Bickenbach et al. (2015).

building the capacity of public servants involved in the disability assessment process at all levels. This RAS involves five sets of activities that will result in seven analytical outputs, as well as ongoing technical assistance and capacity building. The seven outputs include:

1. Diagnosis report on the current disability assessment mechanism
2. Proposed set of medico-psycho-social criteria for disability assessment
3. Proposed working instruments for a modernized disability assessment
4. Report on the recommendation of a comprehensive assessment procedure of people with disabilities
5. Mid-pilot report on recommendations on disability determination and needs assessment17
6. Technical recommendations to facilitate specific expertise in disability assessment for court cases
7. Final report on recommendations on disability determination and needs assessment

The present Output #1 represents the first result of the project and corresponds to component 1 of the RAS. The objective of this component is to take stock of the existing disability assessment mechanism and processes in Romania with regard to: (i) instruments for disability assessment and determination, (ii) the administrative processes of disability assessment, and (iii) the way in which disability assessment is linked to the social protection system for people with disabilities. Specifically, the analysis provides an in-depth understanding of how Romania's system for assessing disability currently works in Romania and its role in referring persons with disabilities to services and benefits that can meet their needs.

To achieve these objectives, this diagnosis report includes, inter alia: (i) an analysis of current institutions, the disability assessment instruments and processes currently under implementation, the profile and capacity of human resources involved in the process (skills, disciplines and their sufficiency given existing needs), and (ii) relevant evidence on international best practices regarding disability assessment and determination, and their role in identifying the needs of services and benefits requested by people with disabilities. The results of these analyses allow for the identification and understanding of changes needed to modernize the system, as well as possible barriers that may delay or block the reform process.

In practice, Output #1 collects evidence to set the stage for all subsequent activities of the RAS, and constitutes the preliminary phase of a process for developing a disability assessment mechanism based on the ICF, enabling the specific identification of people with disabilities' needs.

Output #1 is organized in two volumes. This report represents Volume 1, which focuses on data analysis, main findings, conclusions, and recommendations. Volume 2 is a technical document that details the methodological package developed for the background research that provides evidence to support this report.

The report opens with a description of the general context of disability assessment in Romania (Chapter 1). It continues with an overview that presents the core phases of the delivery chain and statistics regarding Romania's national disability assessment system. The next five chapters (2–6) detail each core phase of the delivery chain starting with outreach, intake and registration, the disability assessment and determination, as well as the individual intervention plans used to assess benefits and services needed. Next, Chapter 7 examines the grievance and redress mechanism. Chapters 8 and 9 look at the key institutional aspects affecting the effectiveness of the disability assessment and determination process in Romania. Chapter 8 focuses on the transition from childhood to adulthood for people with disabilities, and Chapter 9 examines human resources, data management and information systems, procedures, logistics, and other issues for each of the main organizational actors involved. The final chapter draws the main conclusions of the analysis, focusing on the main challenges and constraints to adopting a holistic approach to disability assessment, and lists the recommendations for the next steps of the project.

The primary audience for this report is ANDPDCA specialists who work with both adults and children with disabilities, as well as the hundreds of practitioners involved in disability assessment across Romania.

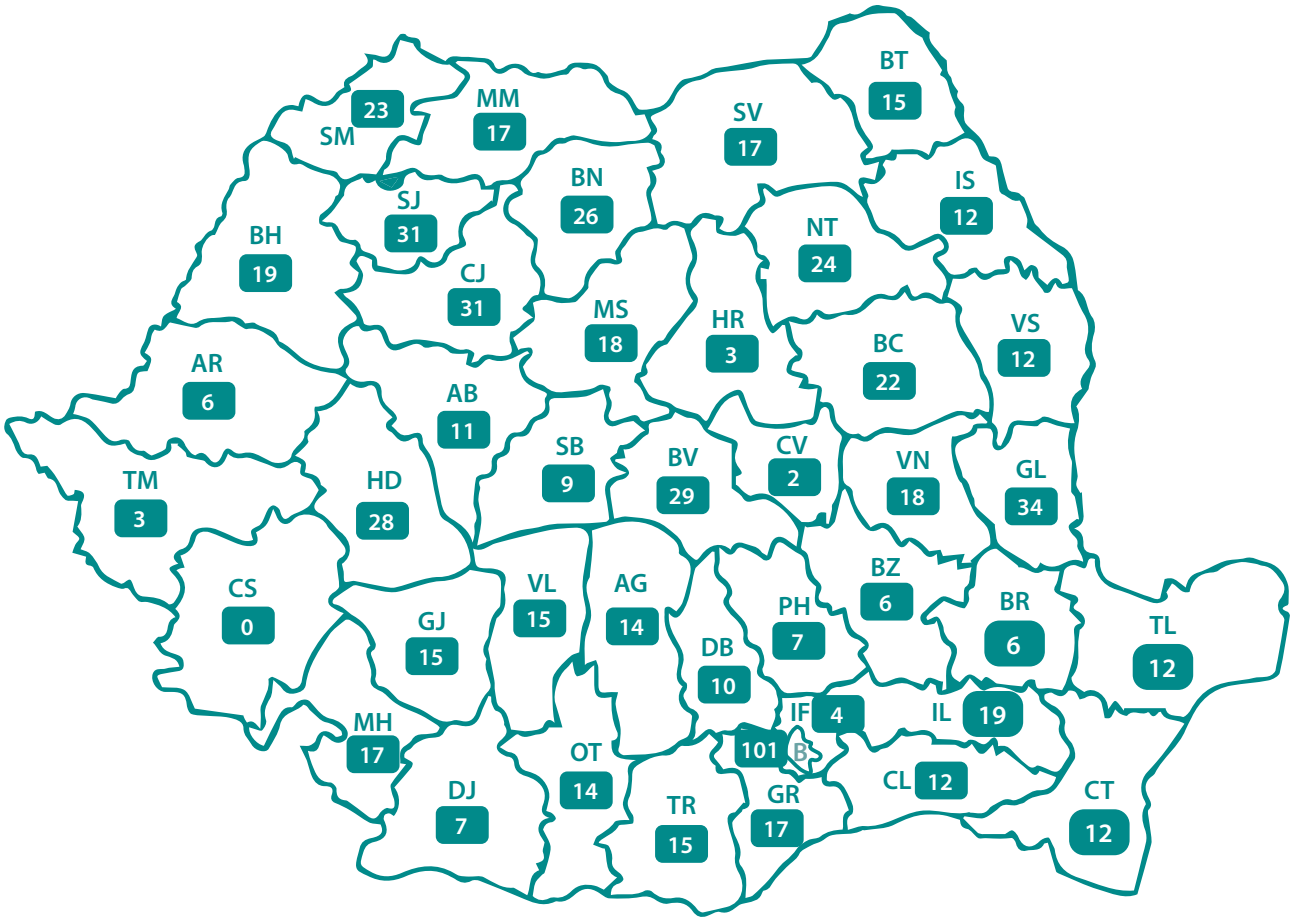
17 The agreement includes an interim report after 6 months of piloting the new methodologies, tools, and procedures and a final report after 12 months of piloting.

Data and method

This report presents an evidence-based analysis that is grounded in comprehensive data collection. The entire methodological package, including the research tools and description of the data collection process, is presented in a separate document (Volume 2). This section briefly describes the main elements of the research methodology developed for this report. Data collection was carried out in close cooperation with the World Bank and the ANDPDCA teams in January–March 2021.

The research is structured according to the analytical framework for social protection delivery systems as defined in the World Bank's *Sourcebook on the Foundations of the Social Protection Delivery Systems.*[19] It is therefore structured considering the core phases of the process for obtaining a disability certificate in Romania, namely (1) outreach, (2) intake and registration, (3) disability assessment, (4) disability determination, (5) individual plans for intervention (or determination of the benefits-service package) and (6) appeals and complaints against the disability certificate. As such, the research covered all key actors - people and institutions, governmental and nongovernmental - participating in the disability assessment and determination system across the country.

Map 1: Geographical coverage of the background research (number of participants by county)



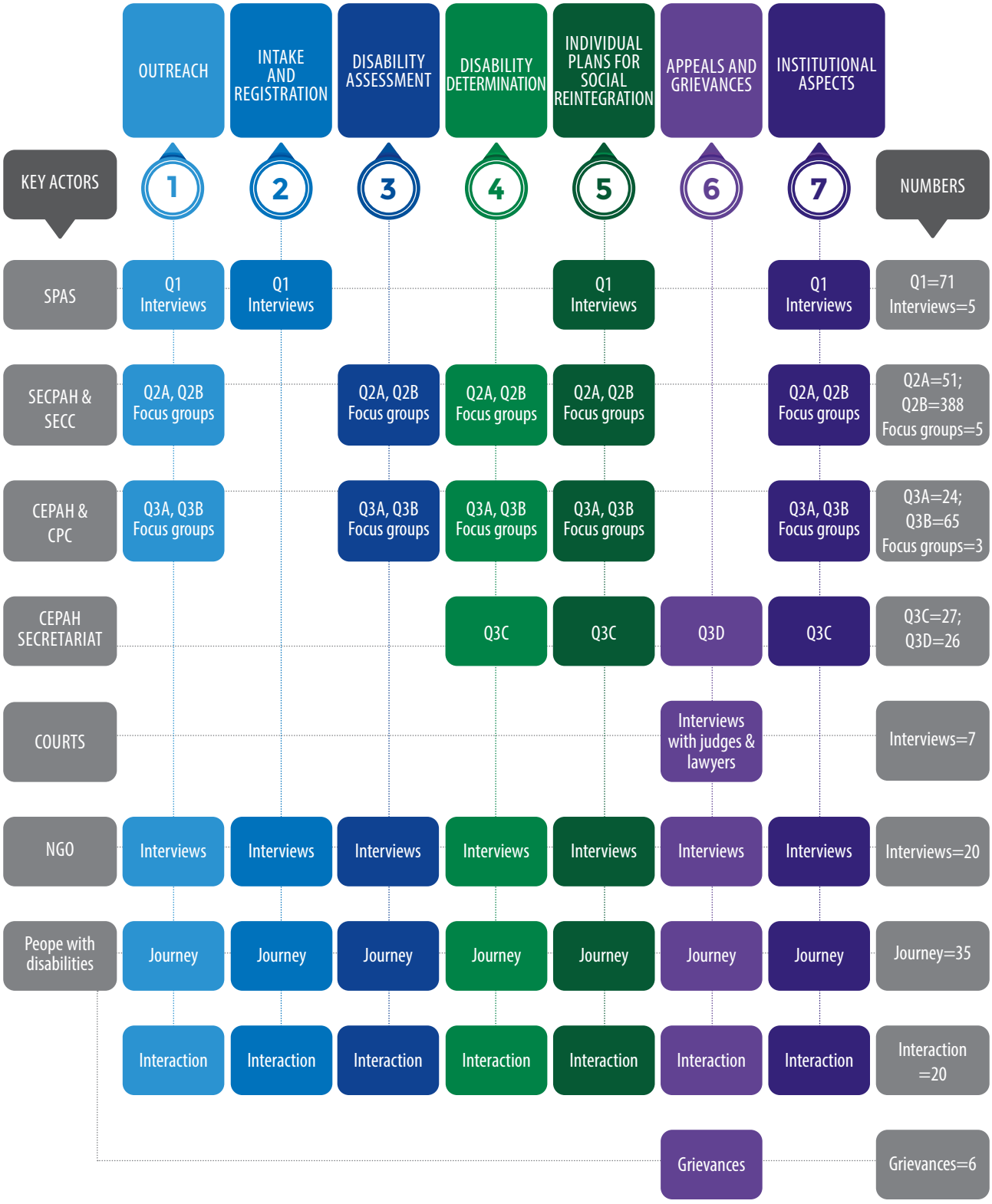
Source: Autors.

Note: At the national level, 741 persons participated to this background research.

18 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.

19 Lindert et al. (eds.) (2020).

Infographic 1: Background research at a glance



Source: Authors.

The research methodology combines quantitative and qualitative techniques and includes institutional surveys, opinion surveys, interviews, and group discussions. In total, 741 specialists took part in the data collection activities; 570 responded to the surveys, and around 170 were involved in interviews and focus groups. An at-a-glance illustration of the research is shown in Infographic 1.

Based on desk research and analysis of the current legislation, a set of research instruments was developed. The instruments were extensively consulted with the ANDPDCA team and other practitioners from county and local institutions, and pretested by the public services of social assistance (SPAS) at the community level. All stakeholder feedback was incorporated into the final version.

The research instruments foster analysis of the current disability assessment and determination system by providing: (i) a description of the current institutional structure (including interinstitutional relations), business processes, the assessment process (including current instruments and equipment used for disability assessment and determination), and their focus on the beneficiary (the person with disabilities); (ii) a profile of the human resources involved in the assessment, their operation across multidisciplinary teams, the workload, job descriptions/roles, training needs of local and county level staff, etc.; (iii) a description of the information system, data analysis processes, and proactive outreach to persons with disabilities; (iv) the range of benefits and services recommended (as part of the individual plan of intervention) and available following the disability assessment and determination process; and (v) current institutional arrangements for contesting the disability certificate in court.

At the community level: The SPAS survey

The SPAS survey collects data and opinions from practitioners within communities about three core phases of obtaining a disability certificate, namely outreach, intake and registration (the beginning of the process), as well as case management and persons with disabilities' actual access to benefits and services (the end of the process).

Table 1: The SPAS survey

Typology of communities at the national level:	All localities in the country (number)	Selected in the sample (number)	Q1_SPAS completed (number)	Total response rate (%)
URBAN				
Cities with >20,000 inhabitants as of January 1, 2020	105	31	18	58
Small cities with up to 20,000 inhabitants as of January 1, 2020	214	31	10	32
RURAL				
Communes developed and close to the county seat	352	28	12	43
Other communes (typical rural localities)	2,226	35	15	43
Communes underdeveloped and remote	283	30	16	53
Total	**3,180**	**155**	**71**	**46**

Source: Authors.

Notes: The rural localities were classified according to: (i) Human Local Development Index (LHDI2011) at the commune level and (ii) Geographical isolation (Teşliuc, Grigoraş and Stănculescu, coord., 2016).[20] The developed communes are those at the top 33 percent of the national rural distribution of communes by LHDI, while the underdeveloped communes are those at the bottom 33 percent of the national rural distribution of communes by LHDI. The communes far from the county seat are those at the top 40 percent of the national distribution of communes by the number of kilometers to the county seat, while communes close to the county seat are found among the bottom 40 percent of the national distribution of communes by the number of kilometers to the county seat.

20 The LHDI2011 is strongly correlated with the housing modernization index; Pearson coefficient of 0.86, p =.000. At the same time, the LHDI is significantly negatively correlated with the relative poverty rate (AROP) estimated by the World Bank at the locality level based on the same data from the 2011 Census; Pearson coefficient of -0.74, p =.000.

Q1_SPAS is a questionnaire for the public services of social assistance (SPAS). In the first step, the research team developed a typology using all localities (administrative-territorial units) in the country. The typology distinguishes between cities, small cities (up to 20,000 inhabitants), communes developed and close to the county seats (where the institutions in charge of disability assessment are located), communes underdeveloped and remote, and all the other rural localities. Based on this typology, DGASPC representatives were asked to randomly select (according to their knowledge and working relationship) one locality of each type per county. A total sample of 155 administrative-territorial units covering 31 counties[21] was selected. The questionnaires were distributed to the SPAS from the localities selected in the sample with the support of the focal points designated for this research in each county DGASPC (at the ANPD's request). SPAS sent back the completed questionnaires either directly to the research team or through their county focal point. The total response rate was 46 percent, with a total of 71 completed Q1_SPAS questionnaires from 26 counties.[22]

Along with the survey, five in-depth interviews (one for each type of locality) were conducted with SPAS representatives that have responsibilities in the field of disability. Interviews focused on their participation in the disability assessment system, as well as the main constraints and concerns regarding access to benefits and services for persons classified in a category and type of disability at the local level.

At the county level: Surveys on SECPAH, CEPAH, and CEPAH secretariat

At the county level, two surveys collected factual data and opinions from specialists who work on the comprehensive evaluation services for both adults (SECPAH) and children (SECC) with disabilities. Another two surveys collected factual data and opinions from members of the Commission for Assessing Adults with Disabilities (CEPAH), its secretariat, and members of the Commission for Child Protection (CPC), which assesses children with disabilities. SECC and CPC opinions were related to persons with disabilities' transition from childhood to adulthood, respectively, for youth aged 16–17.[23]

Q2_SECPAH: At SECPAH/SECC level, the background study employed two questionnaires, corresponding to the institutional survey and the opinion survey, respectively: (A) an institutional questionnaire on facts and indicators regarding the services for comprehensive evaluation for adults and children with disabilities; and (B) an opinion questionnaire on practices and experiences for practitioners working in these services. These questionnaires were sent to all 47 DGASPCs in the country. The first (A) was completed by the SECPAH and SECC chiefs, either jointly or separately. The second (B) was self-completed independently by practitioners working in these services and sent directly to the research team to ensure confidentiality.

Q3_CEPAH: Similarly, at CEPAH/CPC level, two questionnaires were used: (A) an institutional questionnaire on facts and indicators regarding the activity of the evaluation commission for adults and children with disabilities; and (B) an opinion questionnaire on practices and experiences for the members of these commissions. These questionnaires were sent to all 41 counties and the 6 districts of Bucharest. The first (A) was completed by the CEPAH and CPC presidents, either jointly or separately. The second (B) was completed independently by the members of these commissions and sent directly to the research team to ensure confidentiality.

Q3_CEPAH secretariat (within DGASPC): (C) a questionnaire on the result indicators of the disability determination process, and (D) a questionnaire on appeals, complaints, and the redress mechanism concerning the disability certificate. These questionnaires were sent to all 41 counties and the 6 districts of Bucharest, and both were completed by secretaries and presidents of the evaluation commission for adults (CEPAH).

21 Requests to select localities to participate in the survey on SPAS were sent to all 41 counties. Out of these, 31 DGASPCs sent back the selection of localities. In Bucharest, the 6 DGASPCs also play the role of SPAS and were not included in this survey.

22 The number of Q1_SPAS completed per county varies between one and five (maximum).

23 The age of 16–17 years old refers to teenagers up to 18 years old.

Table 2: Institutional surveys regarding disability assessment and determination - overview of types and response rates

Disability assessment			Disability determination		Appeals	
Institution/ Completed by:	Q2A_SECPAH		Q3A_CEPAH	Q3C_CEPAH secretariat/ DGASPC	Q3D_CEPAH secretariat/ DGASPC	Total number of counties
SECC alone	SECPAH alone	SECPAH and SECC jointly	CEPAH	CEPAH secretariat	CEPAH secretariat	
Yes	No	No	No	No	No	15
No	Yes	No	No	No	No	5
No	Yes	No	Yes	No	No	3
No	Yes	No	Yes	Yes	No	1
No	Yes	No	Yes	Yes	Yes	6
No	Yes	No	No	Yes	No	1
No	Yes	No	No	Yes	Yes	3
No	No	Yes	No	No	No	6
No	No	Yes	Yes	No	Yes	1
No	No	Yes	Yes	Yes	Yes	8
No	No	Yes	No	Yes	Yes	2
No	No	No	Yes	Yes	Yes	5
No	No	No	No	Yes	No	1
No	No	No	No	No	Yes	1
No	No	No	No	No	No	5
15	**19**	**17**	**24**	**27**	**26**	

Source: Authors.

All questionnaires were sent in parallel through the focal points designated for this research in each county DGASPC. However, Table 2 shows that only some of the various institutional structures cooperated or communicated in some counties, while in others they function as independent players, rather than integrated parts of a sole delivery chain. Overall, 63 questionnaires of all types were collected. Nonetheless, full information on disability assessment, determination, and appeals cover 14 counties,[24] while for 22 counties and 6 districts of Bucharest the data are partial (only about the assessment, the determination, appeals, or a combination of two of those). No institutional questionnaire was completed for 5 counties.[25]

In Romania, the comprehensive disability assessment includes six mandatory areas in which the evaluation must be carried out by experts with different specializations, as per GD no. 268/2007, Art. 48.[26] However, there is no instrument or methodology for these six mandatory areas to be uniformly applied at the national level. Instead, current regulations leave it up to each assessment service (SECPAH) and determination commission (CEPAH) to develop its working instruments and detailed procedures (Annex to Order no. 2298/2012). The institutional questionnaires asked SECPAH/CEPAH to provide their procedures and

24 These counties are Arad, Argeș, Bihor, Bistrița-Năsăud, Brăila, Dolj, Galați, Hunedoara, Mehedinți, Neamț, Olt, Sălaj, Sibiu, and Suceava.

25 The counties without data are Caraș-Severin, Covasna, Ilfov, Prahova, and Vrancea.

26 "The mandatory areas of assessment are (i) social assessment provided by social workers; (ii) medical assessment provided by medical specialists; (iii) psychological evaluation provided by psychologists; (iv) vocational assessment of professional abilities provided by psycho-pedagogues, educational instructors, or rehabilitation pedagogues; (v) assessment of the level of education provided by psycho-pedagogues, educational instructors, or rehabilitation pedagogues; and (vi) assessment of the skills and level of social integration provided by psychologists, psycho-pedagogues, educational instructors, recovery teachers or social workers" (GD no. 268/2007, Art. 48).

instruments used to evaluate the six mandatory areas as attached documents to questionnaire Q2A/Q3A, so the research team could identify their strengths and weaknesses, along with items that could possibly be adapted for national use.

In addition, there are two main instruments for identifying services for people with disabilities: the Individual Rehabilitation and Social Integration Program (PIRIS) and the Individual Service Plan (PIS).[27] At the national level, there is no clear methodology for implementing and monitoring the proposed interventions in these key instruments that are essential for ensuring consistency between what a person needs, how he or she wants to live, and the type of support he or she receives. To address this gap, the institutional questionnaires include dedicated sections on PIRIS and PIS. Additionally, the packages[28] of documents approved (after being rendered anonymous) for three individuals, namely the last individuals assessed by CEPAH during the most recent meeting before filling in the questionnaire, were requested as attachments to Q3A. Only eight counties responded to this request, but the sample of documents is used to analyze how they are filled in (especially PIS and PIRIS) and how the proposed interventions are implemented and monitored.

Regarding the opinion surveys, out of a total of 370 SECPAH practitioners,[29] 201 completed an opinion questionnaire (Q2B_SECPAH), which makes a response rate of 54 percent. In addition, 187 SECC specialists also completed a Q2B questionnaire focusing on the issue of persons with disabilities' transition from childhood to adulthood.[30] Regarding the disability determination, 46 CEPAH members and 19 CPC members completed Q3B_CEPAH.[31] These respondents provided data on the practices and experiences of evaluation commissions from 23 counties and 2 districts of Bucharest.

Thus, more than 450 practitioners participated in the opinion surveys, covering all regions of the country, most of the counties, including mostly women (over 75 percent) but also men, and from ages 23 to 72, graduates of different specializations (doctors, social workers, sociologists, psychologists, psycho-pedagogues, legal experts, economists, etc.), holding a management position or not, newly hired in SECPAH/designated in CEPAH or with more than 25 years' experience.

Courts: Regarding appeals and grievances, factual data were collected from the institutional survey Q3D_CEPAH secretariat. In addition, seven interviews with judges and lawyers were conducted. Three structured interviews were carried out online with judges from administrative and fiscal litigation divisions in tribunals, who were involved in appeals cases against the disability certificate between 2017 and 2020. The other four structured interviews were conducted with lawyers who worked on cases to challenge the disability certificate in administrative and fiscal litigation divisions of the tribunals and/or courts of appeal (in appeal proceedings) between 2017 and 2020.

At the regional level: Focus groups with SECPAH and CEPAH

SECPAH: The World Bank team organized four regional focus groups with SECPAH representatives to understand the extent to which the ICF principles are integrated into SECPAH's work procedures and assessment instruments, and to what extent the SECPAH professionals understand and promote a paradigm shift regarding the disability assessment.

To complete the information on the psychological assessment, an interview was conducted with the head of the psycho-pedagogy department of Babeș-Bolyai University from Cluj-Napoca, as well as a lecturer at the special psycho-pedagogy department of the University of Bucharest.

CEPAH: Other three regional focus groups were carried out with CEPAH members to understand the extent to which the ICF principles are integrated into their work procedures and reflected in the process of establishing the disability severity category, and to what extent the professionals in this

27 As per Law no. 448/2006 on the protection and promotion of rights of persons with disabilities, republished, as amended and completed.

28 Including the comprehensive assessment report, the certificate of handicap, its annex, the professional orientation certificate, PIRIS, and PIS (and others, if needed).

29 This number represents the total number of SECPAH employees from 36 (of 41) counties and 5 (of 6) districts of Bucharest as reported in the institutional questionnaire Q2A_SECPAH, the section on human capital. Did not provide data on human capital the counties Alba, Caraș-Severin, Covasna, Ilfov, Prahova, and the fourth district of Bucharest.

30 Data on SECC human resources were not collected hence the response rate cannot be determined.

31 The 25 CEPAH that responded to institutional survey Q3A consist of about 125 members. Consequently, the estimated response rate within the opinion survey Q3B is about 37 percent. However, some CEPAH members from counties that have not filled in the Q3A questionnaire also participated in the opinion survey. Therefore, based on the total population of CEPAH members within the country (47 by 5 members), the estimated response rate decreases to around 20 percent.

commission understand and promote a paradigm shift in the field of disability status evaluations. The focus groups also aimed to understand how the commission's activity, through access to data and information on persons with disabilities' quality of life, can contribute to documenting public policies related to disability.

The discussion groups were structured based on a specific guide and were carried out online, facilitated by a World Bank expert. They were organized regionally; between 6 and 12 specialists (from SECPAH, SECC, and CEPAH) from 3–4 counties in the region were invited to attend each group discussion. Invitations were sent to the heads of SECPAH/SECC or the CEPAH presidents, as well as to other specialists, to have a diverse set of respondents in terms of their specialization and experience. In total, 61 specialists from 9 counties took part in the 7 focus groups.[32] The group discussions were recorded, subject to all ethical and data confidentiality standards in compliance with Law no. 363/2018.[33]

At the national level: Interviews

NGOs: A total of 20 in-depth interviews were carried out with NGOs that represent persons with disabilities in Romania and are active and directly involved in the protection, representation, and inclusion of persons with disabilities in the community.[34] Of the NGOs, 12 are local, 2 are regional, and 6 are large national federations. Overall, they represent or provide services to over 10,000 persons with disabilities. These interviews aimed to gather the NGOs' experiences with the disability assessment system (especially with SECPAH and CEPAH) and in tackling the obstacles that persons with disabilities face in terms of access to education, health, the labor market, and civic participation.

Adults with disabilities: A total of 61 semi-structured interviews with persons with disabilities were conducted online by World Bank experts, out of which some adults with disabilities themselves.[35] Depending on the level (severity) and type of disability, the help of a sign language specialist or language interpreter was enlisted. Someone caring for the person with disabilities (personal assistant, professional personal assistant, or any other family member or person from the person's with disabilities' support network) could also attend the interview, particularly if he or she accompanied the interviewee to obtain a disability certificate, and only with the consent of the interviewee. The interviews were recorded with the written (or audio recorded) consent of the interviewee and in compliance with all ethical standards and assurance of data confidentiality per Law no. 363/2018, on the protection of individuals concerning the processing of personal data.

For interviews, a variety of adults with disabilities who applied (at least once) for a disability certificate in the 2012–20 period were recruited, including: persons who started the procedure and abandoned it along the way; people who completed the procedure but were not assigned a category of disability; young people aged 18–26 with a disability certificate who made the transition from childhood to adulthood in 2017–20; people who first applied for a disability certificate in the period immediately following the COVID-19 pandemic (after March 2020); people who filed an appeal against the disability certificate (at least once) between 2017 and 2020; adults (18+ years old) with a disability certificate and with different characteristics, so that the group of interviewees would be as diverse as possible regarding severity and type of disability, gender, age, ethnicity, marital status, level of education, employment history and residence environment.

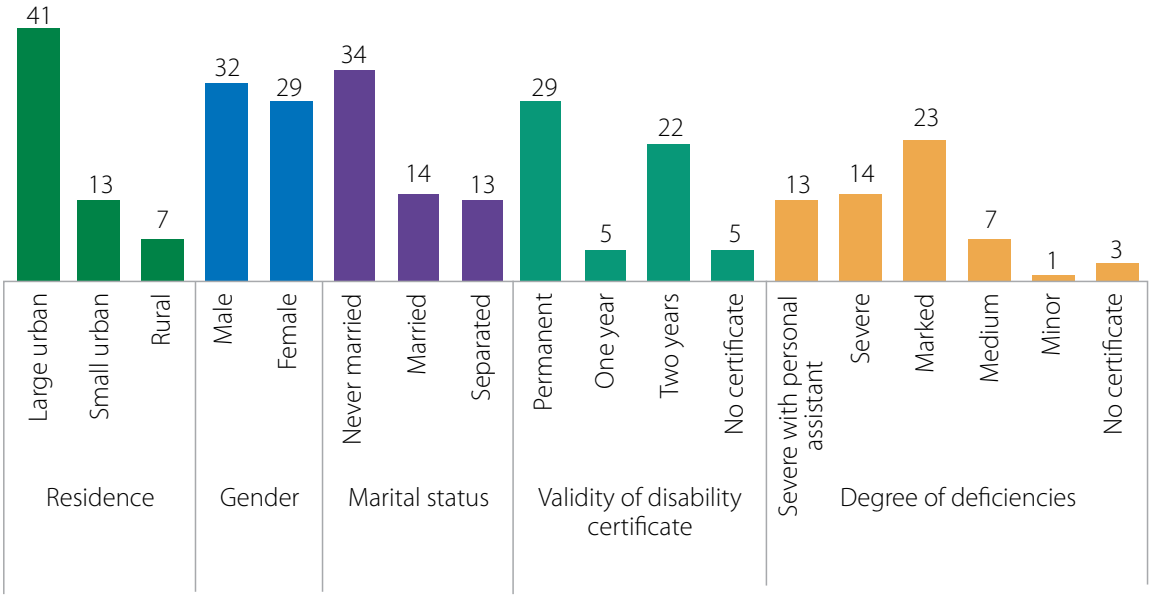
32 On average, focus group sessions lasted 120 minutes.

33 Law no. 363 of December 28, 2018, on the protection of natural persons regarding the processing of personal data by the competent authorities for the purpose of preventing, discovering, investigating, prosecuting and combating crimes or carrying out punishments, educative measures and precautionary measures.

34 The list of interviewed NGOs is provided in Annex 1; interviews lasted about 90 minutes, on average.

35 An interview with adults with disabilities lasted 50 minutes, on average.

Figure 1: Profile of the 61 interviewed adults with disabilities



Source: Authors' calculations based on the disability survey.

The interviews with adults with disabilities were carried out in three directions based on three separate guides, which are presented below.

Interview Guide 1 — The journey: Thirty-five interviews captured the opinions of adults with disabilities on their direct experiences with each step of the assessment process, including suggestions for improvement, using a person-centered design approach. This guide was aimed at the entire population of adults who have applied for classification in a category and type of disability, whether they have abandoned the procedure along the way or were eventually not assigned any category of disability. These interviews allow the person's journey along the disability assessment delivery chain to be systematically structured across four dimensions: (i) the actions that were taken by that person; (ii) the time required to complete that stage; (iii) the costs paid by the person during that stage; and (iv) how the person felt at the end of the stage. During the interview, the interviewee could freely describe the process of obtaining a disability certificate and its results.[36] If the natural storytelling did not yield the stage spontaneously or did not provide enough answers about the four research dimensions, the researcher guided the interviewee through easy-to-understand questions.

Interview Guide 2 — The interaction: Twenty structured interviews focused on the interaction between the person and the key institutional actors along the disability assessment delivery chain. During these interviews, researchers guided the adults with disabilities to talk about the way they perceive they have been treated by medical staff in hospitals, social workers in SPAS, and DGSACP employees in the run-up to submitting their application to SECPAH. Also discussed were what financial and time resources it took to submit their application, how they collaborated with the SECPAH team and CEPAH members, and how the procedure went compared to their expectations, but also in relation to their specific needs, as well as how they would have liked to have been treated.

Interview Guide 3 — The grievances: Six interviews referred to the experiences they had as claimants in the process of challenging the disability certificate (which assigns the person a degree and type of disability): whether/how they were informed, whether/how they received support/assistance before, during, and after the proceedings; how they perceived the treatment they received in court; how they would have liked to have been treated, and/or what they think would have improved things, based on how they evaluate and reflect on their experience.

36 For example, a person with disabilities said, "I could no longer move. I started to go to the doctor. I went to 7 doctors; it took me 3 months to get the medical report and spent more than 500 lei. I was tired and felt awful after I had spent so much time in hospital corridors. After that, all the other papers came." In this case, the researcher recorded (i) 7 visits to doctors; (ii) 3 months; (iii) over 500 lei; and (iv) "I felt awful."

1. Scope of the study

This report describes and analyzes the disability assessment system of adults (18 years or older) in Romania. Two delineations are necessary.

First, Romania has two disability systems—"invalidity" and "handicap"—with separate legal and institutional frameworks, as shown in Box 1. According to the Terms of Reference of the present RAS, this report is limited to the second system; the invalidity assessment is out of the scope of this report and the current RAS agreement. The granting of invalidity pensions is based on a different system of assessing a person's situation, associated with a decrease in work capacity.[38] Invalidity pensions are paid to persons who have not yet reached the standard retirement age, have lost all or at least half of their work capacity, and have made contributions for a predefined period. The assessment of work capacity to establish the degree of invalidity is made on request by a specialist doctor in occupational medicine within the National House of Public Pensions. These assessments are mainly medical and are not based on a bio-psychosocial approach to disability.

There were several projects[39] that sought to unify the system for assessing the situation of persons with disabilities with the system for assessing work capacity (invalidity). However, the previous projects did not have any of the results pursued by the legislation, and the assessment of work capacity has remained a separate system. Currently, there is no analysis of the profile of invalidity pension beneficiaries, and no coordination between the ANDPDCA and the National House of Public Pensions to streamline policies for persons with disabilities. Some of those who receive invalidity pensions cumulate disability-related benefits, but there is no analysis of how these benefits overlap or how the cumulation of benefits might create additional disincentives to enter the labor market.

37 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.

38 Grigoraș et al. (coord.), World Bank (2020: 128).

39 For example, the project implemented by the Ministry of Labor and Social Protection between 2016 and 2018, Japanese Grant PHRD for Technical Assistance and Development to Support Persons with Disabilities, Project for Improved Policy-Making and Institutional Framework for Persons with Disabilities (TF010417).

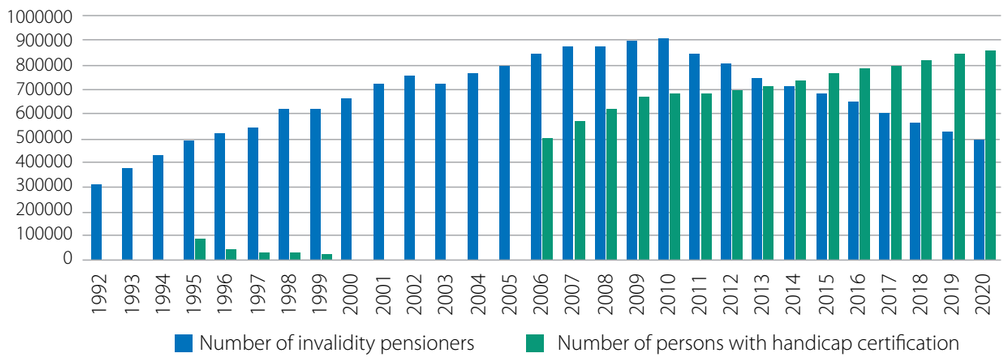
BOX 1

A short history of Romania's two disability systems

The invalidity pension represents the traditional disability system in Romania, set up during the communist regime. The second disability system (regarding "handicap" and not related to social insurance) was initiated in 1995. For the period 1995–1999, the disability assessment and determination was regulated by Law no. 53/1992 on the special protection of persons with disabilities. A certificate was issued by the medical expertise and work capacity recovery commissions working within the medical expertise and work capacity recovery offices. These offices operated in the territorial polyclinics. The criteria used during this period were strictly medical, with the Baremas method being the dominant one.[40]

In 2000, the second disability system was created, completely independent from the invalidity system. The responsibility[41] of issuing disability certificates was given to the newly established medical commissions at the county level.[42] Once the new system was set up, the number of adults classified by degree and type of disability increased sharply at the beginning of 2000s, reaching almost half a million persons in 2006, compared with less than 25,000 in 1999. Also, in 2000, a major reform in the child protection sector was undertaken and the County Directorates for Social Assistance and Child Protection (now DGASPC) were established.

Evolution of the number of invalidity pensioners and persons with disability ("handicap") certificate in Romania, 1992–2020



Source: MMPS/ANDPDCA, multiple Statistical Bulletins.

Note: Up to 2005, data as of September 30. Starting from 2006, data as of December 31.

Between 1999 and 2002, the assessment was regulated by EGO no. 102/1999 on the special protection and employment of people with disabilities, and was characterized by a combination of the Baremas method and the functional capacity method.[43] The criteria used in the assessment process, both for children and adults, were called "criteria of anatomo-clinical diagnosis, functional diagnosis and assessment of work and self-serving capacity."[44] The assessment criteria were based on "functional impairment, therapeutic possibilities and psychosocial assessment," but in reality, the elements of the person's social context, activity limitations, were practically nonexistent in the analysis and assessment process.

40 The Baremas method consists of using reference scales, to which values or percentages are attached, to define impairment, according to the Council of Europe (2002: 13).

41 As per Order no. 66/2000 of the State Secretariat for persons with disabilities.

42 According to Order no. 102/1999 modified and completed by EGO no. 40/2000.

43 The functional capacity method is based on descriptors of the person's abilities or difficulties in relation to different body functions, according to the Council of Europe (2002: 13).

44 EGO no. 102/1999, Art. 2.

In 2002, the development of the criteria reached a turning point. The assessment of adults became the responsibility of the medical expert commissions of the Territorial Inspectorates for People with Disabilities (specialized units at the county level). The assessment criteria were revised by Order of the Ministry of Health and Family no. 726 of 1 October 2002 on the criteria for determining the degree of disability for adults and applying special protection measures for them. Although in the text of the order they were called "medico-social," their content referred strictly to the medical diagnosis and its stage or severity. At the same time, the assessment of children was undertaken by the county child protection commissions. Unlike for adults, the criteria for assessing children were first aligned with the ICF by the Joint Order of the Ministry of Health and Family and the National Authority for Child Protection and Adoption no. 725/12709 of 1 October 2002 on the criteria for determining the degree of disability of children and applying special protection measures to them. The criteria included both elements relating to the assessment of impairment of the body's functions and structures, as well as activity limitations and participation restrictions. At the same time, since 2002, once the disability classification certificates were issued, the two commissions (adults and children) were obliged to draw up an "Individual Rehabilitation and Social Integration Program" (PIRIS), which provided for the medical, educational, vocational, and social actions necessary for the recovery, rehabilitation, training, and social integration or reintegration of the person with disability.

Starting in 2006, the system was modernized to introduce the specialized comprehensive assessment services within the DGASPC. The assessment of adults with disabilities was transferred to the DGASPC and placed under the responsibility of the assessment commissions for adults with disabilities, based on Law no. 448/2006 on the protection and promotion of the rights of persons with disabilities, as subsequently amended and updated. Since 2006, this law has become the framework law in the field of disability. After 2006, in the area of disability in children, the boost generated by the translation of the ICF-CY into Romanian, the pressure from the child protection specialists and the political decisions taken at the level of the National Authority for Child Protection and Adoption led to a more accelerated introduction of bio-psycho-social criteria in the assessment. Currently, the assessment is regulated by the Joint Order of the Ministry of Health and the Ministry of Labor, Family, Social Protection and the Elderly no. 1306/1883/2016 of 17 November 2016 approving the bio-psycho-social criteria for classifying children with disabilities.

In 2007, the assessment criteria used for adults were revised and renamed "medico-psychosocial" criteria.[45] Although the intention of the Romanian legislator was to align the adult disability assessment criteria with the ICF, the result unfortunately remains a reflection of the three methods used at European level before 2001: the Baremas method, the functional capacity method, and the care needs assessment method.[46] The latter is the only element that adds value to the previous criteria from 2002. Attempts to introduce ICF-based bio-psycho-social criteria in the assessment of adults with disabilities from 2014–18 were discontinued by the Ministry of Labor, Family, Social Protection and Elderly People before completion, due to technical and administrative difficulties of the national coordinating bodies, as well as the county assessment teams, to integrate the new assessment paradigm.

However, the two disability systems have remained completely separate and use different types of assessments. A person can obtain both invalidity and disability certificates and benefits, based on distinct assessments. Statistical data and reporting have also been separated. At the end of 2020, the Statistical Bulletin reported 493,671 invalidity pensioners and 857,638 persons classified by degree and type of disability ("handicap").

45 These were included in the Joint Order of the Minister of Labor, Family and Equal Opportunities and the Minister of Public Health no. 762/1.992/2007 approving the medical-psycho-social criteria for disability determination, with subsequent amendments and additions: Order no. 982/692/2013, Order no. 707/538/2014, Order no. 131/90/2015, Order no. 874/554/2016, Order no. 1070/403/2018, Order no. 741/577/2019.

46 The care needs assessment method refers to the time periods or amount of care needed by the person with a disability, according to the Council of Europe (2002: 13).

Second, regarding the assessment of children with disabilities, this report is limited to discussing the transition from childhood to adulthood. In Romania, the legal and institutional framework for assessing disability in children (up to 18 years old) is different than that for adults. The next chapters will present only briefly how the disability assessment and determination for children is done to highlight ways in which the two systems can be better coordinated. However, most of the analysis is focused on young people aged 16–26 and their transition from the disability assessment as children to that as adults when they turn 18.

The 16–26 age bracket was chosen for the following reasons: (i) the age of 16 represents the minimum age of employment (Labor Code),[47] which is an attribute of independent living that was considered in legally setting the minimum age for the transition to adult life (Joint Order 1985/1305/5805/2016); (ii) the age of 16 is also the age at which discernment is presumed,[48] which is another aspect that was taken into account when legally establishing the minimum age for the transition to adult life; (iii) the age of 16 is also the legal age for expressing informed consent in specific medical situations regarding reproductive health (Law 95/2006 on health care reform); (iv) the age of 26, although older than the UN and World Health Organization (WHO) definitions for "young" (15–24 years),[49] is in line with Law 272/2004 on the protection and promotion of child rights, and it ensures a unitary/integrated approach between the protection system for children and that for persons with disabilities, as a young person can benefit from special protection, at their request, if they are in school through age of 26; (v) the age of 26 also takes into consideration, from a medical point of view, the prolonged adolescence (up to 25) and the delay in development and education that children with disabilities can experience, especially those with mental and psychic deficiencies.

The next sections of this chapter introduce the main regulations and institutions that shape the disability assessment and determination of adults in Romania.

1.1. Legal framework

Romania benefits from a legal framework that regulates the disability assessment system, named "classification into degree and type of handicap" within the national legislation (Chapter VI, Law no. 448/2006). In Romania, the rights of persons with disabilities are established by the Constitution (Art. 50), Law no. 448/2006 on the protection and promotion of the rights of persons with disabilities, and the Convention on the Rights of Persons with Disabilities (UNCRPD, ratified through Law no. 221/2010). The key regulations in the disability field are listed in Annex 2.

The national legislation uses different terminology than the UNCRPD. The term "disability" is enshrined in UNCRPD (Art. 1, Scope), while the Romanian Constitution (Art. 50) and Law no. 448/2006 (Art. 2, para. 1) use the term "handicap," so that in Romania, "disability" and "handicap" have the same meaning. Regarding the definition of persons with disability/handicap, the UNCRPD refers to "physical, mental, intellectual or sensory deficiencies of long duration," whereas Law no. 448/2006 refers to "physical, sensory, psychic, mental and/or associated deficiencies." The Romanian legislation refers to "protection measures in support of social integration and inclusion" (Law no. 448/ 2006) and to "special protection of persons with disabilities" (Constitution, Art. 50), while the UNCRPD refers to "the full and effective participation of people in society, on equal terms with others."

According to the national legislation, in Romania, persons with disabilities benefit from rights to (i) health protection - prevention, treatment, and recovery; (ii) professional education and training; (iii) occupation and adaptation of the workplace, professional orientation, and reconversion; (iv) social assistance, i.e., social services and social performances; (v) dwelling, arrangement of the surrounding personal environment, transport, access to the physical, informational, and communicational environment; (vi) leisure time, access to culture, sport, tourism; (vii) legal assistance; (viii) fiscal facilities; and (ix) disability assessment and reassessment by examination at home for immobilized persons, every two

47 With the written consent of the parents can be 15 years.

48 According to the Penal Code, the minor who has reached the age of 16 is criminally liable according to the law.

49 The age of 26 is also in line with the Law of Youth 350/2006, which defines young people as between 14 and 35 years old.

years.[50] The promotion and observance of the rights of persons with disabilities are mainly the duty of the local public administration authorities where the person with disabilities has his/her domicile or residence and, in the subsidiary, of the central public administration authorities, and, complementarily, of the civil society, and his/her family or legal representative. Based on the equal chances principle, the competent public authorities shall ensure the necessary financial resources and take specific measures so that persons with disabilities have direct and unlimited access to services.[51]

Access to the previously mentioned rights conferred by the law is conditioned by the existence of a disability certificate, which is the document that testifies a person is classified into a degree and type of deficiency ("handicap"). According to the law, the process of assessing the degree and type of deficiency must be governed by the eight guiding principles of the UNCRPD.[52] Currently, this is regulated as a three-stage process:

1. The first stage involves the SPAS at the community level, where the person should register and obtain a mandatory social inquiry.
2. The second stage refers to the disability assessment[53] done by the specialized services of comprehensive assessment for adults (SECPAH) from the county/Bucharest district level, based on the medico-psychosocial criteria.[54]
3. The third stage refers to the final decision regarding the degree and type of deficiency, which is the responsibility of the CEPAH at the county/Bucharest district level. The evaluation commission for adults issues the certificate of degree and type of deficiency, along with other documents, such as a vocational orientation certificate and the PIRIS, including recommended activities and services that the adult needs, as well as protection measures such as admission to residential or day centers, public or public-private; placement with a professional personal assistant; and home care services, where appropriate. The activity of the evaluation commission is methodologically coordinated by ANDPDCA,[55] through the Higher Commission for Assessing the Adults with Disabilities (CSEPAH) that carries out methodological coordination activities and monitors the assessment and classification into a degree and type of deficiency.[56]

The key institutional actors mentioned above are detailed in Section 1.2, while the process is analyzed in the following chapters of the report.

Disability certificates can be challenged[57] within 30 calendar days of being received, to the competent administrative contentious court, according to the Law of Administrative Litigation no. 554/2004 (see details in Chapter 7). The disability certificate can only be annulled based on an action filed in court. According to the law, appeals against the disability certificate should be swiftly judged.[58] The plaintiff can benefit from both extrajudicial and judicial assistance for contesting the disability certificate (including to request summons and representation in the process). In this case, public legal aid is granted, regardless of the applicant's material condition.[59] The person with disabilities has the right to a representative under the conditions of Art. 58 para. 3 that establishes the limits and duration of the representation.[60]

50 Law no. 448 of 2006, Art. 6.

51 Law no. 448 of 2006, Art. 7.

52 The eight guiding principles are (i) respect for inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons; (ii) non-discrimination; (iii) full and effective participation and inclusion in society; (iv) respect for difference and acceptance of persons with disabilities as part of human diversity and humanity; (v) equality of opportunity; (vi) accessibility; (vii) equality between men and women; and (viii) respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

53 GD no. 430/2008 on the organization and functioning of the Commission for Assessing Adults with Handicap, Annex 4 Methodology.

54 Law no. 448/2006 (Art. 85, para. 10) and Order no. 762/1.992/2007 for the approval of the medico-psychosocial criteria based on which a degree of disability is established.

55 Law no. 448/2006, Art. 87.

56 Law no. 448/2006, Art. 90, para. 1.

57 Law no. 448/2006, Art. 87, para. 5.

58 Law no. 448/2006, Art. 25, para. 2.

59 EGO no. 51/2008 on public legal aid in civil matters, Art. 8.

60 Code of Civil Procedure, Art. 80.

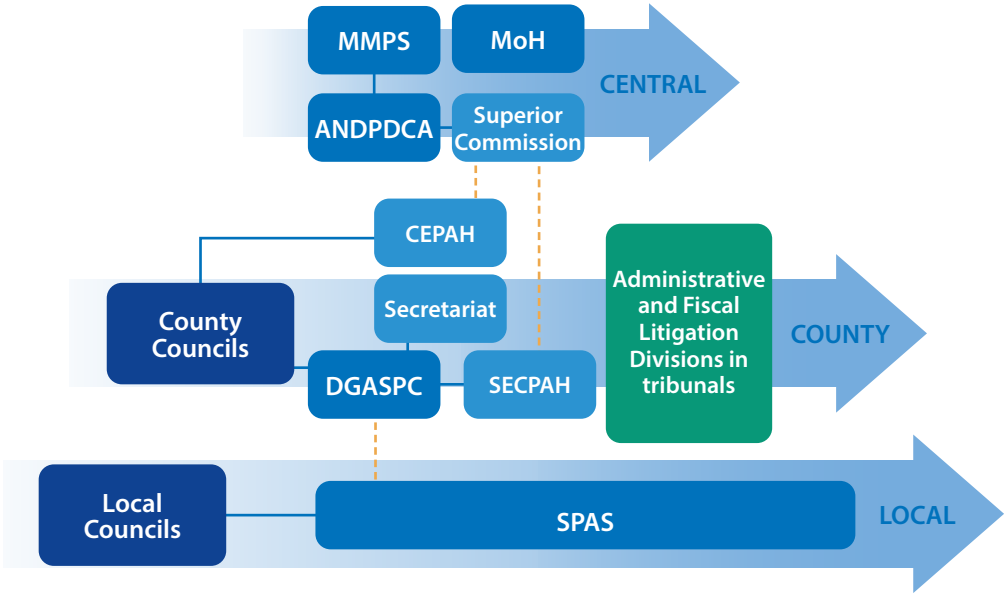
1.2. Institutional framework

This subchapter presents the governmental institutions in charge of the disability assessment for adults, while a second section brings information on NGOs for persons with disability active in Romania.

1.2.1. The Governmental Institutions in Charge with the Disability Assessment in Romania

Romania's current disability assessment system involves several institutions at different levels (see Flowchart 1). First, at the local level, social workers or social work departments are responsible for conducting a social inquiry, a mandatory step in the disability assessment process. At the county level, the SECPAH, part of the DGASPC, are responsible for checking and analyzing the file of someone applying for disability assessment; conducting the assessment; and making recommendations about the person's type and degree of deficiency, as well as on his or her PIRIS and PIS. CEPAH is the specialized body of County Councils[61] that takes the final decision regarding the type and degree of disability. The Higher Commission (CSEPAH) ensures the methodological coordination and monitoring of the disability assessment and determination. The ANDPDCA elaborates, implements, and monitors the disability assessment system. The next paragraphs present the attributions of these key institutional actors as stipulated in the current legislation.

Flowchart 1: Key institutional actors involved in Romania's disability assessment system



Source: Authors.

At the local level

SPAS: Following the current regulations, the SPAS at the community level is the main institution responsible both at the beginning and the end of the delivery chain. Thus, in compliance with GD no. 430/2008, (Art. 6, para. 6, letter a), the file for certifying the various degrees of disability is submitted by the applicant or legal representative thereof to the registering office of the municipality in the domicile/residence town or with the registering office of DGASPC. The social workers from SPAS complete the social inquiry necessary to apply for a disability certificate. Also, after a person receives the disability certificate, SPAS oversees the provision of many of the benefits and services, as well as ensuring the case management of those with an individualized plan of intervention under implementation.

61 As well as for the Local Councils for the districts of Bucharest.

At the county level

SECPAH: According to the current legal framework, SECPAH is a county-level institution in charge of the disability assessment of all adults living in that county. As per Law no. 448/2006 (Art. 88) and Law no. 292/2011 (Art. 85, para. 1), the Service for Comprehensive Assessment for Adults with Disabilities is established at the DGASPC level in each (41) county and (6) district of Bucharest. The SECPAH's role is to conduct the medico-psychosocial evaluation of adults for assignment into a deficiency degree category and determine needs related to personal care. According to GD no. 268/2007 (Art. 49), the SECPAH has the following main responsibilities: (i) conducts the comprehensive evaluation/reevaluation of adults applying for a (new) disability certificate, at their own offices or at the person's residence; (ii) drafts the comprehensive evaluation report for each evaluated person; (iii) makes a recommendation for the assignment of a person into a disability category and type (or rejects the application), and for the PIRIS; (iv) endorses the PIS of the person with a disability certificate, which is drafted by the case manager; (v) evaluates whether the necessary conditions are met for certification as a professional personal assistant, drafts the comprehensive evaluation report, and makes recommendations to the CEPAH; and (vi) recommends protection measures for the person with a disability certificate, according to the law.

CEPAH: Current regulations establish CEPAH as the body responsible for determining both disability and the benefit-service package for persons with disabilities in a county/Bucharest district. CEPAH is organized and operates as per the provisions of Art. 85 of Law no. 448/2006, as a specialized body with no legal personality, attached to the County and Local Council of each district of Bucharest. Thus, the CEPAH assigns adults a deficiency degree category, as well as promotes the rights of persons with disabilities. CEPAH's key responsibilities include:[62] (i) assigning adults to deficiency degree categories and the certificate's period of validity, as applicable; the date of disability onset; establishing the professional orientation of adults with disabilities, based on the comprehensive assessment report prepared by SECPAH; (ii) establishing the measures for protecting adults with disabilities, as provided by law; (iii) repealing or replacing the protection measure established, subject to law, if the circumstances under which the measure was decided have changed; (iv) releasing professional personal assistant certificates; (v) informing the person with disabilities or their legal representative about the protection measures established and obligations incumbent upon them; and (vi) promoting the rights of persons with disabilities in all their activities.

DGASPC: Within the national Framework Procedure for the Assessment of Adult Persons, Order no. 2298/2012, Art. 1(2), at the county level, the DGASPC is responsible for "drafting its own detailed internal procedures for the activity of assessing adults in order to establish their level and type of disability." The research underlying this report focused on the various operating models and practices developed and used at the county level to assess adults for their degree and type of disability, as well as to ensure the transition from childhood to adulthood targeting young persons aged 16–26.

DGASPC also appoints a secretariat for CEPAH that has the following main responsibilities: (i) receives and registers the files of adults evaluated by the SECPAH; (ii) prepares and participates in CEPAH meetings, with no role in the decision; (iii) draws up minutes and keeps records of CEPAH meetings; (iv) drafts the certificates that classify the degree/type of disability and certificates of professional orientation, within a maximum of three working days from the date the CEPAH meeting took place; (v) manages the registry of appeals; (vi) notifies applicants of the results and sends the disability certificate, with all the other documents approved by the CEPAH (certificate of professional orientation, individual rehabilitation, and social integration program—PIRIS, PIS, etc.); and (vii) fulfills any other attributions established, under the conditions provided by law, by the head of DGASPC.[63]

At the national level

MMPS: The Ministry of Labor and Social Protection fulfills the following specific duties in the field of protection of persons with disabilities: (i) initiates and approves the drafts of normative acts; (ii) monitors and evaluates the implementation of policies and strategies; and (iii) accredits the social services.[64]

62 Law no. 448/2006, Art. 87, para.1.

63 GD no. 430/2008, Art. 15.

64 GD no. 81/2020 on the organization and functioning of the Ministry of Labor and Social Protection.

MoH: The Ministry of Health, through its specialties commissions, plays a major role in establishing and modifying the disability assessment criteria. Additionally, the MoH is responsible for many national health programs of critical importance for the well-being of people with disabilities.

ANDPDCA: The National Authority for the Rights of Persons with Disabilities, Children and Adoption was established in 2019 (EGO no. 68/2019) by incorporating the National Authority for Persons with Disabilities and the National Authority for the Protection of Children Rights and Adoption, which were disbanded. Thus, ANDPDCA has undertaken the duties of the former National Authority for Persons with Disabilities, which, among other responsibilities: (i) elaborates, implements, and monitors the disability assessment system; and (ii) elaborates methodologies, norms and working procedures, and evaluation and monitoring tools necessary for the disability system's organization and functioning.

CSEPAH: As part of the ANDPDCA, the Higher Commission for Assessing Adults with Disabilities was initially set up (through Order no. 1261/2016) as the national body responsible for resolving grievance and appeal cases. Although Order no. 1261/2016 has not been revised, the provisions governing the grievances and redress mechanism have been amended as per EGO no. 51/2017, according to which the complaints against the disability certificate should be filed with the courts that handle administrative disputes. Consequently, the role of the CSEPAH as part of the grievance and redress mechanism has been canceled. Currently, ANDPDCA Order no. 136/2020 specifies that the CSEPAH ensures the methodological coordination and monitors the evaluation and classification by degree/type of deficiency, at the national level, and it fulfills the duties provided by Law no. 448/2006 on the protection and promotion of the rights of persons with disabilities.

1.2.2. The NGOs for People with Disabilities in Romania

In Romania, the establishment and functioning of NGOs are regulated by Ordinance no. 26/2000 on associations and foundations. NGOs are associative bodies created voluntarily by natural or legal persons, with the role of promoting civic values, democracy, and the rule of law. Three types of NGO are recognized, namely associations, foundations, and federations.

The movement of people with disabilities in Romania includes organizations that represent people with specific types of disability (physical, visual, auditory, intellectual, rare disease, chronic disease, HIV/AIDS, etc.), organizations coordinated by parents of people with disabilities, and organizations that provide social or rehabilitation services to people with disabilities. The main role of these organizations is to promote and protect the rights of people with disabilities and remove obstacles to accessing education, health, the labor market, and social participation.

Among the nationally representative NGOs for people with disabilities are the Federation of the National Council of Disability in Romania (CNDR), the Coalition of Patient Organizations with Chronic Diseases in Romania (COPAC), the National Union of Organizations of People Living with HIV/AIDS (UNOPA), the Federation of the National Organization of Persons with Disabilities in Romania (ONPHR), the Foundation Motivation Romania, the Federation of Nongovernmental Organizations for Social Services (FONSS), the Dizabnet Federation, and the "Alături de Voi" Romania Foundation (ADV). More details about NGOs for people with disabilities are provided in Annex 3. Some of the largest NGOs for persons with disabilities receive financial support from the state budget through ANDPDCA.[65]

NGOs play an active role in disability assessment. According to Art. 85 of Law no. 448/2006, any CEPAH must include as a member an NGO representative appointed by the County and Local Council of each Bucharest district, respectively.

65 These include the Association of the Blind in Romania, the National Association of the Deaf in Romania, the Romanian Association of the Blind War Invalids, the National League of Organizations with Persons with Disabilities from the Craft Cooperative, and the Romanian National Disability Council. (ANDPDCA Order no. 136, Section 13, para. 6).

1.3. People with disabilities in Romania: National statistics

According to the Ministry of Labor and Social Protection (MMPS), in Romania there were 857,638 people with a valid disability certificate on December 31, 2020, representing 3.87 percent of Romania's stable population. However, not all adults with a health condition mentioned in the disability criteria apply for a certificate or they abandon the process along the way. Regarding those who do not apply or abandon the process, the representatives of SPAS, SECPAH, and CEPAH provided estimates in the institutional studies conducted for this report. According to these estimates, the "real" share of people who could apply for a disability certificate would have been higher than the officially reported rate; that is, 4.7 percent of the total population, at 2020 levels. Finally, a third estimate of the rate of people with disabilities is provided by Eurostat, based on internationally comparable statistics. Eurostat uses a different definition of disability, namely the rate of people (aged 16 and over) with self-reported severe limitations in normal activities due to health problems. According to this definition, Romania registers a rate of disabilities even higher than the official rate of 3.87 percent persons with certificate or 4.7 percent persons with impaired health (with or without certificate), namely 6.1 percent of the total population (Figure 2b). So, information at national level on the population of people with disabilities is marked by discrepancies caused mainly by system fragmentation in "invalidity" and "handicap," as we showed at the beginning of the chapter, as well as the dysfunctions of the current system. The discrepancies and incompleteness of the data are accompanied by the absence of a system that allows either a census of people with disabilities in the country (invalidity and handicap) or real-time data on benefits and assistance they received in a reference period. As accurate information is crucial for policy making, planning, budgeting, and monitoring of policy implementation, the effectiveness of the system cannot currently be rigorously assessed.

In the European context, Romania has a lower share of people with disabilities (who self-declare severe limitations in their regular activities) lower than the EU-28 average (6.1 percent of the total population compared to 7.3 percent), and much lower than countries such as Estonia, Croatia, Greece, Austria, Belgium, France, Montenegro or Slovakia (with rates of 9 percent or higher), as shown in Figure 2a.[66]

Based on the MMPS/ANDPDCA statistics, the number of people with disabilities is steadily increasing over time, rising from half a million in 2006 to 857,638 people in 2020, children and adults (Figure 2b and Box 1). Most of these people are women (over 53 percent) over the age of 50 (approximately 66 percent of the total),[67] as can be seen in Figure 2c. In fact, the share of women increases monotonously with age, from under 40 percent in the age group 5-14 years, to almost 58 percent of people aged 70–79 years, respectively 68 percent of those aged 80 and over. In terms of the type of deficiency, as illustrated in Figure 2d, the majority of adults with disabilities have a physical (27 percent), somatic (19 percent), or mental type (16 percent) of deficiency. The other types of disability include associated handicap (13 percent), visual (11 percent), psychic (10 percent), auditory (3 percent) and HIV/AIDS (1 percent). Finally, in terms of the deficiency degree, most adults with disabilities have a marked (51.4 percent) or severe handicap (38.3 percent), while an medium degree has 9.3 percent and a minor degree have only 1 percent of the total.[68]

A vast majority of people with disabilities live with families or on their own, while only 2 percent are institutionalized in public centers managed by MMPS/ANDPDCA. The disability rates differ significantly across regions, ranging from 8.2 percent in Mehedinți, 6.9 percent in Vâlcea or 6.2 in Olt, while 2.8 percent in Covasna and 2.5 percent in Dolj. Maps 2 and 3 illustrate the existing discrepancies between counties regarding the number and rate of people with disabilities. The significant difference across regions suggests a significant variation in the assessment processes.

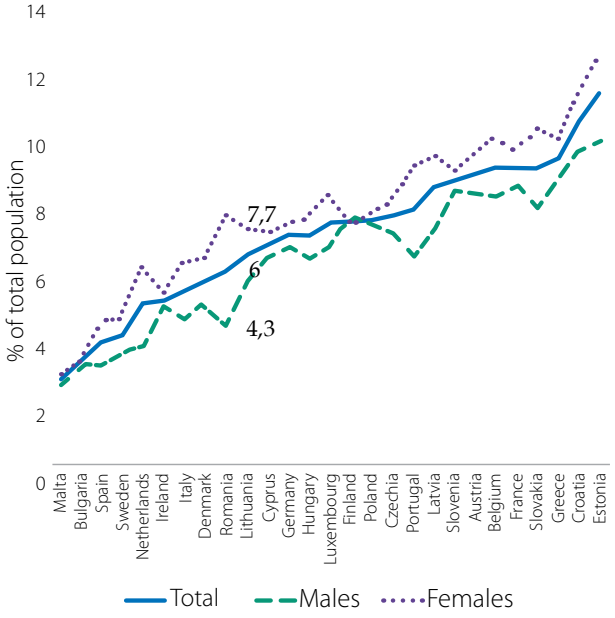
66 Eurostat date for 2019. The 2020 data are not available for some countries, including Romania.

67 Close to half of the persons with disabilities (47 percent) are elderly (older than 65) while 8.5 percent are children.

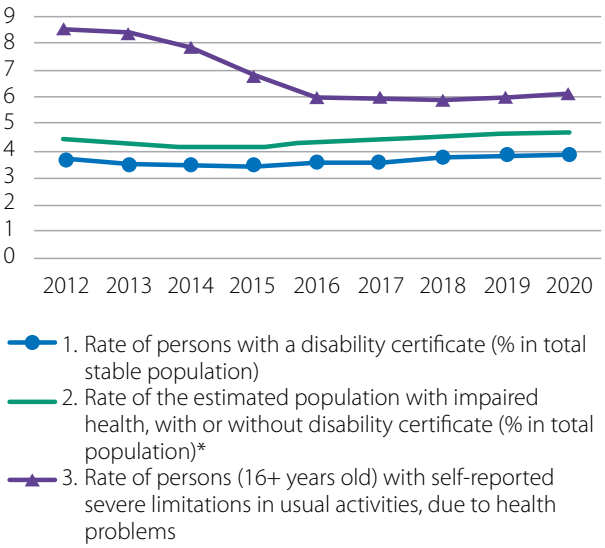
68 By contrast, the distribution of children with disabilities by deficiency degree is the following: severe – 59 percent, marked – 14 percent, medium – 25 percent, and minor – 2 percent.

Figure 2: Disability statistics from Eurostat and the Ministry of Labor and Social Protection

a. Rate of persons (16+ years old) with self-reported severe limitations in usual activities, due to health problems, by gender, 2019

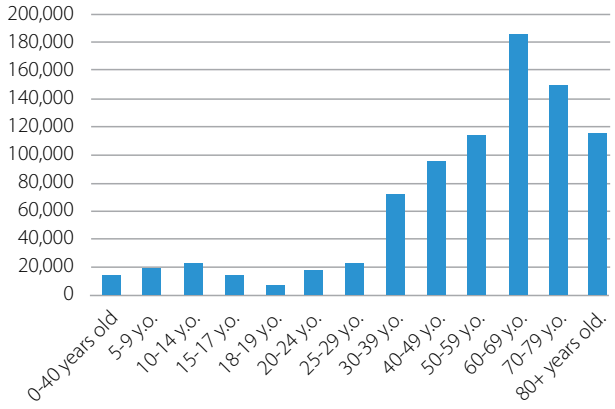


b. Evolution of the rates of persons with disabilities in Romania (%)

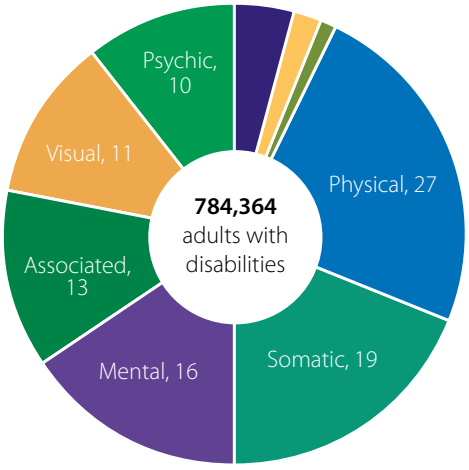


Sources: a. Eurostat [HLTH_SILC_07]; b1. MMPS/ANDPDCA, Statistical Bulletin (2021); b2. Consolidated data from the SPAS survey and the opinion surveys Q2B_SECPAH and Q3B_CEPAH; b3. Eurostat [HLTH_SILC_07].

c. Distribution of persons with a disability certificate by age groups, in Romania (number)

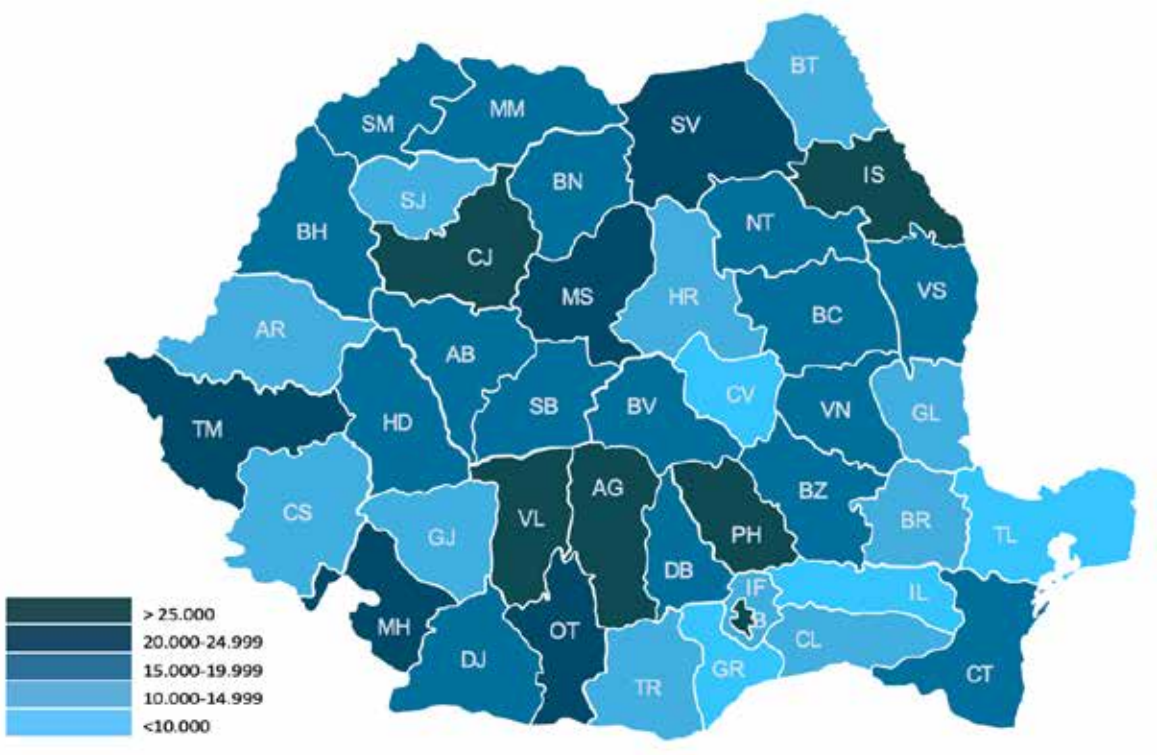


d. Distribution of adults with a disability certificate by deficiency type, in Romania (%)



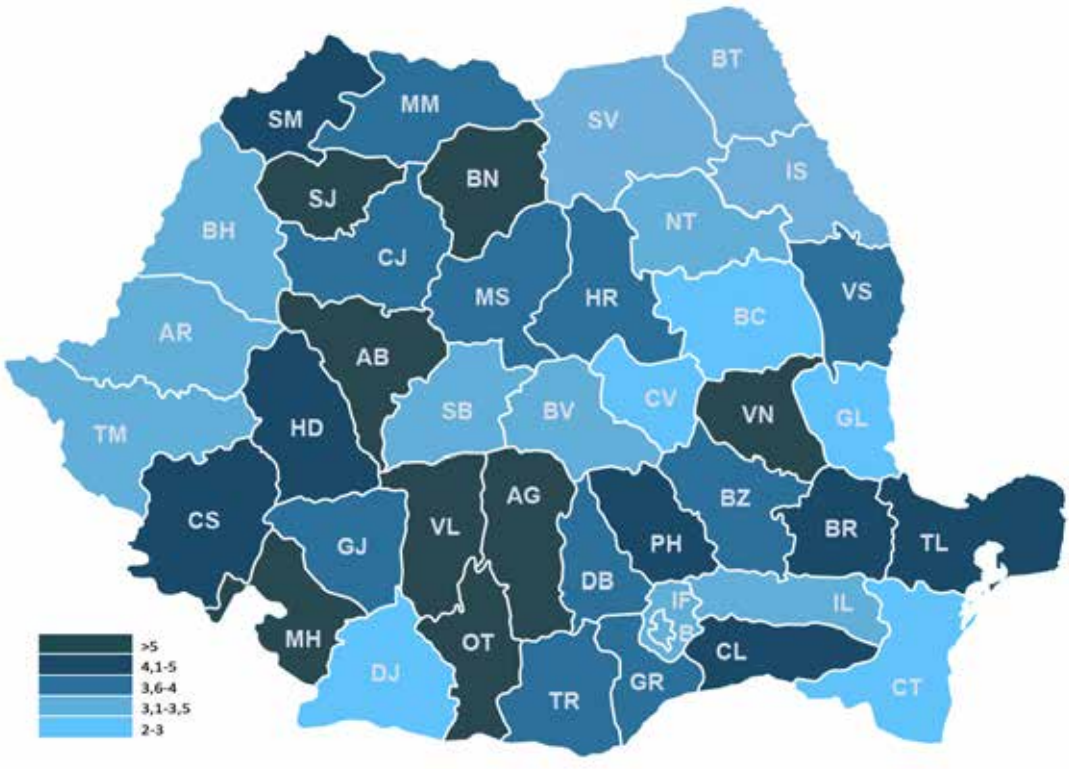
Source: MMPS/ANDPDCA, Statistical Bulletin for December 31, 2020.

Map 2: Discrepancies between counties regarding number of adults with disabilities registered in the county



Source: MMPS/ANDPDCA, Statistical Bulletin for December 31, 2019.

Map 3: Discrepancies between counties regarding the proportion of total persons with disabilities in total population of the county (%)



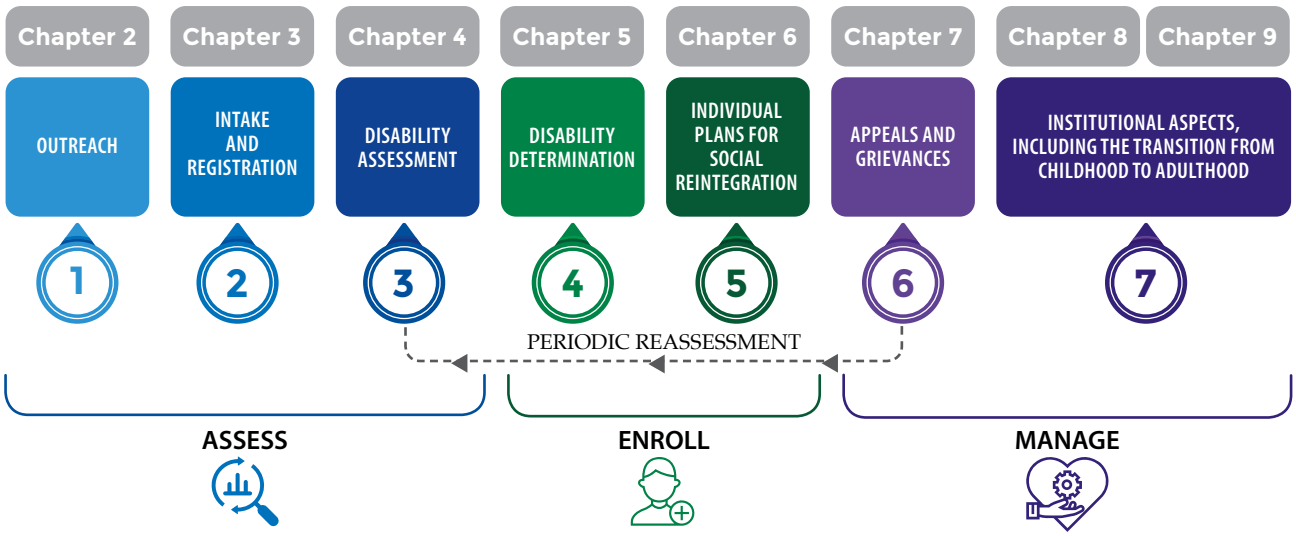
Source: MMPS/ANDPDCA, Statistical Bulletin for December 31, 2019.

1.4. Analytical framework: Overview of Romania's disability assessment system

The disability assessment system is approached in this report using the framework of social protection delivery systems as defined in the *Sourcebook on the Foundations of the Social Protection Delivery Systems*.[69] Therefore, the framework of analysis is anchored in the core implementation phases along the delivery chain, which includes (1) outreach, (2) intake and registration, (3) disability assessment, (4) disability determination, (5) individual plans of intervention (determination of benefits and service package), and persons with disabilities' access to the benefit-service package associated with the disability certificate in Romania, as well as (6) beneficiary operations management including their compliance, data updates, grievances, and exits from the system. In this report, the general analytical framework is adapted, the assessment and determination refer to the degree and type of deficiency, and the benefits and services are those for people with disabilities, as shown in Flowchart 2. In addition, the actual provision of benefits and services is only marginally treated.[70]

In terms of concepts, we distinguish between disability assessment, disability determination, and disability eligibility, as defined in Bickenbach et al. (2015): "disability assessment is the process of making an authoritative determination about the kind and extent of disability a person has, as part of a larger administrative process usually called disability evaluation or disability determination" while "disability evaluation, which includes disability assessment as a component, determines the eligibility of an individual claimant for some social benefit, service, or protection."[71]

Flowchart 2: Core implementation phases of disability assessment in Romania



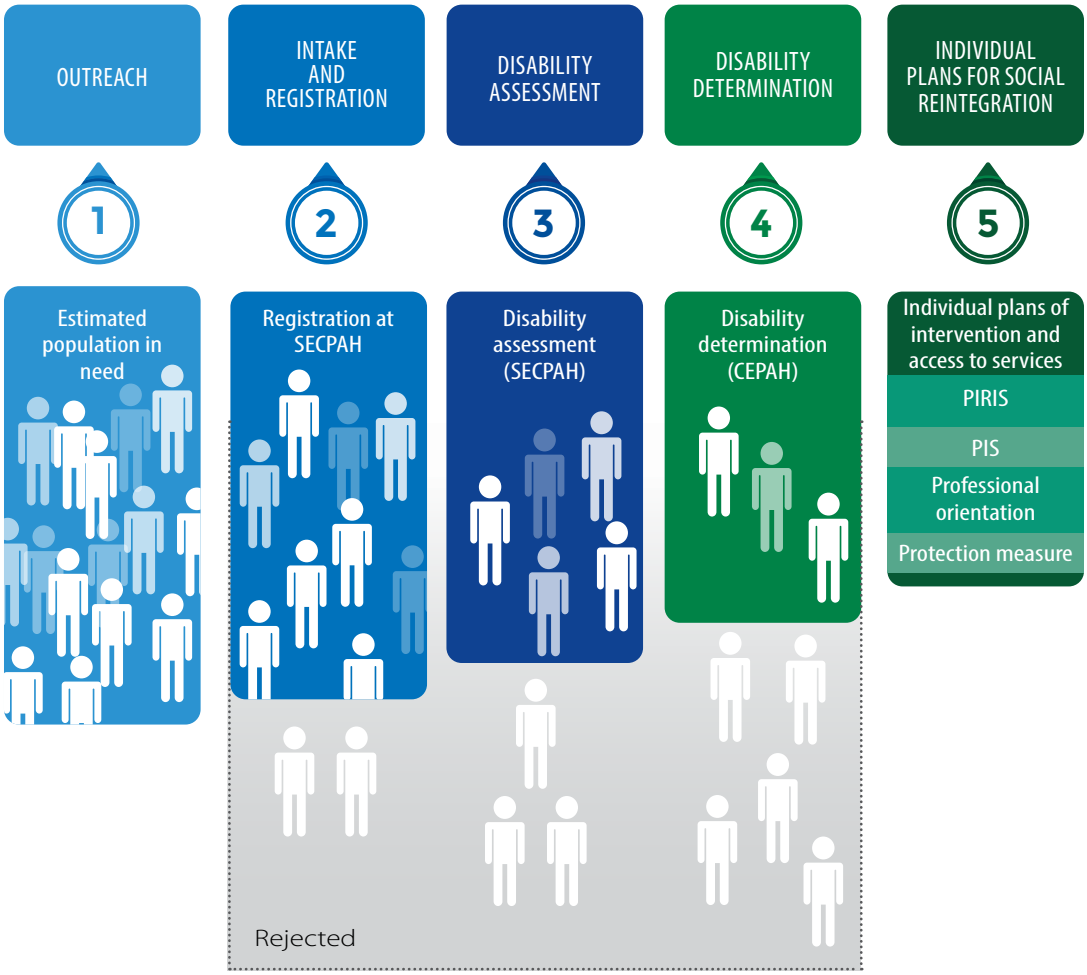
Source: Adapted to the Romanian context after Lindert et al. (eds.) World Bank (2020: 11).

69 Lindert et al. (eds.), World Bank (2020).

70 For such an analysis, see Grigoraș et al. (coord.), World Bank (2020: 128).

71 Bickenbach et al. (2015).

Infographic 2: Overall statistics on the reference population groups corresponding to the Romanian's disability assessment system, by core implementation phase, for November 2020



	Estimated population in need	Registration at SECPAH	Disability assessment (SECPAH)	Disability determination (CEPAH)	Individual plans of intervention and access to services
Admitted	5418	4265	4497	4082	PIRIS = 3581
Rejected		-97	-377	-374	PIS = 1183
					Professional orientation = 44
					Protection measure = 33

Source: Data for November 2020 regarding 10 counties that reported the necessary data. The estimated population in need represents the sum between the current population of people with disabilities and the number of adults who could apply for a degree of disability due to a deficient state of health, but either did not apply or did not get the certificate, as estimated by social workers from SPAS (in Q1), specialists of SECPAH/SECC (in Q2B), members of CEPAH/CPC (in Q3B), and representatives of NGOs (in interviews).

Within the delivery chain, the outputs of any implementation phase are inputs in the next, and changes in any stage may trigger changes in the others. Therefore, in tracing the delivery chain of the disability assessment system in Romania, the chapters of this report are devoted to individual phases of the delivery chain, namely the core implementation phases, as shown in Flowchart 2. However, within each chapter, the more detailed levels and aspects of implementation are described and analyzed, including the linkages with other stages. Also, the opinions and beliefs of the various stakeholders are presented.

Although the disability assessment system's legal and institutional framework is defined at the national level, the DGASPCs have developed and used at the county level a variety of operating models that reflect local conditions, resources, and decisions of the County Councils. Thus, for each implementation phase, the report presents the various operating models from the county level.

Throughout the delivery chain, the reference population groups change as the operational status of a person with disabilities changes between core implementation phases. The outreach phase targets the intended population, which in Romania refers to children and adults "whose social environment, un-adapted to their physical, sensory, mental, mental, or associated deficiencies, totally impedes or limits their equal access to society, needing protection measures in support of integration and social inclusion."[72] During the phases of intake and registration, disability assessment, and disability determination, the reference group refers to applicants for a disability certificate. Once the certificate is obtained, the reference group changes to persons with disabilities (in Romania, persons classified by degree and type of disability), while it refers to beneficiaries once the benefits and services are provided. Thus, the reference population groups change from intended population to applicants, persons with disabilities (with a disability certificate), and beneficiaries. Infographic 2 shows the dynamic statistics corresponding to the disability assessment system, in terms of the number of persons included in the reference population groups, in 14 counties that provided the full set of data for November 2020.

Key actors interact along the delivery chain, including people and the institutions presented in the previous section (central and local). Those interactions are facilitated by communications, information systems, and technology, among other factors. Correspondingly, each chapter addresses these enabling factors to understand the changes that should be made to facilitate the paradigm shift from a medical to a holistic approach.

In Romania, the disability assessment represents a single-program system that is on-demand (meaning the process is initiated by individuals) and allows dynamic inclusion (people can apply, ask for assistance, or update their information at any time). The existence of the parallel system of invalidity as well as the separate system for children shows that the disability system is characterized by marked fragmentation. The existence of many other program-specific delivery systems for most of the benefit-service packages attached to the disability certificate (for example, most of the health-related ones) deepen the fragmentation. It is costly and inefficient for people to navigate each program separately, provide the same information and documentation over and over, and wait in long lines at different offices. It is also inefficient for administrators, because it can result in duplications or gaps in coverage, overlapping processes, and wasted resources, making it difficult to keep track of which clients have received which services or how social protection money for persons with disabilities is spent. The integration of all disability-related systems in Romania is out of the scope of this report and these advisory services. Nonetheless, it remains a factor that must be considered when designing the new set of instruments, methodologies, and procedures.

1.5. Analytical lens: The ICF/UNCRPD

The ICF: functioning and disability

The International Classification of Functioning, Disability and Health (ICF) has a variety of applications in clinical care, health information systems, health care management, finance, and research. In all these contexts, the use of ICF requires intermediate instruments: checklists, clinical assessment tests, questionnaires, standard data sets, e-health templates, and so on. ICF classifies dimensions of functioning and serves as a conceptual framework for describing, assessing, and measuring functioning and related problems - that is, disability.

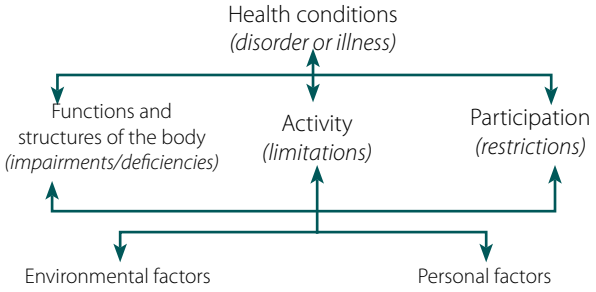
The ICF is comprised of separate classifications of Body Functions and Structures, Activities and Participation, and Environmental Factors (Box 2). Each classification has categories arranged in a standard genus-species format. In addition, the ICF presents a conceptualization of functioning as the experience of living with a health condition in one's daily environment. For each category of functioning, the level of functioning a person

72 Law no. 448/2006, Art. 2, provisions of which benefit Romanian citizens, citizens of other states or who are stateless, during the period in which they have, according to the laws, domicile or residence in Romania.

experiences is the outcome of the interaction between the health problem and the person's physical, interpersonal, attitudinal, social, cultural, and political environment.

The ICF is based on an interactive person and environment model called the biopsychosocial model. ICF does not only refer to disabled persons; in fact, **ICF refers to everyone**. It tells us that functioning and disability are not only clearly delineated categories in which to integrate individuals, but are the extreme limits of a continuum on which we all exist. Each domain of functioning, at the body, person, or social level, is a continuum ranging from full functioning to no functioning. Disability is understood to be at the end of this continuum that represents some degree of limitation.

In the biopsychosocial integrative model:



- **Functioning** is a general term for body functions and structures, activities, and participation.
- **Disability** is a general term for impairments/deficiencies of body functions and structures, activity limitations, or participation restrictions.

The graphic illustration of the model shows that functioning and disability are the result of the interaction between the health condition and personal and environmental factors.

In other words, the ICF understands the phenomena of functioning and disability to be determined both by a person's intrinsic health *capacity* to perform an action and *performance* of an action in his/her full environmental context. Assessing disability, therefore, requires an assessment of both the person's health-related capacity and their environment, which together determine their level of performance; that is, the degree of disability they experience.

BOX 2

ICF, ICD-10 and WHODAS 2.0 as WHO key instruments for modern disability assessment

ICF is the WHO framework for measuring health and disability at both individual and population levels. ICF was officially endorsed by all 191 WHO Member States in the 54th World Health Assembly on May 22, 2001 (resolution WHA 54.21) as the international standard to describe and measure health and disability.

The ICF classifies domains of functioning and contextual factors. ICF and ICD-10 are WHO international classifications, and are complementary. ICD-10 provides a "diagnosis" of disease, disorder, injury, or other health condition, while ICF provides an international reference language for the lived experience of these health conditions, considering environmental and personal factors. WHODAS 2.0 is a generic assessment instrument for health and disability, directly linked to ICF concepts. The tool is used across all diseases, including mental, neurological, and addictive disorders. It is short, simple, and easy to administer, applicable in both clinical and general population settings.

From the ICF perspective, two people with the same disease may have different levels of functioning, just as two people with the same level of functioning may have different diseases. Because of this, the use of both classifications in conjunction with WHODAS 2.0 assessment instruments increases the quality of data used for medical, rehabilitative, and social purposes. With the help of ICF, the full experience of living with a health condition, both as a matter of intrinsic capacity and actual performance, can be described in internationally comparable language.

The ICF uses the following dimensions and key principles:

Functioning is a general term for body functions and structures, activities, and participation.

Body functions are the physiological functions of the body's systems, including psychological functions. For example: functions of consciousness, temperament and personality, functions of attention, memory, thinking, sensory functions, functions of speech, functions of the cardiovascular system, functions of the respiratory system, and functions of mobility.

Body structures are the anatomical parts of the body, such as their organs, limbs, and components. For example: brain structure, spinal cord, eye, ear, cardiovascular system structures, respiratory system structures, head, neck region, shoulder region, skin areas, nails, and hair.

Impairments are problems with body functions or structures, such as a significant deviation or loss. For example: accelerated heartbeat (tachycardia) is an impairment of heart function; myopia is an impairment of vision functions; an amputated leg is an impairment of the structure of the lower limb; a fracture is a damage to the bones (as a structure), and so on.

Activities are the execution of a task or action by an individual.

Participation is involvement in a life situation. Examples include learning to read, making decisions, completing a task, coping with stress, communicating, handling objects, walking, dressing, eating, doing household chores, maintaining interpersonal relationships, and participating in education, employment, and recreation and leisure.

Activity limitations are difficulties that an individual has performing activities.

Participation restrictions are problems that an individual faces when engaging in life situations. Examples of activity limitations and participation restrictions include not being able to walk (in need of a wheelchair), not being able to manage stress effectively, not being able to have a normal conversation, not being able to go to school at school age, and not having a job.

Environmental factors make up the physical, human-built, social and attitudinal environment in which people live and act. For example: mobility products and technologies (such as wheelchairs), communication technologies, building design and construction, financial goods, air quality, family, knowledge, other people's attitudes, construction architecture, and the social assistance system.

Personal factors (not included in the ICF) are the individual's characteristics that are not part of his health. For example: age, sex, education, social status, life experiences, and habits.

Factors in a person's environment that, through their absence or presence, improve functioning and reduce disability; these are considered facilitators. Factors that limit functioning and create disability are barriers. For example: for a wheelchair user, the steps at the entrance to a building are a barrier, while a ramp with the correct inclination is a facilitator.

ICF provides a scientific basis for understanding health and functioning. People with the same health condition may have different functioning; therefore, to see how they live with that health condition, it is necessary to consider all the components mentioned above.

Source: https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health

What is disability assessment?

A disability assessment is a summary measure of a person's performance of an adequately representative set of behaviors and actions, simple to complex, in their actual environment, in light of the person's state of health.

As the administrative act of establishing eligibility for services and supports, disability is assessed as the *overall experience of an individual living with one or more health problems* - or, in ICF terms, the level of a person's performance in light of their intrinsic health capacity and environmental facilitators or barriers. Disability assessment is a "whole person" or global assessment of the extent or level of person's disability. This is important because a disability assessment should be a summary measure of functioning levels across domains of actions, simple and complex, from walking, taking care of children, to working a job. A disability assessment considers the overall level of disability that a person experiences in his or her life. A summary or global assessment of disability, necessarily, must be based on both the individual's state of health and on specific assessments of specific activities. Yet a summary assessment of disability

is only valid if the specific assessments can be statistically summarized into a single assessment score.

Disability assessment and disability determination

Across the globe there are many approaches to establishing eligibility for health and social services and supports for individuals who, because of underlying health problems and impairments, experience some level of disability. This administrative process goes by various names in different countries. As a general matter, however, what is most often termed "disability evaluation" or "disability determination" is an authoritative, legally sanctioned, administrative process—which may involve several steps and official actors—that provides some form of support, service, or assistance to individuals on the basis of eligibility criteria and a disability assessment procedure that identifies the kind, degree, or level of disability a person experiences. The overall process of disability determination may employ a variety of other preconditions of eligibility—income level, geographical location, legal status, employment status, age, and so on—in addition to disability assessment. In some countries, disability determination and disability assessment are simultaneous administrative acts; in others, they are separated by additional administrative steps and official determinations.

Why the ICF is the best platform for disability assessment

The ICF is the only international standard reference language for functioning and disability that is available. Aligning assessment instrumentation with ICF terminology and classification is a precondition for scientific and administrative legitimacy as a model of collecting of health and functioning information.

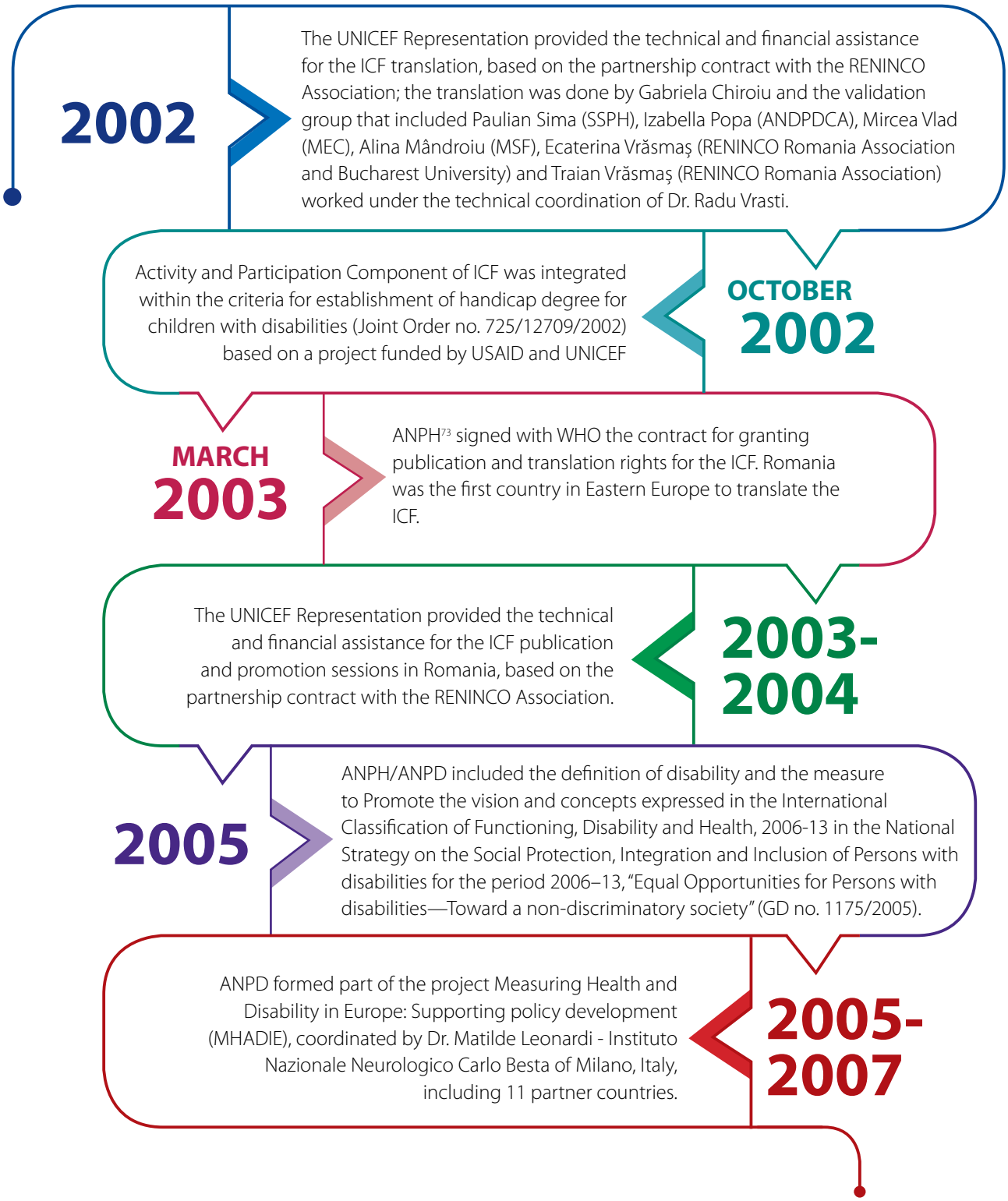
More significantly, an intuitively obvious precondition for any scheme of disability assessment is that it assesses disability, and not something else. The ICF is the international scientific model of functioning and disability - it not only represents the international scientific consensus on the concept of disability, but provides the means for operationalizing disability for measurement purposes. Only in ICF terms is it scientifically possible to produce an evidence-based, "whole person" summary assessment of someone's experience of disability. Moreover, the ICF model represents the international human rights, legal and ethical consensus on disability, as shown by the UNCRPD, which characterizes disability as the experience of individuals "who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

Disability assessment must be a valid and reliable assessment of the phenomenon of disability, and the only prospect for achieving this is a regime of disability assessment in which the assessment instrumentation, threshold criteria, and procedures are aligned with the ICF conceptualization of functioning and disability.

The human rights dimension

As mentioned, the ICF conceptualization of disability is represented in the UNCRPD as a human right, a legal and moral principle. But the human rights dimension of disability assessment extends beyond this. Many rights listed in the UNCRPD are also relevant to disability assessment: the procedure, criteria, and means of assessment must be publicly available and transparent; the process must not be unnecessarily onerous or insult the individual's dignity; the process must be physically and informationally accessible to everyone; and, in general, the process must not discriminate against persons with disabilities or violate their human rights.

Infographic 3: Overview of activities regarding the ICF implementation in Romania



73 At that moment, ANPD was called the National Authority for Persons with Handicap (ANPH).

2010

Romania ratified the UNCRPD by Law no. 221/2010, which requires the analysis and revision of the social policies and practices so that persons with disabilities can fully and equally exercise all fundamental rights and freedoms and live-in dignity.

2011-2012

ANPD translated and published the International Classification of Functioning, Disabilities and Health - version for children and young persons (ICF-CY), with the support of the UNICEF Representation in Romania, as a result of the initiative and collaboration between Ministry of Labor, Family, Social Protection and the Elderly and the RENINCO Romania Association; the translation was done by Gabriela Chiroiu and the work group to validate the translation included the following people, mentioned alphabetically: Mirela Chiru (Ministry of Health), Adina Codres (MMFPSPV-DPC),[74] Adrian Cozma (ISMB and MECTS),[75] Gabriela Dobre (MMFPSPV-DPPH),[76] Livius Manea (Bucharest University), Dana Petcovici (UNICEF), Izabella Popa (MMFPSPV-DPC), Voichita Pop (UNICEF), Paulian Sima (MMFPSPV-DPPH), Aurora Sima (Ministry of Health), Andreea Sorescu (The 'Învingem autismul' Association), Monica Stanciu (independent expert), Ecaterina Vrasmas, (RENINCO Romania Association and Bucharest University), Traian Vrasmas (RENINCO Romania Association and „Ovidius" University in Constanta).

2012

Activity and Participation Component of ICF-CY was integrated within the criteria for establishment of handicap degree for children with disabilities (modification of Joint Order no. 725/12709/2002) based on SECC experience.

2016

ANPD included concepts from ICF in the National Strategy "A Society Without Barriers for Persons with Disabilities" 2016-20, approved by GD no. 655/2016.

DECEMBER 2016

Environmental factors Component of ICF-CY was integrated within biopsychosocial criteria for establishment of handicap degree for children with disabilities (Joint Order no. 1306/1883/2016) and within the methodology of assessment and intervention (Joint Order no. 1985/1305/5805/2016) based on a project funded by UNICEF.

APRIL 2017

Training sessions for SECC. CPC and representatives from education system, including a module on ICF-CY, funded by UNICEF.

74 Former name of the Department for Child Protection (currently under ANDPDCA) within the Ministry of Labor, Family, Social Protection, and the Elderly (currently MMPS).

75 Inspectorate for Education of the Bucharest Municipality (ISMB) under the Ministry of Education, Research, Youth, and Sport (currently Ministry of Education).

76 Former name of the Department for the Protection of Persons with Disabilities (currently under ANDPDCA) within the Ministry of Labor, Family, Social Protection, and the Elderly (currently MMPS).

1.6. Romania in the world community: Disability assessment

Although there is little academic or governmental research comparing disability policy or assessment across countries, it is fair to say that there are a significant variety of approaches to the disability assessment process, criteria, and instrumentation. Disability policy is generally shaped by historical, cultural, and even linguistic factors, and tends to be ad hoc and reactive to specific crises or shocks. It is highly fluid and dependent on economic forces, especially in the labor market. Countries in the same region of the globe may model their policies on close neighbors. Still, countries that are formally part of the Commonwealth, colonial groups, or other affiliations share approaches even if they are not in the same region. Fieldwork at the WHO[77] and World Bank suggests there are roughly three broad approaches to disability assessment around the world, as described below:

Approach	Key features of the disability assessment	Examples of countries
(1) The advanced modern disability systems	Multistage disability assessment procedures with instrumentation based on the ICF conceptualization of disability that fully considers information on medical condition, extensive documentation of socio-demographic and environmental audits of home, neighborhood, community, and other dimensions.	Taiwan, South Korea, Japan, France, England, Canada, Nordic countries
(2) Countries in transition	Countries in this group are either completing or in the process of reforming disability assessment (and often disability policy more broadly) away from a purely medical and discretionary approach to one that augments medical Baremic instruments with information about the applicants' activities of daily living and instrumental activities of daily living (*) or, increasingly, functioning status in general.	Romania, Latvia, Lithuania, Czech Republic, Slovenia, Bulgaria, South Africa, most Latin American countries
(3) Medical-based assessments	The disability assessment relies on a decision by a medical professional, based on clinical judgment alone, with or without a template or Baremic medical expertise table.	Greece, Saudi Arabia, Russia, Turkey, Azerbaijan, nearly all African countries

Source: Authors.

Notes: (*) ADLs - activities of daily living are basic self-care tasks. The six basic ADLs are eating, bathing, dressing, toileting, mobility, and grooming. IADLs - instrumental activities of daily living include managing finances, handling transportation, shopping, preparing meals, using the telephone or other communication devices, managing medications, laundry, housework, and basic home maintenance. Together, these skills represent what someone needs to successfully and independently live on their own.

(1) The advanced modern disability systems

Many high-resource countries have developed advanced modern disability systems based on ICF principles. High-resource countries such as Taiwan, South Korea, Japan, France, England, Canada, and the Nordic countries have created complex, multistage disability assessment procedures with instrumentation based on the ICF conceptualization of disability that fully record information on medical condition and history, impairments of body function and structure, the performance of activities of daily living and instrumental activities of daily living, documentation of major life areas such as education, work, and community life, extensive documentation of socio-demographic and environmental audits of home, neighborhood, and community, as well as other dimensions. Instrumentation includes either standardized international tools or ICF-based tools that have been thoroughly tested and have good psychometric properties.

The Taiwanese system is one of the most sophisticated and scientifically sound in the world, and its critical steps are presented in Box 3. The other countries in the first group have similarly complex, multi-instrument processes that incorporate medical, rehabilitative, socio-demographic, and home/neighborhood/community environmental information to supplement a broad-based functioning assessment. Needs assessments are

77 For example, https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health

uniformly employed for service matching. All countries in this group, significantly, are not only well-resourced, but they all have a wide range of health, social, and vocational supports and services available to persons with disabilities.

BOX 3

Taiwan's disability assessment

Taiwan has one of the most sophisticated and scientifically sound disability assessment systems in the world. Taiwan's system is comprised of five phases:

- A medical screening protocol is used in which applicants are either diverted to other health or social services (or simply denied further consideration), or moved to a secondary, complete medical analysis based on health records and a medical expertise template (or in-person examinations).
- Next, a team of health professionals use a separate impairment checklist to identify specific problems in body function and structure. Together, these two instruments form the basis for a preliminary and reviewable administrative decision on whether the applicant should proceed for disability assessment or be diverted to medical, psychiatric, or rehabilitation services for care and treatment.
- Social workers then administer an extensive questionnaire and occupational therapists on activities of daily living and instrumental activities of daily living, based on a modified version of the WHO's WHODAS 2.0 instrument, which was developed and thoroughly tested. A separate socio-demographic and environmental template is used to fully describe the applicant's situation (and may involve home visits). If further details are required, especially if the return to work or other employment or vocational services are appropriate, a bank of work capacity assessments are performed.
- A social worker then follows a case management procedure to administer a needs assessment checklist to determine which services or supports (temporary or ongoing income support or supplementary funding for special needs, assistive technology, personal assistant, social skill training, vocational rehabilitation services, home modification, job counseling, and so on) are appropriate. The case manager assists the individual with applications for relevant supports.
- Finally, the case manager or local social worker periodically monitors the person to determine if his or her situation has changed, whether a new assessment should be made, and whether additional services are required or no longer required.

Source: Teng et al. (2013).

(2) Countries in transition

Many countries are transitioning towards modern, ICF-centered disability systems. Medium and high-low resource countries such as Latvia, Czech Republic, Slovenia, South Africa, and most Latin American countries are either completing or in the process of reforming their disability assessment (and often disability policy more broadly) away from a purely medical and discretionary approach to one that augments medical Baremic instruments with information about the applicants' activities of daily living and instrumental activities of daily living, or, increasingly, functioning status in general. Romania is within this group.

There is considerable variety in principles and developmental stages in this group of countries. Many have developed "homegrown" functioning assessment tools that use ICF terminology and classification, and often incorporate into the process and criteria the ICF conceptualization of disability in some manner. These assessment

tools are rarely empirically tested or validated. While some countries (e.g., Latvia and Lithuania) have algorithms for merging Baremic percentages or scores with functioning scores, there is rarely a scientific basis for these algorithms. As a rule, the medical score dominates the decision. These countries primarily rely on medical professionals alone or other health professionals, rehabilitation professionals, or social workers.

Depending on the stage of reform, some of these countries (e.g., Lithuania) are attempting to merge or rationalize disability assessment for social protection benefits with active labor policy and return-to-work programming based on work capacity assessment. Others are investigating the possibility of combining disability and needs assessment into a single agency with policy development and advocacy roles (e.g., Bulgaria). Although there are various patterns in this group, most of these countries are similar in that they have a modest or limited social protection budget, gaps in health care coverage, and limited labor activation programming. For this reason, the disability assessment process and criteria based primarily on medical professional discretion and scientifically questionable instrumentation may not be viewed as particularly problematic or in need of reform. Uniformly, the success rate in these countries tends to be very high (80–90 percent), which is another reason the system may not raise concerns across the population.

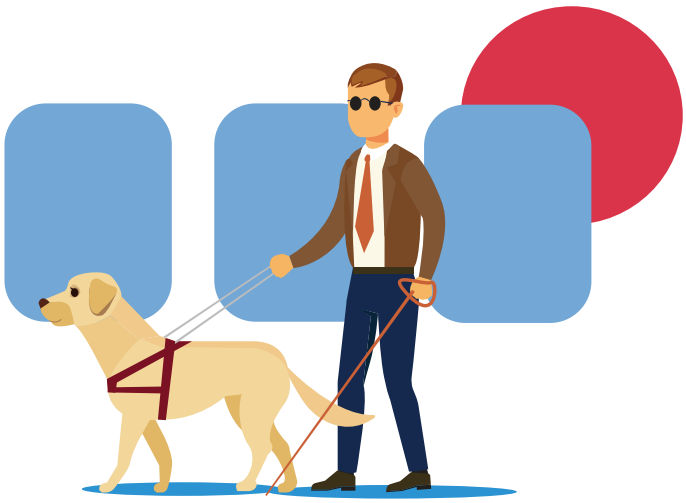
(3) Medical-based disability assessments

The third group includes countries that rely solely on medical-based assessments. This group includes low, low-medium, and some medium and high-medium resource countries, such as Greece, Saudi Arabia, Russia, Turkey, Azerbaijan, and nearly all African countries. Some countries do not have a disability assessment system at all. Also, most countries in this group rely on a medical professional's decision, based on clinical judgment alone, with or without a template or Baremic medical expertise table. The system may have historical or ideological roots (e.g., in Russia and former Soviet countries, a highly centralized, discretionary, and often unreviewable approach to disability assessment predominates). In low-resource countries, the issue is more financial. There are too few resources to support a complex administrative process, and eligibility is decided by a single individual on a discretionary basis with little or no supporting documentation.

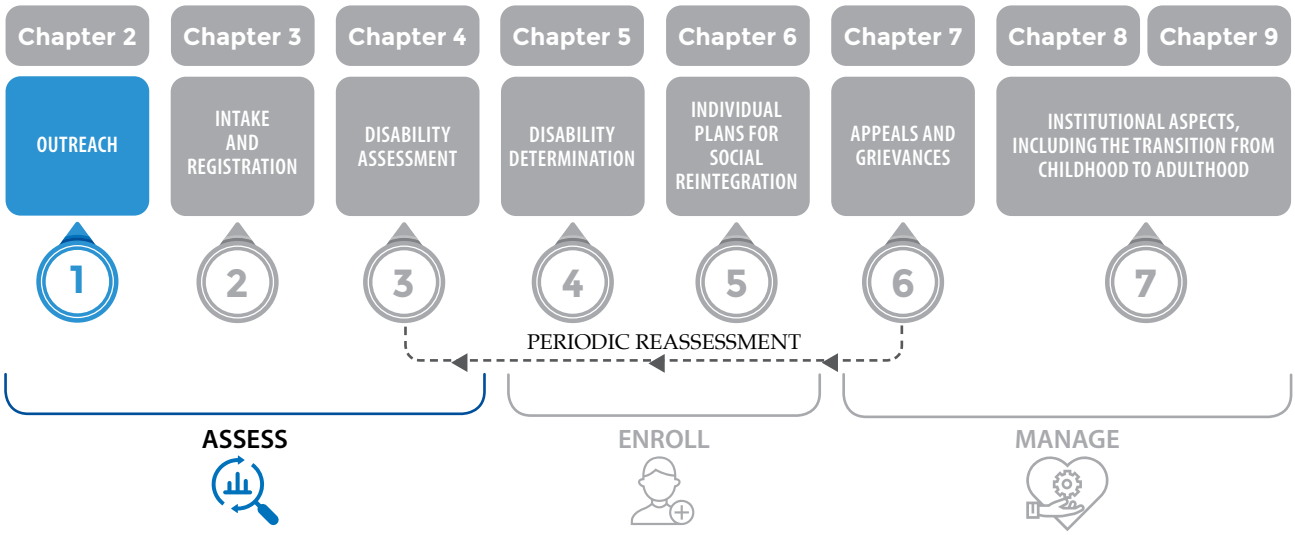
(4) Romania

Based on this classification, Romania is in the middle group of countries. As will be discussed in later chapters, in Romania, the disability assessment is carried out by CEPAH and SECPAH teams using legislative criteria, and a collection of medical, social, and functioning assessment tools and checklists. The medico-psychosocial criteria is a Baremic tool that has been modified to attempt to link medical diagnostic categories to "whole person" disability and activities of daily living and instrumental activities of daily living, focusing mainly on vocational capacities. While the children's disability assessment system has introduced many ICF standards, attempts to align the adults' disability assessment procedures and instrumentation with the ICF have had very limited success. The instrumentation is not evidence-based or psychometrically sound, and the diverse information from various sources has no impact on the decision. In the end, the decision is based primarily on medical evaluation. In the absence of quantifiable criteria, the system allows both a predominantly medical evaluation and sometimes a discretionary decision by a medical professional.

Like many other countries in this second group, however, specific reforms can remedy many of the inherent limitations of the process, criteria, and instrumentation. It is both unrealistic and unnecessary to try to achieve the level of a country in the first group—available support and services do not warrant it. The Romanian disability assessment and needs assessment processes can be modified to be more effective, efficient, and administratively sound. The instrumentation can also be supplemented by a proper psychometric tool that is quick to use, efficient, and fully aligned with the ICF. In this way, a degree of continuity can be maintained with the existing Baremic medical tool. In contrast, the medical assessment scores could be modified to adequately consider reliable information about functioning and its impact on the assessment of disability.



2. Outreach regarding disability in Romania



The first core implementation phase of the delivery chain is outreach,[78] understood as "deliberate efforts to reach and inform intended populations and vulnerable groups about social protection programs and delivery systems in ways that they will comprehend so that they are aware, informed, able, and encouraged to engage".[79] Although this core phase is crucial for the effectiveness of any delivery system, it is often neglected for many social protection programs in many countries.[80]

This chapter focuses only on the initial outreach phase related to the disability assessment system in Romania, although communications and outreach extend across the entire delivery chain. The purpose of initial outreach is to build awareness, inform people about the existence of the disability certificate and its associated benefit-service package. The initial outreach is not limited to the provision of information but also aims to facilitate the understanding of the steps and rules for obtaining

78 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.
79 Lindert et al. (eds), World Bank (2020: 61).
80 Idem, p. 6.

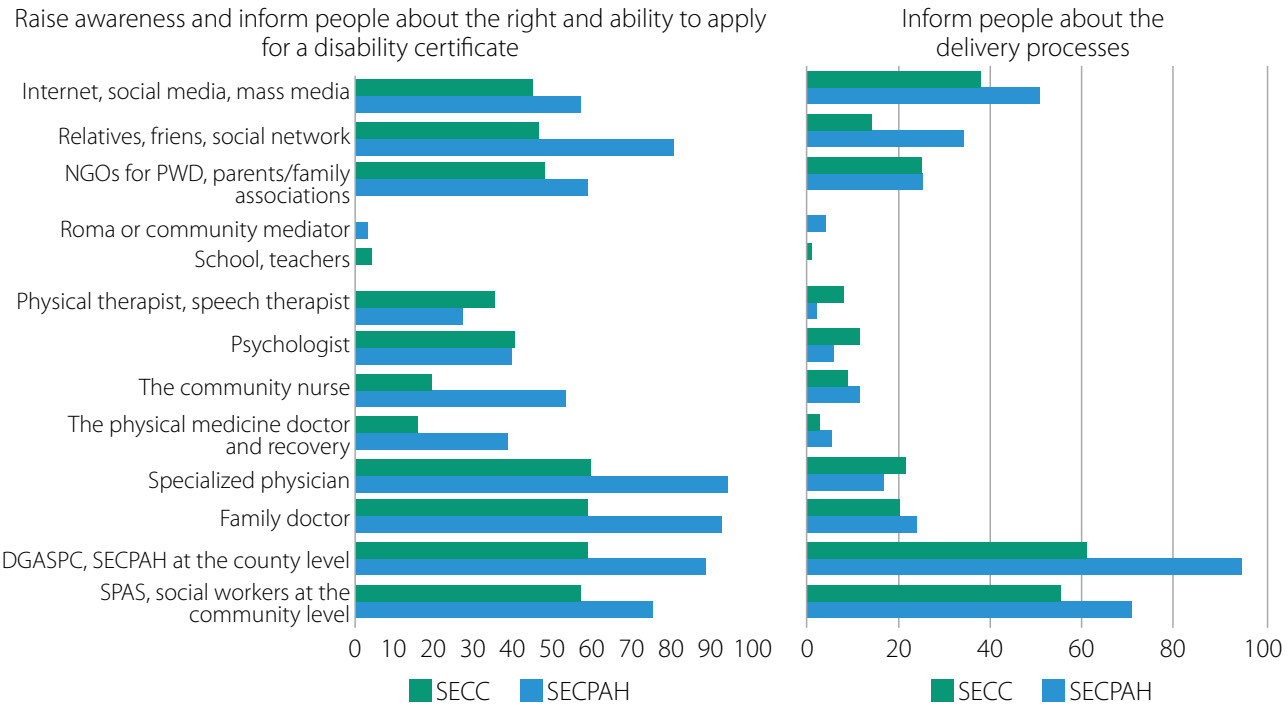
such a certificate, including institutional actors; points of contact and how to access them; timing and place of registration; rights and responsibilities of registrants and eventual beneficiaries; channels for filing grievances, complaints, and appeals, etc.

To this aim, outreach activities should be carried out based on a carefully prepared strategy, with clear roles and responsibilities, as well as protocols and guidance tools to reach target groups. Initial outreach can be carried out through direct interaction and face-to-face communication or with the help of "active search" tools, with the aim of providing information, facilitating understanding, but also encouraging and ensuring access for all interested groups of the population, children, young people, older people, people with different types of disabilities, people with different cultural or linguistic backgrounds, people who have no formal education, poor people, homeless people, people in detention, people living in remote areas and vulnerable people and families at social risk. In this phase, poor communication has multiple negative effects, but the main risk is that the target population that is missed, unaware of the program, or fails to understand the program or how to register.

2.1. How do people find out about the disability assessment system?

In Romania, there is no official disability-related outreach mechanism based on strategic planning, earmarked budget, or network of professional agents. The key actors responsible for conducting the initial outreach are DGASPC through SECPAH, at the county/Bucharest district level, and SPAS at the community level. These actors inform people at their local or county offices or on websites and do not use mobile teams or door-to-door activities for outreach purposes. They play a critical role in informing people of the program and its operational aspects (steps, rules, points of contact, timing and place of registration, and so forth), from the first phases of obtaining a disability certificate to encourage the intended population to engage, apply, and provide their information as inputs to the intake and registration phase. In the perception of the SECPAH/SECC practitioners, both SPAS and SECPAH largely fulfill these duties, as the figure shown below.

Figure 3: Sources of initial information for persons requesting a comprehensive disability evaluation (%)



Source: Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=201) and children (SECC, N=187), January–February 2021.

In fact, medical professionals, especially specialized physicians and family doctors, represent the main actors in raising awareness and informing people about their right and ability to apply for a disability certificate, according to the SECPAH and SECC specialists (see Figure 3). However, there are no nationwide systems for referrals, protocols, rules, or assigned responsibilities regarding medical staff's duty to conduct the initial outreach for disability. For example, in some countries, specialized physicians must complete a special (colored) form for any person diagnosed with a medical condition eligible for disability status. Once the person receives such a form, the medical unit provides him/her with the initial package of information. Then it is the person's decision to apply for a disability certificate. This kind of procedure was also mentioned as "the best outreach option" by the interviewed persons with disabilities (see also quote 2.1).

As focus groups with SECPAH/SECC specialists showed, "In the last five years there has been an avalanche of people sent by doctors."[81] Nonetheless, at the same time, during interviews and focus groups, all key actors gave examples of communities with no family doctor or with an indifferent one, and of medical staff who did not inform the person even though the diagnostic would have allowed them to be classified in a disability category.

"I would put the emphasis on clear information, not just on a list of documents and that is that. A person-to-person information. ... Specialized physicians should tell you if you are entitled to a disability certificate. And in every doctor's office, general physicians should display patient rights on a board or should have a brochure that patients could buy, if not offered for free." (Interview with person with disabilities, woman, 20 years old)

"Lately, doctors refer a lot of people, regardless of their condition, even with a common fracture. They come to us and say that if the doctor told them, it was necessary, why we tell them that they cannot be classified as having a disability. Doctors believe that if they have a functional problem, someone needs to take care of them, that social workers must handle their cases. In most cases, doctors, rather than social workers, refer them to us [the comprehensive assessment service]. [...]

Yes, and then, in the hospital, every social case is referred directly to the social worker, doctors easily prepare the medical reports for people that represent social cases with or without the right to be classified as person with disabilities." (Focus group, SECPAH)

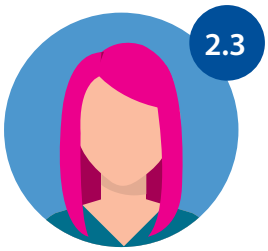
Regarding SPAS, the Social Inspection[82] shows that over 75 percent of the (310) audited communities do not have a social diagnosis or early identification, early intervention, and preventive services, and do not identify vulnerable groups (including people with disabilities) or their specific needs.[83] Nonetheless, there are significant differences across communities. While some SPAS guide, encourage, and assist people (especially the elderly) to apply for a disability certificate as a strategy to reduce the number of beneficiaries for other social assistance benefits (such as guaranteed minimum income), other SPAS not only fail to inform but also refuse to do the mandatory social inquiry and deliberately discourage people from applying for a disability certificate, as "the mayor does not want handicap in his commune."[84]

81 Focus group SECPAH.

82 The Social Inspection is a structure within the National Agency for Payments and Social Inspection, respectively within the County Agencies for Payments and Social Inspection.

83 ANPIS (2019: 7).

84 Focus group SECPAH.

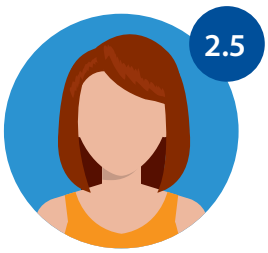


"I found out about this story with the disability at the Mayoralty because I did not have a job anymore, and, they said that I was sick after all. There was an employee who was not a doctor and who told me the following: that I was being given the chance to be classified as person with disabilities. And indeed in 2008–2009 I got my disability certificate, and I had a disability certificate for 1 year. Accentuated disability certificate, as the one I have now. I had it for 1 year after which I told myself that it sounded bad to be disabled and I gave it up and I also tried to get the Guaranteed Minimum Income (GMI) in the same way, through the Mayoralty, and, I do not know, they did not really agree to this. So, they said: 'You had a disability certificate, you should have continued with it and that is it.' And then I was without income for about 4–5 years and finally my brother helped me a bit." (Interview with person with disabilities, women)

"But there are also cases of discrimination. Just to give you an example, a recent case, a person with an amputated leg. That person's daughter is struggling to prepare the file, and those [the SPAS] in the respective person's locality of domicile refuse to conduct the survey, the mayor of the community said to the daughter: 'I do not want a person with disabilities in the commune.' The daughter filed a complaint with the Prefect's Office and with us and with the Police. And we are waiting to see how things will unfold." (Focus group, SECPAH)

Within communities, other types of community workers have an active outreach role, besides SPAS. First, there is the network of community nurses managed by the County Public Health Directorates (deconcentrated institutions of the Ministry of Health). This network is unevenly distributed in the territory, and most rural communities lack a community nurse. Second, teachers and schools exist in all localities, but are rarely involved in outreach regarding disability, and only for children. Third, especially for Roma communities, there are Roma experts or social mediators who facilitate the population's access to information and mediate the relationship with institutions. However, Roma experts are rare and unevenly distributed across the country. Fourth, there are other types of professionals, such as the social workers from hospitals or jails (nearly all in urban areas), community facilitators, and informal leaders who were mentioned in interviews and focus groups as participating in outreach to various groups. However, none of these specialists benefit from protocols or are assigned specific duties pertaining to raising awareness or informing people about the disability assessment.

The NGOs of persons with disabilities, together with the Internet and social media, also play a significant role, although for fewer people, say the SECPAH and SECC practitioners (see Figure 3). Also, nearly all interviewed NGO representatives (17 out of 20) highlighted their involvement in the initial outreach by providing information services for adults with health problems who might or do require evaluation for obtaining a disability certificate, within all their subsidiaries/branches, both in urban and rural areas. In the context of the COVID-19 pandemic, most of them developed online services, such as Voices for Hands (using videoconference). Although the demand for this type of support is very high, the interviewed NGO representatives note that they often do not have either the necessary funds, or specialized human resources to carry out outreach work.



"A friend, who is also a person with disabilities but who has legal experience in this field, informed me about how to obtain it, about the steps and formalities for obtaining a disability certificate. I had a general idea about the steps but, more specifically, I learned about each step as I went from one stage to another. I put together information from several sources: the DGASPC, the Internet and other persons with disabilities." (Interview with person with disabilities, woman, 36 years old)

Nevertheless, most of the interviewed persons with disabilities, as well as the NGO representatives and a large portion of the practitioners, consider that for the majority, peer-to-peer outreach represents the first contact with the disability system. Most people find out "by chance" from a relative, friend, co-worker, or neighbor that a certain medical condition could be associated with disability status. Then they go to a doctor or a social assistance office (either SPAS or DGASPC) and learn more. For help completing and understanding the information or for solving sensitive issues, they ask trusted, knowledgeable people in their community (such as teachers or mediators), use the Internet or social media, if they can, or request assistance from an NGO, if available.

2.2. Information and communication practices regarding the disability assessment system

Once persons with disabilities find out about the right to apply for a disability certificate, they need to be able to (i) learn the procedure for obtaining the certificate and who to contact; (ii) understand how and where to register, and navigate the process for doing so; (iii) understand and be informed of decisions regarding their eligibility status, enrollment, and benefit-service package (if enrolled); (iv) participate in onboarding activities (if enrolled); (v) interact with payment or service providers and receive timely delivery of benefits and quality services; and (vi) update their information, be informed of any changes to their status[85] (including for noncompliance of conditionalities), and file grievances or appeals.[86]

Regarding this recommended set of information, Table 3 shows that the information available for claimants of a disability certificate is incomplete on the DGASPC websites. Eight of the 36 studied counties that participated in the research provide full information on their DGASPC site in an easy-to-use format. In contrast, 5 counties do not provide any of the necessary information. Claimants can usually find out how to access SECPAH, what the application file contains, and how it should be prepared, as well as how and where the application and file are submitted. In less than half of the country's counties, claimants can find out from the first try what benefits and services are available in connection with the certificate. And in less than a third of the counties, claimants can understand how the classification by degree and type of disability is done, how decisions regarding their eligibility status are made, and how to file grievances or appeals.

Table 3: Information on disability available on DGASPC websites

Information about …	No	Yes, some information	Yes, full information
a. What the file contains and how should it be prepared	1	10	25
b. How and where the application and file are submitted	1	10	25
c. How to access SECPAH	0	7	29
d. What the comprehensive assessment consists of, and how this is done	9	17	10
e. How the degree and type of disability are established	13	13	10
f. Which are the related benefits and services	7	14	15
g. How to challenge the disability certificate, including how and where this can be challenged, and how to apply for and obtain legal assistance	14	11	11
None of the above			5
All of the above			8

Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest municipality, January-February 2021.

85 In the context of the current disability assessment report, we are referring to any changes that may affect the provision of benefits and services.

86 Lindert et al. (eds.), World Bank (2020: 22).

The SPAS and the NGOs only partially fill the information gap. Regarding available information about the disability assessment, the project surveyed the opinions of practitioners working in SECPAH and SECC[87] and the results shown in Annex 4. Table 1 indicate that only some municipalities (SPAS) provide information about the disability assessment, and most of these follow the same incomplete pattern as the DGASPC websites. Also, only a small share of municipalities provide complete information, while some do not offer any information.

Regarding information provided by the NGOs, the majority of SECPAH and SECC specialists either do not know or believe that most NGOs do not provide any of the necessary information (see Figure 3 in Section 2.1). However, the NGOs representatives declared in interviews that they place critical importance on outreach and have implemented a series of projects in this area. Besides statements, they provided materials and examples proving a rather strategic approach to information, education, and communication with the applicants to, and beneficiaries of a disability certificate. Also, the interviewed persons with disabilities mentioned that NGOs provided support, information and advice when they decided to apply for a disability certificate.

"We have, within a larger social assistance Help Family department, this component of informing and assisting people with the preparation and submission of the file when requested. We did not refuse to provide support to any person who asked for our help, not only to our beneficiaries. If I get a phone call from the mother of an 18-year-old child diagnosed with infantile autism asking for my support, I will not send her to the DGASPC, I will make a phone call and get some information and keep in touch with her. We provide information and emotional support." (Interview with an NGO representative, national association)

Current regulations require the relevant institutions to only post the standard forms on their sites.[88] The standard forms refer either to the application for a comprehensive evaluation (to be submitted to the SECPAH/SECC) or the application for social inquiry (to be submitted to the SPAS). In this regard, while all DGASPCs report complying with this regulation, less than half of the selected SPAS do.[89] The share of SPAS that have the standard application for social inquiry posted on the municipality site is under 60 percent, a higher share (72 percent) recorded only among the large cities (see Annex 4. Table 2).

Communication is intrinsic to outreach, as it facilitates interactions and ensures all actors understand all processes along the delivery chain. Therefore, the existence of a specific procedure concerning communication with claimants, applicants, and beneficiaries is a good indicator of how well organized the initial outreach phase is. Out of the 36 studied SECPAH, 26 reported having an approved outreach procedure. At the same time, in line with the current legislation, claimants who apply for a disability certificate for the first time "shall receive, free of charge, information concerning social risks and social protection rights from which they may benefit, and also, as the case may be, any counseling required to surmount any difficult situations."[90] The SPAS are in charge of providing such information. Out of the 71 SPAS in the sample, less than a quarter reported having a specific procedure (or paragraph/section in the general procedure) referring to the information on social risks and the rights of persons with disabilities; a larger share (50 percent) was registered only for larger cities (Annex 4. Table 3).

87 Opinion survey Q2B: Practices and experiences of the practitioners working in SECPAH/SECC from 39 counties and the 6 districts of Bucharest, January-February 2021.

88 GD no. 430/2008, Art. 6, for adults with disabilities; Order no. 1985/1305/5805/2016, for children with disabilities.

89 The question referred to two standardized applications for comprehensive assessment, for adults (GD no. 430/2008, Art. 6) and for children (Joint Order no 1985/1305/5805/2016). The results were similar for the two types of forms: 42 percent of SPAS in the sample reported to have posted the application for adults and 45 percent for the one for children.

90 Art. 47, para. 4, of Social Assistance Law no. 292/2011.

BOX 4

Example of a SECPAH communication procedure

The Service for Comprehensive Assessment for Adults with Disabilities provides information to all adults with disabilities, families of adults with disabilities, legal representatives, personal assistants, professional personal assistants, nongovernmental organizations whose members are adults with disabilities, and any person representing adults with disabilities regarding the activity of the service, the manner of obtaining a disability certificate, and the type of documents required for submitting a file that will be the basis for the disability assessment, as provided for by Art. 6 (4) of GD no. 430 4/16/2008 approving the methodology regarding the organization and functioning of the committee for assessing adults with disabilities, as subsequently amended and supplemented, and by Art. 7 of Order no. 2298/2012 approving the framework procedure for the assessment of adults in order to be classified as having a certain degree of disability. It also receives, highlights, and settles the standard requests for comprehensive assessment.

An objective, clear, complete, timely, easy to understand information about the stages of the comprehensive assessment procedure, as well as the preparation of a file, is always underscored by medical documents, submitted by the applicant. These should show the onset of the disease, the present condition, as well as other important aspects regarding the person's medical condition. The communication system must be flexible and fast. The information provided within the service is also posted on the entity's website, or may also be transmitted, in the case of electronic requests, by email.

Note: Response received as communication procedure within a questionnaire Q2A, which is part of the general procedure of that SECPAH.

However, among both the SECPAH and SPAS, only a few of those reporting the existence of a communication procedure were also able to attach it to the survey response package.[91] Furthermore, most of the communication procedures given to the research team are rather general statements, as illustrated in Box 4. In other cases, the communication procedure refers to complying with Order no. 2298/2012,[92] which includes just one provision related to communication (requesting that SECPAH communicate to the claimants the date and location for the assessment interview).

This last point of this section refers to the core message of communication regarding disability. This report uses the term "disability," but in Romania, all institutions and documents involved in the disability assessment use the term "handicap" which is established in the Romanian Constitution (Art. 50) and included in Law no. 448/2006 on the protection and promotion of the rights of persons with disabilities. Thus, translated verbatim, the disability certificate is called the "certificate of classification in degree and type of handicap;" the assessment services are called "Services of Comprehensive assessment for the Adult Persons with Handicap;" while the commission is the "Evaluation Commission for the Adult Persons with Handicap."

"I lost a breast. The handicap entitles me to receive that money [the disability benefits]. The state must compensate as the breast will never grow back. I will not recuperate it." (Interview with person with disabilities, woman, 61 years old)

More generally, both in legal terms and casual language, people with disabilities are "persons with handicap" because "only the handicap confers entitlements, while disability is just a term use in the academic or strategic papers, without power in courts or institutions".[93] This

91 Nine out of 16 SPAS, and 9 out of 26 SECPAH (see Annex 4. Table 3).

92 Order no. 2298/2012, framework procedure for the assessment of adults for the classification in a degree and type of disability. ANDPDCA told the research team that this regulation is currently under review.

93 Interview with ANDPDCA representatives. For comparison, for children, the ICF has been partially incorporated into the

is an important element of the general social and institutional environment. Although the process of modernizing the legislation started several years ago, and the medico-psychosocial assessment criteria were introduced in 2007, the language still reflects a general way of thinking about disability as a medical problem, deficiency, or impairment. Even interviews with persons with disabilities revealed that underlying the use of "handicap" is the belief that the certificate shows the existence of a medical condition that entitles the individual "to be compensated by the state," as illustrated in quote 2.7. Therefore, to change the paradigm from a medical to a holistic (ICF) approach, information, education, and communication with the current beneficiaries as well as with the general population should go hand-in-hand with training practitioners. Otherwise, misunderstanding and misconception can cause mistrust among actors, impede implementation, waste resources, generate inefficiencies, reduce effectiveness, and lead to the reform's failure.

2.3. Adapting information and communication for "hard to reach" populations

The persons with disabilities population is diverse, and includes women, men, children, youth, elderly, people from different ethnic groups, people living in large cities and those in remote rural areas, people living with family and those in residential institutions, patients in psychiatric facilities or those in detention, homeless people without a fixed address, and people in families with varied socioeconomic status and conditions. These groups may require particular adaptations or accommodations to ensure they are reached and served. Active outreach is critical for promoting potential inclusion of all these groups.[94] Vulnerable populations may not be aware of social program benefits they could be eligible to receive. Evidence shows that in the absence of a well-thought through outreach strategy, social protection programs may run the risk of exacerbating exclusion errors for lack of information and skepticism that the programs may not yield immediate or longer-term benefits, particularly for people living in remote and isolated locations. A proactive outreach effort can help to manage expectations, minimize grievances, and develop better mutual understanding to avoid the risk of negative spiral, program failure, external manipulation, loss of credibility, and politicization.

Figure 4: Adaptation for persons with visual impairment of the information found on the DGASPC websites

Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January-February 2021.

disability assessment, and the institutional, legal, and common descriptions predominantly use "children with disabilities" (although, there still are cases in which this is mandatorily accompanied by "children classified in a degree of handicap").

94 Lindert et al. (eds.), World Bank (2020: 63).

The information provided by DGASPC (SECPAH) online is only partially adapted for the specific access barriers by type of disability. In the context of movement restrictions (such as those imposed during the COVID-19 pandemic), the lack of or insufficient virtual access to information has become more important than ever. Table 3 shows the available information on the DGASPC websites. Figure 4 offers additional information and shows that less than one in every three counties in Romania provides accessible information for visual impairment concerning the disability assessment. Furthermore, an analysis of the DGASPC websites done by members of the research team who are persons with disability showed that: (i) out of the 22 selected websites, only 11 have an accessibility tool; (ii) the accessibility tool menu varies across counties; (iii) blind persons need assistance to navigate the websites, as screen-reading software is not available; (iv) on many sites, the standardized forms and other documents can be accessed only after several clicks, presuming that the user is already well documented and knows the institutions (and their acronyms), the legislation, the legal name of the document, and so forth; (v) some of the pop-up lists include long lists of documents from various areas of social protection, which requires a preliminary search to identify the information the user is looking for; and (vi) on many sites, the menu of public interest information includes categories of uploaded documents that are difficult to access or cannot be opened.

Still, most people with disabilities do not use the Internet to access institutions and services intended for the public. For instance, a recent study shows that most persons with disabilities did not use the Internet in the previous month: 50 percent of persons with some limitations and 64 percent of those with severe limitations.[95]

Accessibility of offline communication and information is also limited at both county and local level, although it falls under the responsibility of public authorities.[96] Table 4 shows that less than half of the studied SPAS provide accessible information and communication for different types of disabilities. Furthermore, 54 percent of them have no adaptations at all. The majority of the others benefit from only one type of accessibility tool. The most common accessibility tools among SPASs are: information available in simplified language (easy-to-read-and-understand) and a designated person to assist people with disabilities (who knows how to speak in plain language, easily understood by people with intellectual disabilities), along with other adaptations that vary from one locality to another. The SPAS are better endowed in larger cities, whereas those from rural, underdeveloped, and remote localities do not provide accessible information and communication for persons with disabilities.

The situation is better among the SECPAH and SECC (within DGASPC), as presented in Table 4. All have developed at least one adaptation, but the majority benefit from 4-5 types of accessibility tools. The most common include easy-to-read information, staff appointed to assist persons with intellectual disabilities, sign language-certified interpreters, protocols with NGOs, and other adaptations. Most often, these "other adaptations" refer to a screen that offers information (audio, video, sign language, transcriptions) for all categories of persons with disabilities; a website equipped with accessibility tools; a public e-mail address; flyers differentiated by type of disability. And sometimes "all our specialists know how to handle such situations on their own"[97] is reported under the category "other adaptations available to facilitate access to information for people with different types of disabilities".

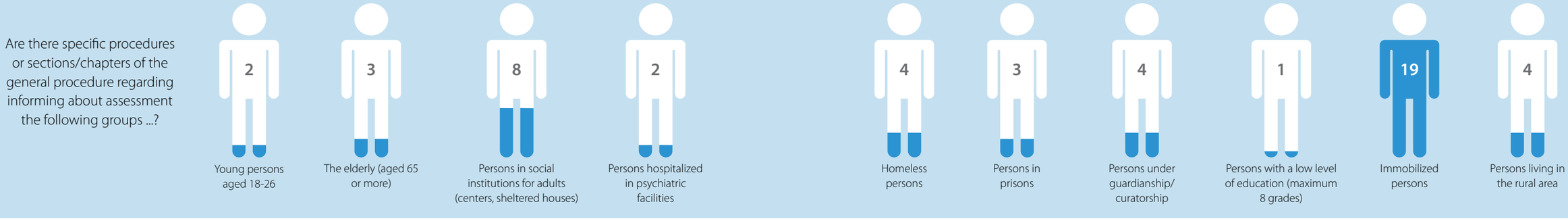
Therefore, inclusive outreach is available only in some counties, and mainly in the larger cities. A deaf individual living in Romania who applies for a disability certificate has a chance of being assisted by a sign language interpreter in just 1 in every 10 SPAS offices, and only in about half of the country's DGASPC offices. For people using a wheelchair, physical access is also very limited, as most of these offices lack a ramp, do not have special parking, or do not provide wheelchair-adapted toilets.[98] Also, as we have shown above, offline communication is rarely adapted to the needs of the people with visual impairment.

95 Grigoraș et al. (coord.), World Bank (2020: 12).
96 Law no. 448/2006, Art. 61-64.
97 Excerpts from questionnaire Q2A.
98 Grigoraș et al. (coord.), World Bank (2020: 52).

"Recently I needed to get a disability certificate issued for a family member. I am completely blind. I rely heavily on remote communication, because getting to the institution's office is far too complicated for me. Furthermore, this was a matter of obtaining some basic information, i.e., I needed to know what documentation was required for the submission of the file in order to obtain the disability certificate. Before moving on to the access barriers, I would like to highlight a few extremely important aspects. I have been using access technologies for over 20 years. I am using computers since I was a kid, so I am an advanced user. Not only have I been passionate about technology since childhood, but I also work in the field. I am an expert in accessibility, and, over the years, I worked as a consultant for both public institutions and private operators. I tell you all this to contextualize, to underline that I am not a beginner who cannot find his way among all those buttons. And yet, I failed to extract the information that I needed from the institution's website, https://www.das-voluntari.ro/. Although there is a 'Required Documents' section on the website, I have not been able to access it in any way, no matter the array of technical means that I am familiar with. I had to call their number, have someone answer me, someone who sent me to the unavailable website. It was only after I explained the problem that I was given the necessary information. And situations like this are not isolated. The accessibility measures taken by certain institutions are, most often, inappropriate. The subcontracted companies often do not have a clue about the correct implementation of the accessibility standards. Until we have a legislative and educational framework for training specialists and recognizing them as such, officially, the only solution remains to engage persons with disabilities and their representative organizations in building an accessibility plan and in the audit process." (Interview with a person with disabilities, man)

Besides type of disability, adaptations for vulnerable groups systematically followed in this report are also very limited. Figure 5 shows that SECPAH has adapted information and communication in more counties (19) only for immobilized persons, as this situation requires that assessment take place at the claimant's home. Adaptations for all other groups - young and elderly, people in detention, illiterate, people living in rural areas (including in isolated areas), homeless people, and those in the care of social institutions (managed by DGASPC) - are available in only a few counties.

Figure 5: Number of SECPAH that adapted their communication procedures regarding information about assessment to vulnerable groups



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January-February 2021.

Table 4: Accessibility of offline communication

Accessibility of the offline communication	URBAN		RURAL				COUNTY
	Larger cities	Small cities	Communes type 1	Communes type 2	Communes type 3	Total sample of SPAS	SECPAH (within DGASPC)
Number of cases, of which equipped with...	18	10	12	15	16	71	36
a. Braille language signs placed in an easily identifiable and accessible place	0	0	1	0	1	2	8
b. Icons easy to understand and placed at the right height	3	0	2	1	0	6	16
c. Adequate electronic notice boards	1	1	1	1	0	4	5
d. Audio files, Braille printed texts, texts written in a simplified language	2	0	1	0	0	3	11
e. Sign language certified interpreters	5	0	1	1	0	7	19
f. Person appointed to assist disabled persons, who can speak a plain language that is easily understandable by persons with intellectual disabilities	7	0	3	4	0	14	19
g. Information available in a simplified language (easy-to-read-and-understand)	9	1	4	5	0	19	31
h. Any other possible adaptations to facilitate access to information for persons with different types of impairments	7	3	4	5	1	20	25
i. Other procedures approved by the DGASPC for communication with disabled persons (e.g., protocols with NGOs)	2	0	2	2	1	7	19
None of the above	4	7	5	7	15	38	0
At least one of the above	14	3	7	8	1	33	36

Sources: SPAS survey with responses from 26 counties, January-February 2021. Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January-February 2021.

Notes: Small urban = small cities up to 20,000 inhabitants as of January 1, 2020; larger cities = cities with >20,000 inhabitants as of January 1, 2020; rural = communes of all types; communes type 1 = communes developed and close to the county seat; communes type 2 = other communes (typical rural localities); communes type 3 = communes underdeveloped and remote.

BOX 5

Hopes for website accessibility, expressed by persons with disabilities and organizations that represent them

An accessible website that can be used by (almost) any person, regardless of their personal limitations, including sensory, visual, auditory, mobility, or cognitive impairments.

WEB ACCESIBILITY FOR THE BLIND

A blind person can use an electronic device such as tablet, smartphone, or laptop via a screen reader or a Braille screen. Screen readers can read any text, regardless of the language or punctuation, but they cannot read images. A blind person using this type of software would thus be unable to read captions on images, texts scanned as images, or non OCR (optical character recognition) processed PDFs. A web page accessible to the blind should include the following minimum options:

- A description of the image, which is not visible, but can be interpreted by the screen reader to convey the content of the image to the user.
- Text blocks that include a header or ARIA code.[99] The header is a title coded differently from the rest of the text; the headers help the blind person easily navigate from one section to another using a keyboard shortcut—usually the letter H. Headers can be used to navigate to the menu, different sections of the article/page, the Help section, etc.
- CAPTCHA codes to include an audio version. A Completely Automated Public Turing test to tell Computers and Humans Apart (CAPTCHA) code is used to prevent robots/automatic services from filling out forms. By their function, CAPTCHA codes are inaccessible to screen readers. Alternative audio solutions must be used for these types of codes, e.g., Google's reCAPTCHA.
- Limited use of accordion menus and interactive pages. Menus that drop down to reveal other submenus when the user places the cursor on a link are almost impossible to navigate by users of accessibility technologies.

WEB ACCESIBILITY FOR THE VISUALLY IMPAIRED

There is much diversity in visual impairments, making it necessary to adapt accessibility solutions to each individual impairment. For low-vision persons, there is no blanket solution, unlike for blind persons. However, an international good practice guide lists the following minimum requirements for a web page to be accessible to low-vision persons:

- It must include the option to increase/decrease font size and/or contrast.
- It must include several color schemes and/or enable toggling background and text color (e.g., black on white/white on black, black on yellow, etc.).
- It must use legible fonts.
- It must be responsive, i.e., maintain its appearance regardless of the size of the screen or the magnification software a low-vision person might use.

WEB ACCESIBILITY FOR THE HEARING IMPAIRED

Information accessibility for the deaf and persons with hearing loss is achieved mainly through written messages and sign language. A web page that is accessible to the hearing impaired should include the following minimum options:

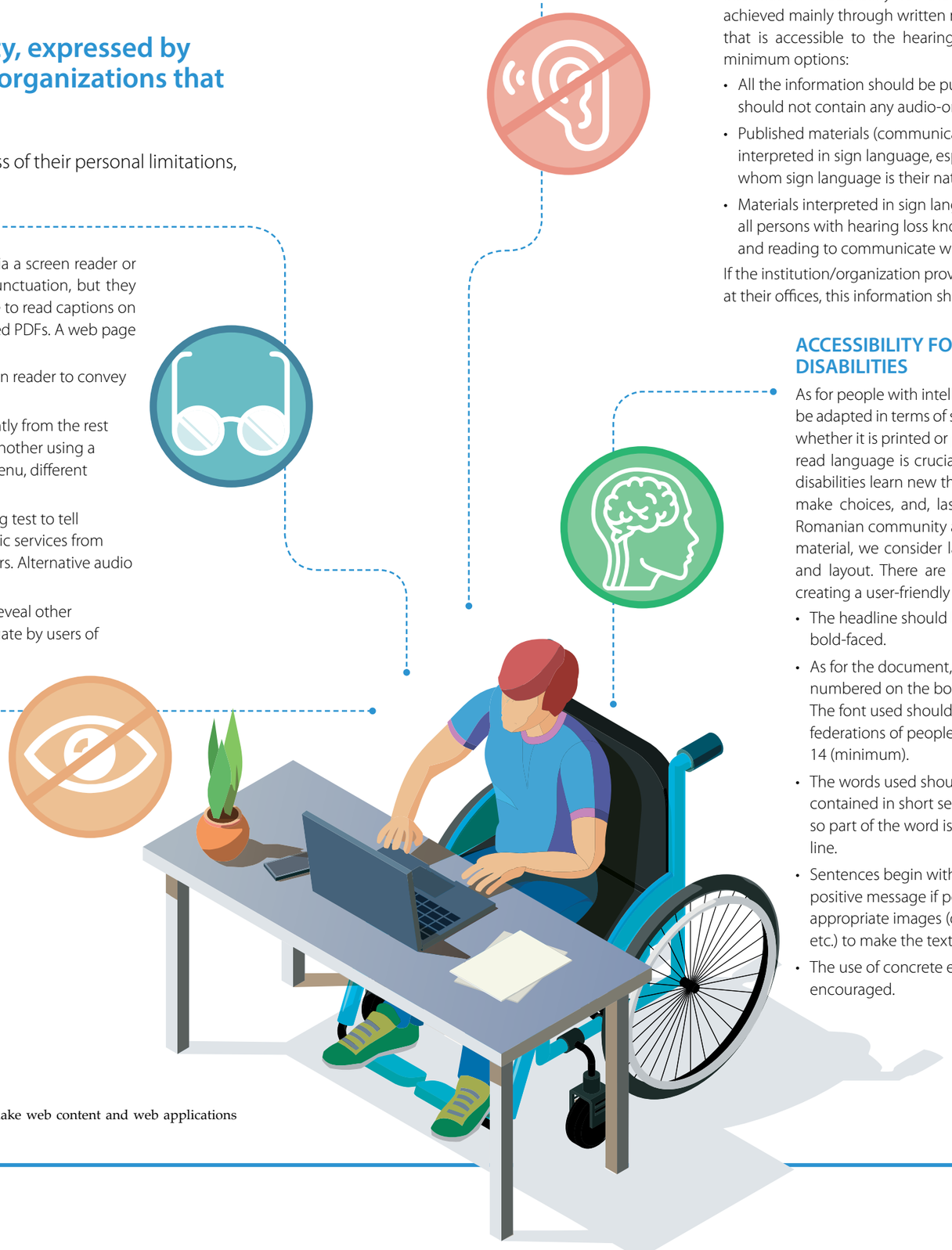
- All the information should be published in written format—the page should not contain any audio-only messages.
- Published materials (communications, messages, rules, etc.) should be interpreted in sign language, especially for deaf community members for whom sign language is their native language.
- Materials interpreted in sign language should also be subtitled, since not all persons with hearing loss know sign language, and instead use writing and reading to communicate with hearing persons.

If the institution/organization provides sign language interpretation services at their offices, this information should be featured on the website.

ACCESSIBILITY FOR PEOPLE WITH INTELLECTUAL DISABILITIES

As for people with intellectual disabilities, the information needs to be adapted in terms of simplification and attention to presentation, whether it is printed or presented electronically. The use of easy-to-read language is crucial because it helps people with intellectual disabilities learn new things, be better informed, know their rights, make choices, and, last but not least, feel they are part of the Romanian community and society. When developing easy-to-read material, we consider language, content and illustrations, design, and layout. There are a few basic rules to keep in mind when creating a user-friendly text, namely:

- The headline should be simple and easy to read, preferably bold-faced.
- As for the document, except the first page, it should be numbered on the bottom right-hand corner of each page. The font used should be that recommended by the European federations of people with intellectual disabilities, i.e., Arial, size 14 (minimum).
- The words used should be familiar and straightforward, contained in short sentences. Word breaks should be avoided, so part of the word is on one line and the rest on the following line.
- Sentences begin with a hyphen, are short and contain a positive message if possible. They must be complemented by appropriate images (drawings, symbols, pictograms, pictures, etc.) to make the text/message easier to understand.
- The use of concrete examples to further explain the message is encouraged.



99 ARIA - Accessible Rich Internet Applications is a set of attributes that define ways to make web content and web applications (especially those developed with JavaScript) more accessible to people with disabilities.

Conclusions of Chapter 2

1. On-demand systems, such as the disability assessment, depend on people being informed enough to take the initiative to apply. If outreach efforts are inadequate, target populations or vulnerable groups may lack the awareness or ability to seek aid and may be missed. The analysis presented in this chapter indicates that regarding the disability assessment, more efforts are needed to meet the UNCRPD (Art. 9) requirement on ensuring accessibility to information and communication to enable all persons with disabilities to fully enjoy all human rights and fundamental freedoms.[100]

2. The existing interface between people and institutions is a "weak link" of the disability system. The information provided is incomplete and poorly adapted, both to the various types of disabilities and to vulnerable groups facing social risks. The main communication gaps at this phase risk a target population that is missed, unaware of the program, or that fails to understand what the program offers or how to register.

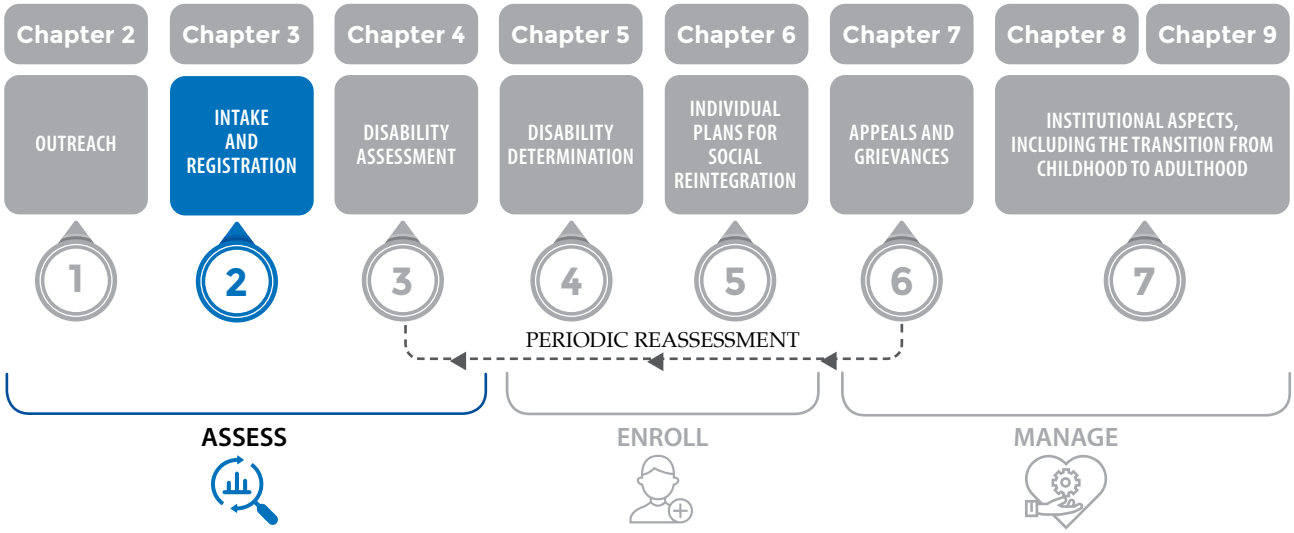
3. The persistent core message of "handicap" needs to be changed to "disability" to support reforms that shift the system from a medical to a holistic approach. This is not possible without legislative change. But equally, sustained information and education and communication campaigns are needed to change the perception of current beneficiaries, as well as the general perception of disability as a "handicap" and of the disability certificate as compensation for medical conditions.

4. One method that considerably improves outreach, used in some countries, is to introduce a standardized form (such as a "green form") that must be completed by any specialized physician once he/she establishes a medical diagnosis that is mentioned in the disability classification criteria. For example, this could be done by establishing a list of disease codes to be jointly approved by the Ministry of Health and the Ministry of Labor and Social Protection. In addition, the "green form" could be accompanied by a brochure with essential information that the health facility would have to hand out to people who receive the form completed by the physician. The introduction of such a measure would not only have the potential to improve the initial information of all categories of the population, but would also increase access to disability assessment while restricting the opportunities to obtain/provide medical documents prone to fraud regarding the accuracy of the information they contain.

5. The ANDPDCA website should include a dedicated page, updated permanently, that includes complete and fully accessible information on the disability assessment for children and adults, to fill the gaps from the DGASPC and SPAS websites and to ensure all citizens have equitable access to information.

100 Preamble to the Convention on the Rights of Persons with Disabilities (UNCRPD, paragraph 22).

3. Intake and registration for disability certificate



Intake and registration represent the second phase of the delivery chain. For any social protection system, the objective of this phase is to efficiently register the target population and the vulnerable groups, and record their information accurately. Following outreach efforts (discussed in the previous chapter), the inputs to intake and registration involve individuals who apply for assistance, engage with SPAS/SECPAH/CEPAH (for adults), and provide information and documentation. Registration consists of recording and verifying that information.

In Romania's disability assessment system, intake comprises what applicants[102] must do to obtain medical documents, the social inquiry done by SPAS, and the other documents needed to compile the application file (see Flowchart 3). These steps are described in the following sections, which consider the more detailed aspects of implementation, linkages with other stages, various operating modes developed at the local and county levels, and multiple stakeholders' opinions and beliefs.

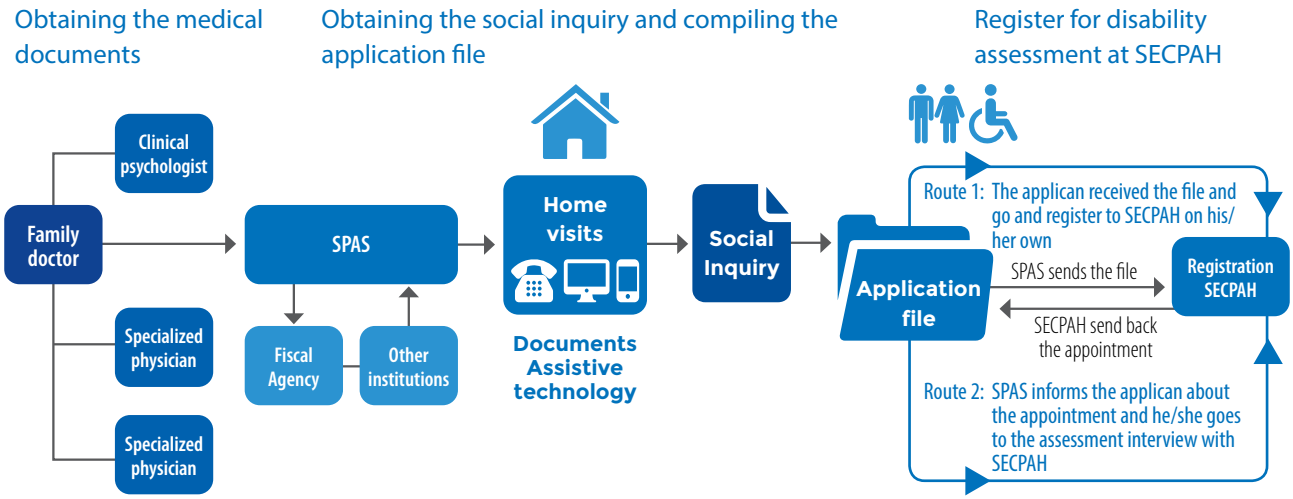
101 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.

102 At this stage of the delivery chain, we refer to people as applicants since they have not been issued a disability certificate (the first one or a new one).

3.1. Intake and registration: An overview

Information is a core input and output of intake and registration. Applicants gather information from various institutions, which is recorded and verified by SPAS and subsequently by SECPAH, and then used to support the disability assessment done by SECPAH (see Chapter 4). Once the evaluation is completed, the entire information package is sent to the CEPAH, which decides on the degree of deficiency. Thus, information systems play an important role in supporting those processes: recording, transforming, and using that information and helping to automate the processes themselves. In many countries, information reported by applicants for a disability certificate is complemented by additional data from other administrative systems, such as social registries. In Romania, the disability assessment system relies solely on the information collected by the applicants during the intake phase, and sometimes also during the disability assessment phase.

Flowchart 3: The main steps of the intake and registration phase for application for disability assessment

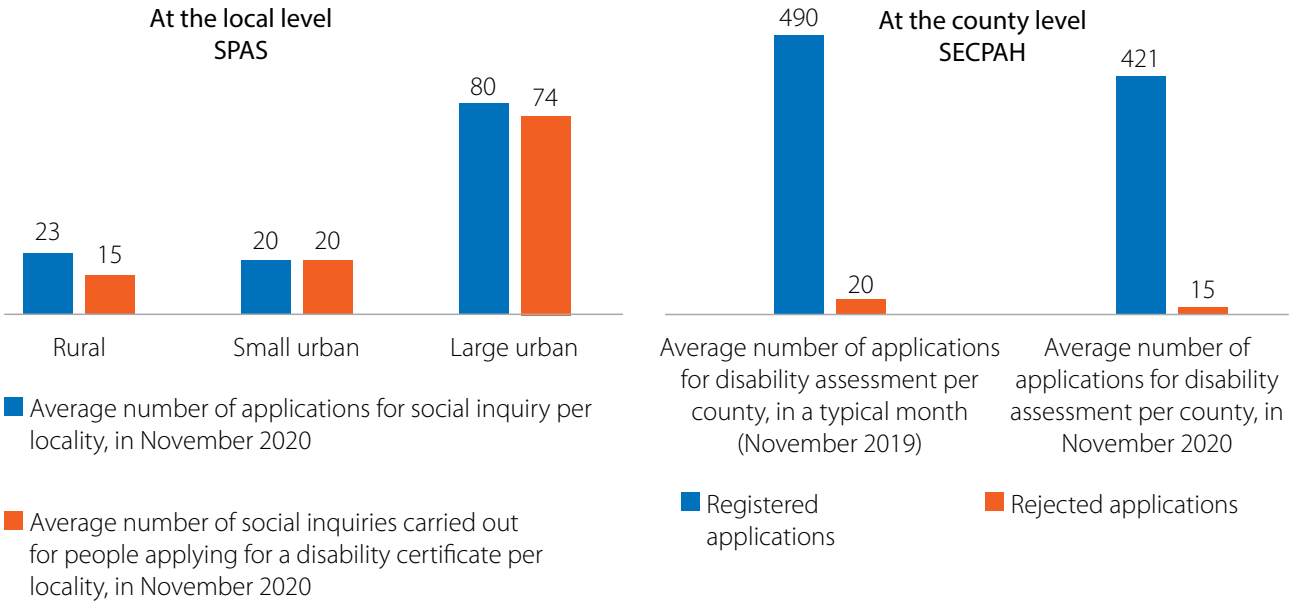


To correct possible malfunctions and increase effectiveness, any social protection delivery system must collect and maintain information on all applicants, not just those who eventually become beneficiaries. Regarding Romania's disability assessment process, neither SPAS nor SECPAH keep records on people who start the process but do not complete it; i.e., people who apply for a social inquiry and give up before they get it, cases in which SPAS refuses to carry it out, for various reasons, people who get the social inquiry but abandon the process while applying to SECPAH, or people who complete the application for assessment at SECPAH but give up before the assessment is completed or SECPAH does not register them, for example, on the grounds of an incomplete application file. However, neither institution monitors the phenomenon of dropouts or refusal to register. Consequently, the data presented in this chapter, which also refer to people who drop out, are only estimates provided as responses to the institutional surveys Q1_SPAS and Q2A_SECPAH and not solid data from registers or administrative databases.

According to the current regulations, once the medical and psychological documents are obtained, a claimant should apply to SPAS for a social inquiry. The SPAS ask claimants to provide a series of other documents, including a copy of their identity papers, documents proving their employment status and income, data about housing, and so on. When all requested documents are gathered, the SPAS social workers conduct the mandatory social inquiry. Once the social inquiry is completed, the SPAS checks again for the existence of all required documents, and the application file can be considered final. Then, SPAS refers the claimant to SECPAH, where he/she should fill out an application for disability assessment and register the file with all the documents. In exchange, the claimant receives an appointment for the assessment interview. This is the most common sequence of events during the intake and registration phase. Some variations within the process are presented in the next sections. Here, we present only the overall statistics corresponding to the previously mentioned steps to indicate the in- and out-flows of claimants from one step to another.

In Romania, no data are available about the number of people who were diagnosed by a specialized physician as suffering from a medical condition connected to the disability criteria, or the number of people who asked/received a medical letter from their family doctors, or the number of people who sought to obtain medical documents to apply for a disability certificate, for a certain period (month or year). In other words, it is not possible to estimate, not even roughly, the extent of the drop-out/refusal phenomenon during the process of obtaining medical documents. It is not possible to know the population making efforts to obtain medical documents and the corresponding success/failure rates for this first step.

Figure 6: Overall statistics regarding the monthly in- and out-flows (number of applications submitted and accepted or rejected/not accepted) by the intake and registration steps (number of persons)



Source: SPAS survey with valid answers from 57 SPAS, located in rural (N=33), small urban (N=8), and larger cities (N=16) from 26 counties, January-February 2021. Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties with valid answers, January-February 2021.

Notes: Small urban = small cities up to 20,000 inhabitants as of January 1, 2020; larger cities = cities with >20,000 inhabitants as of January 1, 2020; rural = communes of all three types included in the sample.

Yet, the research underpinning this report allows an estimation of the drop-out/refusal phenomenon related to the next steps of intake and registration, namely obtaining the social inquiry from SPAS and registering the evaluation application with SECPAH. Figure 6 shows the average number of people per type of locality that apply for a social inquiry at the SPAS, and the number of social inquiries carried out in response to those requests in a month. Data indicate that in both urban and rural areas, in a month, there are about 6–8 persons per locality, on average, who initiate the process but do not benefit from a social inquiry. This is due to both rejections on the part of SPAS and dropout on the part of claimants. The most common reason for refusing to conduct a social inquiry is a lack of identity papers (or updated ones), or the lack of a stable residence within the territorial-administrative unit, as declared within the Q1_SPAS questionnaire. In extreme cases, as shown in interviews, refusals are based on the mayor's "no handicap in my locality" policy. Claimants' reasons for dropping out are much more diverse; some are related to the difficulty of the process, while others are linked to stigma and discrimination against beneficiaries of a disability certificate (on the part of employers, but also the general population).

At the county level, on average per month, about 15-20 applications for disability assessment are rejected by SECPAH/DGASPCs, mainly because they are not accompanied by the corresponding complete file (see Section 3.4.2). These estimates are only indicative as there are significant discrepancies both among SPAS offices from different localities

and across counties. Among the studied SPAS, the numbers of applications for social inquires, and the carried out social inquiries respectively, vary from a minimum of 1 and a maximum of 140, in rural areas, and between 10 and 240, in larger cities. Also, across the SECPAH offices, the variation for November 2020 extends from a low 175 admitted applications to a high 700, while the number of rejected applications is between zero and 70.[103] This is in line with the large disparities in the number of people with disabilities between counties, as shown in Section 1.3.

"There are many situations in which the persons in question give up, because they find it more difficult to undergo these medical procedures and they do not really know what amount they will get. There were situations in which one of the sons submitted the file and the other brother gave up. Or they do not come to us because they do not know that they can also receive a disability pension, and after we informed them, many went to get it as well. [. . .]

We had 3-4 cases where people had been having a certificate for a long time and, in 2018, when the certificates were reprinted, they asked for their cancelation because they had gotten married in the meantime and did not want their partners to know about this. Others wanted to go to work or, in other situations, wanted to become foster parents and did not want this to be known. or the daughter asked for cancelation." (Focus group, SECPAH)

3.2. Obtaining the medical documents

According to GD no. 430/2008 (Art. 6), the application file for disability assessment for adults must contain the following medical documents: (i) a report on the current medical situation, prepared by a specialist physician;[104] (ii) a standard medical letter from the family doctor, only in the case of the first disability assessment (during lifetime); (iii) copies of hospital discharge tickets, if applicable; and (iv) paraclinical investigations requested by SECPAH.[105] Also, a medical report from a clinical psychologist is required for some medical conditions. SPAS checks if the medical documents are included in the file. Then a SECPAH/DGASPC representative checks the entire package of medical documents at registration, while subsequently, the SECPAH specialists use them in the disability comprehensive assessment phase, when they may request additional paraclinical investigations or medical reports as needed.

There are three main problems associated with obtaining medical and psychological documents. The first involves the financial and geographical accessibility of specialized health services. The second involves fraud suspicions and how the suspected cases are tackled. The third concerns medical professionals' limited knowledge of the disability criteria. This section delves deeper into these three problems.

Regarding obtaining medical documents, the first problem involves the financial and geographical accessibility of the specialized health services. On the one hand, applicants who request disability assessment shall be exempt from paying any fees to obtain the medical and psychological documents required to prepare the application file, based on the allocations from the National Health Insurance Fund.[106] On the other hand, under the framework contract concluded by the National House of Health Insurance, the documents issued to substantiate the formal disability assessment are excluded from the exemption.[107] However, a person who cannot afford to pay for the medical examination might wait several months for a free medical investigation, depending on the available ceiling for settlements.

103 The differences for November 2019 (or a typical month) were even higher. The admitted applications varied between 190 and 1,043, while the number of rejected ones was between 0 and 100.

104 No express requirements regarding the medical specialty is provided by the law.

105 For children, a similar package of medical documents is requested, namely A5 medical certificate from a specialist physician and summary medical record from the family doctor only in the case of the first presentation to SECPAH.

106 Art. 10(2) of Law no. 448/2006, as updated under Item 3, single article of Law no. 145 of July 22, 2020.

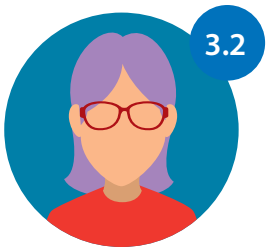
107 Art. 205, para. 1(i), in the Annex to GD no. 140/2018.

Table 5: Number of SPAS/SECPAH that collect information about applicants' obligation to pay for medical documents

	ADULTS		CHILDREN	
	SPAS	SECPAH	SPAS	SECC
Total number, of which:	71	36	71	32
SPAS/SECPAH that collect information about the need to pay for the requested medical documents	14	12	7	10
Report that claimants pay for …:				
- Medical report/A5 medical certificate, from a specialist physician	10	12	5	8
- Medical letter/summary medical record, from the family doctor	7	8	4	5
- A clinical psychologist's assessment, which is required for certain medical conditions	23	25	14	24

Sources: SPAS survey with responses from 26 counties. The districts of Bucharest are not included since the DGASPC also plays the role of SPAS, January-February 2021; Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH) and children (SECC), from 32 counties and 4 districts of Bucharest, January-February 2021.

Very few SPAS and SECPAH/SECC collect data about the need to pay for medical documents (Table 5). The majority of those that collect data report that claimants must pay for documents from both specialized physicians and family doctors. This situation is predominantly reported for adults and rarely for children. Specifically, it is reported about adults living in rural areas, mainly because in many cases, the closest specialized health services are private practices.



"One of the main problems is that some of the medical documents must be submitted in original. Not only in the context of COVID-19 but in general, the problem is that in rural areas there are no specialized physicians hence people must travel to a city for getting the needed documents." (Interview with NGO representative, Brașov)

In the opinion survey,[108] SECPAH practitioners estimated that within a typical pre-COVID-19 month, on average, 75 percent of the total number of adult applicants were forced to pay for medical documents.[109] In 15 counties, the obligation to pay is assessed as a barrier that hampers access to disability assessment "to a (very) large extent,"[110] while in the other counties, SECPAH practitioners do not report it as a barrier. They also confirm that the groups most affected by this barrier include the elderly, those from rural areas, people living alone (with no help from family members), the poor or those from low-income households, and the homeless.

For comparison, regarding children, SECC practitioners estimate that about 22 percent of the total number of child applicants were forced to pay for medical documents within a typical pre-COVID-19 month.[111] They report the obligation to pay for medical documents is a barrier that hampers access to disability assessment "to a (very) large extent"[112] only for three counties. The children mentioned as most affected by this barrier are from poor households and those left behind by migrant parents who do not have a designated legal representative. The NGO representatives shared similar views in interviews, adding that people without health insurance are among the most affected.[113]

108 Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=201) and children (SECC, N=187), January-February 2021, from 39 counties and the 6 districts of Bucharest.

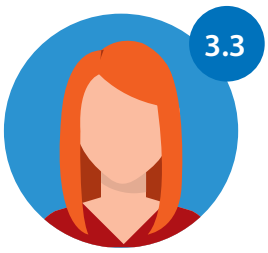
109 With a corresponding standard deviation of only 28 percent.

110 With average values of 4 or 5, on a scale of 1 (to a very small extent) to 5 (to a very large extent).

111 With a corresponding standard deviation of 26 percent.

112 With average values of 4 or 5, on a scale of 1 (to a very small extent) to 5 (to a very large extent).

113 Out of the 20 interviewed NGOs, 11 deliver assistance and support services in obtaining the necessary documents, namely intermediation, referrals and accompanying at specialized physicians, support with a clinical psychologist's assessment, and financial support. Most of these are NGOs with a large number of members and provide these services through all their subsidiaries/branches.



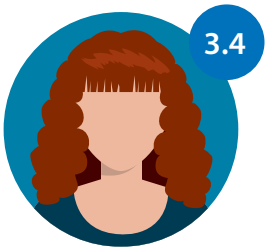
"If the persons have very low incomes and do not have a CAS [Health Insurance Fund] insurance, and the medical tests required for the submission of the file for the disability certificate are not reimbursed by the CAS, the persons give up and stop the procedure for the disability certificate. Uninsured people, for example, who are close to the legal retirement age and are ill and can fall into a category of persons with disabilities. In Bucharest, there are NGOs or partnerships between the General Mayor's Office and Regina Maria Private Health Network, which offer a minimum package of free tests for persons preparing the file for being classified as having a disability. This does not apply to the rest of the country, there is a disaster! ... Uninsured persons who have to prepare the file for being classified as having a disability, if they have to pay for the medical exams, they give up. I think that very clear social policies need to be implemented in this field." (Interview with an NGO representative, Bucharest)

Additionally, in focus groups, SECPAH practitioners mentioned another structural problem that creates difficulties or causes people to drop out of the application process: the uneven availability of imaging assessment services across counties, although there are many deficiencies that require this type of investigation. In some periods, a computer tomography from public health units was not available in some counties. In the case of other types of disabilities, the difficulties do not pertain to "old" structural problems, but to changes implemented because of the COVID-19 pandemic. For example, people suffering from HIV/AIDS had a lot of trouble obtaining the required documents from doctors in the public hospitals, as these have become COVID-19 hospitals and have been overwhelmed by patients.

Based on their interactions, both SPAS and SECPAH/SECC representatives report that most claimants must pay for a clinical psychologist's assessment, requested in the case of mental health problems (Table 5). This situation is common to children and adults, from urban and rural areas.

In the opinion survey,[114] the SECPAH practitioners provided additional information. First, they estimated that in a typical pre-COVID month, on average, about 300 out of 490 applications (or 61 percent) also needed a clinical psychologist's assessment. Second, they reported that, on average, 72 percent of adult applicants with mental impairment were forced to pay for medical documents.[115] Yet, this represents a barrier that hampers the adults' access to disability assessment "to a (very) large extent"[116] only in seven counties.

Child applicants must provide a clinical psychologist's assessment at first assessment (during lifetime), and then only in cases stipulated by legislation (approximately 75 applications, on average per county, in a typical pre-COVID month). According to SECC practitioners, about 45 percent of them pay for this document,[117] but only because "many parents choose to go to a private practice." Accordingly, the SECC specialists do not consider this to be a barrier that hampers children's access to disability assessment.[118] The interviewed NGO representatives agree, and report that especially children and young people with psychiatric or mental health impairments tend to delay applying for a disability certificate as an effect of "hope of healing" or fear of being stigmatized.



"The people who give up – in the case of many illnesses, imagery exams are required, at one point we did not have any functional equipment in the county – in the public system it would take several months, in the private system it would cost a lot, the expenses for such investigations are not reimbursed." (Focus group, SECPAH)

114 Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=201) and children (SECC, N=187), January-February 2021, from 39 counties and the 6 districts of Bucharest.

115 With a corresponding standard deviation of only 31 percent.

116 With average values of 4 or 5, on a scale of 1 (to a very small extent) to 5 (to a very large extent).

117 With a corresponding standard deviation of 31 percent.

118 An average value of 2 and standard deviation below 1, on a scale of 1 (to a very small extent) to 5 (to a very large extent).

"When it comes to mental illnesses/mental disorders there is a certain inertia both on the part of the affected person and of the family. Thus, after the onset of a disease, the first thought is not to get a disability certificate, because there is hope for recovery, so this request follows several years of efforts/hope. […] Strictly from the perspective of the psychiatric disorders/mental disorders/mental illnesses, it is less common for a young person, with the onset of the disease around the age of 16, to immediately apply for a disability certificate, it usually takes longer." (Interview with an NGO representative, Sibiu)

"We have to consider group 1, including persons with potential psychiatric disorders, and group 2, including persons with motor/somatic/physical dysfunctions, separately. The percentage of those applying for a disability certificate in group 2 is higher. Usually, they have their family by their side, which will take these steps, while for the young people in group 1, the family will be tempted to delay the procedure so, in this case, the percentage could be lower." (Interview with an NGO representative, Sibiu)

The second main problem connected to obtaining medical documents involves fraud, and how suspected cases are addressed. According to the SPAS survey, fraud seems to be very rare. For the past 3 years (2018–20), among the 71 surveyed SPAS, only 3 large cities reported a total of 6 complaints/notifications of fraud, regarding the declaration of a health condition by an adult, from family, neighbors, or any other person or institution. In addition, only one SPAS office reported one case regarding a child. In the same period, no SPAS initiated any proceedings *ex officio* in any case suspected of fraud connected to the certification of a persons with disabilities-related health condition. Correspondingly, only one SPAS office from a larger city reported having an approved procedure for how suspected fraud cases are treated, but did not attach it in the survey response package. All other SPAS offices lack such a procedure, saying "it is not needed." Nearly all SPAS make an ad hoc verification or record the suspicion in the social inquiry and notify the SECPAH/SECC; very few refer the case to other institutions, such as the County Directorate for Public Health, the Romanian Physicians' College, police/prosecutor's offices, and so forth.[119]

At the county level, almost half (17) of the surveyed SECPAH reported complaints/notifications of suspicions of fraud regarding the declaration of a health condition by an adult; between 1 and 65 per county, in 2020.[120] In contrast, only one SECC reported such cases. Out of all comprehensive disability assessment services, 11 for adults (SECPAH) and 6 for children (SECC) developed a procedure for how suspected fraud cases should be treated. However, regardless of whether they have a specific procedure, both services investigate any suspicion of fraud regarding medical documents (30 of the 36 surveyed SECPAH, and 27 of the 32 SECC). Most investigations were initiated at the request of the DGASPC (including *ex officio*), but also of the County Agency for Payments and Social Inspection, police/prosecutor's offices, as well as Prefecture, the Adult Phone,[121] ANDPDCA, or people from the community.[122] The dominant practice is to request an additional medical examination, and in the case of SECC, to report the case to the County Directorate for Public Health; rarely are cases referred to the Romanian Physicians' College, the Psychologists' College, or to police/prosecutor's offices.

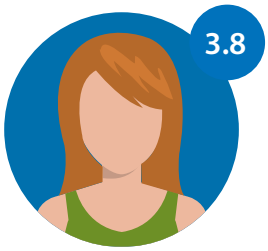
119 Also, 9 SPAS out of 71 in the sample answered: "we do nothing."

120 Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH, N=36) and children (SECC, N=32), from 32 counties and 4 districts of Bucharest, January-February 2021.

121 The Adult Phone is a service for emergency reporting developed in some DGASC.

122 The distribution of the SECPAH's responses was the following: Investigations initiated at the request of DGASPC (including ex officio)—29; County Agency for Payments and Social Inspection—9; Police/Prosecutor's Office—9; Others—5. The corresponding values of the SECC's responses were: 23, 1, 0, and 4.

"The vast majority of people think they are sicker than they really are. Some of them even pretend. We "see" those, and eventually, if the good word is not working, we send them to an additional examination, otherwise, we do not support them." (Interview with a national NGO representative, Brasov)

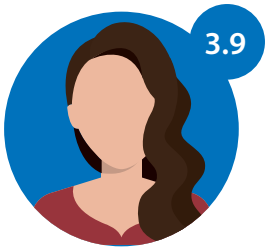


"Other people, although having a severe permanent disability, were called for reassessment following false complaints, which can be considered of criminal nature. Someone filed a complaint about a person, under a different name, i.e. my name. I went and explained to the head of the [assessment] committee that I had not filed any complaint against those people and that what had happened, i.e. that they used my name, could be considered a criminal offence. However, the persons subject to the complaint were sent for reassessment at a university clinic in Bucharest or Târgu Mureș, in the midst of this pandemic. They put those people to a lot of expenses and, more specifically, they endangered their lives following false claims, as I had already told them. Following the reassessment, those persons were still classified as severely disabled and entitled to a personal assistant… Such abuses should be stopped." (Interview with a national NGO representative, Bucharest)

Regarding suspicioned fraud in medical documents, the interviewed NGO representatives said:

1. Cases of fraud are mostly isolated and not systematic:
2. A problem, in the opinion of the NGO representatives, is the "abusive" way in which the system handles the cases of people who are wrongfully blamed or suspected of fraud.
3. NGO representatives say the problem with fraud is structural, an effect of the system's low capacity and fragmentation. The considerable discrepancies between counties in the number of persons with disabilities (from less than 6,000 to 38,000 in the official statistics) is the main reason why NGO representatives say that differences in the medical and social systems are the main source of those discrepancies, since the differences in the composition of the population cannot be that large.
4. Another problem is caused by the lack of data exchange between institutions and the lack of willingness or capability to cross-check data collected from application files with the existing national registries, let alone interoperable systems.

"A few years ago, the organization was receiving many complaints that there were blind people who could actually see and drive their cars, so the organization sent a standpoint to the DGASPC in which it said that a driver's license was not even compatible with a mild disability (third degree) and requested a cross verification of the database with the list of blind people holding a driver's license. This verification did not take place, why…?" (Interview with a national NGO representative, Brașov)



In consensus, NGO and SECPAH representatives mention a "legislative flaw" with the medical-psychosocial criteria and the complex assessment procedure that can pave the way to suspected fraud and non-compliance with specific legislation. The vulnerability of the system concerns people with multiple impairments who choose to apply for just one impairment, most often because they cannot

afford to obtain the required medical documents for all of them, as well as cases of conditions that have fluctuating manifestations. On the one hand, NGOs have raised this issue precisely because, in their experience, it is quite common for such cases to be suspected of fraud. On the other hand, during focus groups, SECPAH doctors mentioned difficulties related to the complex assessment of cases with multiple impairments, as they focus on the "main" one (the one documented in the application file) and not on the collateral ones, as provided by the regulations in force.

Finally, the third main problem involves the fact that medical professionals have limited knowledge of the disability criteria, as pointed out in focus groups with SECPAH and CEPAH members, but not by those persons with disabilities who were interviewed or the NGOs that represent them. At least in recent years, according to SECPAH and CEPAH representatives, an important part of the medical professionals, particularly orthopedic and rheumatologist doctors, wrongly advises people to apply for a disability certificate even for health conditions that do not comply with the disability criteria as per the current legislation. This creates noise in the system, false expectations, and a general perception of inefficiency and unfairness.

3.3. Obtaining the social inquiry from SPAS and compiling the application file

After obtaining medical documents, the next step is to apply to the SPAS for a social inquiry.[123] As shown in Figure 6 (in Section 3.1), the average monthly number of social inquiry applications varies between 23 in rural areas to 80 in larger cities.[124] Most of those applications (about 70 percent) are reassessments to renew an existing disability certificate; approximately a quarter are applications for an initial assessment (during lifetime), while the other 5 percent are from people with a permanent certificate who seek reassessment due to a change in their medical or social situation.

Among the applications for social inquiry, about three per locality per month, on average, belong to young people aged 18–26,[125] out of which two apply for reassessment and one applies for the first time. Applications for social inquiry from people of 16–17 years are fewer than two per locality per month, on average.[126]

Only a third of the surveyed SPAS have an approved procedure (or sections/chapters in the general procedure) concerning the submission and registration of the social inquiry application.[127] In practice, the social inquiry applications should be submitted as written forms to the registration office within the municipality or SPAS. Only a few localities accept telephone applications or ones sent via email. Even among the large cities, only half of those surveyed accept applications by phone or email. In most of the surveyed localities, the application can be submitted in person by the applicant, his/her legal representative, a member of his/her family, or a personal assistant. An applicant subject to interdiction can submit a request for social inquiry in just a third of all localities (both urban and rural). In about half of urban localities and a third of rural ones, the social inquiry application can be submitted by any person who represents the applicant, while just a few localities (mainly urban ones) accept applications from an NGO that represents the applicant.

Beginning in 2019, a simplified electronic procedure for requesting a social inquiry assessment was made available within the Unique Electronic Point.[128]

123 Data in this section come from the SPAS survey with responses from 71 administrative-territorial units situated in 26 counties, January–February 2021.

124 Data for November 2020. However, 55 percent of the surveyed SPAS showed that, in the context of the COVID-19 pandemic (in 2020), the number of applications for a social inquiry submitted to SPAS "stayed flat;" 21 percent of SPAS appreciated that "it decreased;" 17 percent of SPAS said that "it increased;" the other 7 percent of SPAS did not answer to this question. There are no significant differences between rural and urban localities.

125 On average, in November 2020, less than three in rural localities, and more than five in the larger cities (SPAS survey, N=55 valid responses).

126 On average, in November 2020, less than one in rural, and over four in larger cities (SPAS survey, N=55 valid responses).

127 A total of 24 localities, out of which 8 communes, 3 small cities, and 13 larger cities (SPAS survey, N=71 valid responses).

128 This procedure has been included in the handbook of procedures for a standardized implementation of life events, part of the provisions of the Digital Agenda Strategy in Romania. The procedure included in the handbook refers to all the steps for obtaining the disability certificate and corresponding benefits; therefore, it also covers the part on conducting the social inquiry.

On this electronic platform, claimants have access to all the requested information. They can also initiate the procedure and obtain the standard application form. However, only very few municipalities in the country implemented it.[129]

After registration, the applications are sent to a social worker, or, in small localities, the person with social assistance responsibilities who informs applicants of the requested documents. Only after the person gathers the required documents can he/she return to the SPAS and make an appointment for the social inquiry. In fact, the application for social inquiry is only complete after all the other documents are collected (see also Section 3.2).

3.3.1. The Application File and Access Barriers

The documents required for disability assessment are regulated by GD no. 430/2008, Art. 6. However, the SPAS may decide to add other documents or request some in electronic format, photocopy, certified copy, original, or some combination. Nearly all SPAS included in the sample require the applicant to gather a set of documents before the social inquiry can take place.[130]

Table 6 illustrates how many and what documents, and in which format, are included in the application file. It also shows differences between localities. Figure 7 shows that about half of the surveyed SPAS cannot estimate how many days an applicant needs to gather all these documents - they have never measured it. However, among those who provide an estimate, a third of SPAS, especially those from rural areas, tend to say less than a week. The others, particularly from urban areas, provide much longer estimates, between 10 and 30 days.

The interviewed persons with disabilities and NGO representatives reported the following:

1. There are many required documents and, in most cases, applicants must provide the same document year after year: "I brought the same papers last year and the year before, they already know me, why don't they use those and I must pay for more copies?"[131]
2. The photocopied and certified copies involve costs that many have trouble affording. For this reason, some NGOs offer a "photocopy kiosk" service, where they provide all standardized forms, make free photocopies, and help applicants fill out the forms.[132]
3. Those interviewed said that not only the file but the whole procedure is "bureaucratic and the necessary steps are difficult to do as if they want us to give up,"[133] and indeed, "many are giving up because they would need much more support, which unfortunately the authorities do not provide."[134] Notably, the Social Inspection also reports that only 56 percent of the surveyed SPAS offer counseling services on how to compile the file for disability assessment.[135]
4. The file is "thick" and the procedure "cumbersome," even more so given that the initial information is insufficient: "We would need to know from the very beginning not only the list of documents but also from where and how to get them, don't just go to the counter [at SPAS] where they turn us back three or four times because we don't have the necessary documents."[136]
5. Because of these reasons, "many elderly, particularly from rural areas and if they have a pension, do not want to spend their energy and time for applying for a disability certificate."[137] At the same time, such a procedure is "almost impossible, for example, for homeless people. A homeless person cannot compile this kind of file on his/her own; only if he/she stays in a shelter and the social worker of that shelter helps, assists, and accompanies him/her. But they have become homeless due to trauma and usually have difficulties in complying with the rules of a shelter. They need their independence, and generally run away or leave the shelter before such a complex file can be put together."[138]

129 PCUE (2021).
130 The exceptions are only one small city and two communes.
131 Interview with a person with disabilities, male, 45 years old.
132 Interview with NGO representative, Arad subsidiary.
133 Interview with a person with disabilities, female, 52 years old.
134 Interview with NGO representative, Timis.
135 ANPIS (2019: 11).
136 Interview with a person with disabilities applying for the first time, female, 36 years old.
137 Interview with NGO representative, Bucharest.
138 Interview with NGO representative, Bucharest.

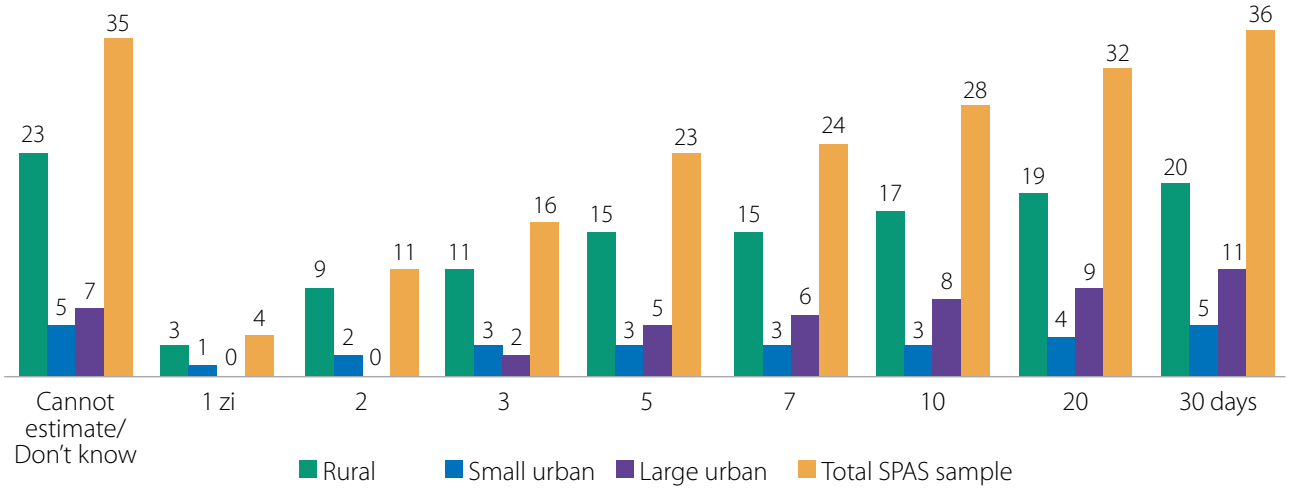
Table 6: Documents collected in different localities prior to the mandatory social inquiry

		Rural	Small urban	Large urban
	Total number of surveyed SPAS	**43**	**10**	**18**
	Any of the below documents	**41**	**9**	**18**
The applicant's ID	On electronic formant	3	1	3
	Photocopy	29	8	15
	Certified copy	1	0	0
	Original	29	5	8
ID of the legal representative (as the case may be)	On electronic formant	3	1	3
	Photocopy	25	8	15
	Original	27	5	6
IDs of the persons living with the applicant	On electronic formant	1	1	2
	Photocopy	14	5	5
	Original	11	4	2
The disability certificate that expires (in the case of reassessments)	On electronic formant	2	1	4
	Photocopy	28	8	17
	Original	19	4	4
Medical report from a specialized physician	On electronic formant	2	1	4
	Photocopy	24	5	12
	Original	23	4	8
Medical letter from the family doctor	On electronic formant	2	1	4
	Photocopy	23	6	12
	Original	23	5	8
Psychological assessment	On electronic formant	2	2	4
	Photocopy	15	5	6
	Certified copy	0	1	0
	Original	18	4	8
Marriage/death certificate/divorce judgment (as the case may be)	On electronic formant	2	0	0
	Photocopy	17	3	10
	Certified copy	0	1	0
	Original	14	4	4
Pension slips (in the case of retired persons)	On electronic formant	2	0	4
	Photocopy	26	6	15
	Original	23	4	5
Hospital certificate (in the case of persons who were hospitalized)	On electronic formant	2	1	2
	Photocopy	15	5	9
	Original	16	2	5
Revenue certificate, for taxable revenues, issued by Fiscal Agency (persons with no income)	On electronic formant	2	1	2
	Photocopy	18	4	9
	Original	19	4	5
Civil judgment - guardian (as the case may be)	On electronic formant	2	1	3
	Photocopy	21	6	13
	Certified copy	0	1	1
	Original	18	4	4
Regarding the applicant's children (including adult children)	Only information from interview or observations from home visits	27	7	13
	Documents	16	3	5
Regarding the applicant's education, employment	Only information from interview or observations from home visits	33	6	14
	Documents	10	4	4
Regarding the applicant's dwelling - address, number of rooms, amenities, etc.	Only information from interview or observations from home visits	37	9	18
	Documents	6	1	0
Rail file	Yes	3	0	2

Source: SPAS survey with responses from 26 counties. The districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January-February 2021.

Notes: If the sum per category of documents is higher than the total shown in the first row of the table, it means that some SPAS request that document in two or more formats. If the sum per category is lower, it means that some SPAS do not require that document at all. The documents requested regarding the applicant's children may include identity documents, marital status certificate, birth certificate, revenue documents, and psychological file. The documents requested regarding the applicant's education and employment may include employee certificate and diploma of studies. Small urban = small cities up to 20,000 inhabitants as of January 1, 2020; larger cities = cities with >20,000 inhabitants as of January 1, 2020; rural = communes of all three types included in the sample.

Figure 7: Average number of days in which a person applying for social inquiry may gather all requested documents, as estimated by the surveyed SPAS (number)



Source: SPAS survey with responses from 71 SPAS from rural localities (N=43), small urban (N=10), and large urban (N=18), which are situated in 26 counties. The districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January-February 2021.

Note: The figure shows the cumulative frequencies. Reading example: Of the total sample of 71 SPAS (blue bars), 35 did not respond and 36 provided estimates between 1 day and a maximum of 30 days. Of these SPAS, 4 claimed that the required documents can be collected in one day, 11 claimed that the document collection process is completed in a maximum of 2 days (the 4 SPAS that estimated a single day are included), 16 said that document collection is completed in a maximum of 3 days (the previous estimates of 1 or 2 days are included), and so on.

"At the end I waited a very long time - 2 months – in order to get the certificate. After that I had to go in the other building to bring a copy of the Certificate and to sign another paper to be registered for payment. But I didn't understand that I had to do this, and I didn't go to sign for being registered for the payment, so I didn't receive the money for this reason. This is something that should be changed. because I lost the money for that period and is not correct." (Interview with the daughter of a person with disabilities, woman, 54 years old)

The SPAS representatives confirm the existence of such access barriers; according to them, in about half of the surveyed localities, there are adults who, because of their health condition (a long-term chronic disease), could have requested the disability certification but have not applied for one.[139] SPAS representatives estimate that about 10 percent, on average, do not apply.[140] The most frequently cited reasons for not applying involve various access barriers (similar to those mentioned by NGOs), such as (i) lack of support provided by authorities, including municipalities, SPAS, as well as DGASPC; (ii) lack of money to obtain documents for the file; (iii) lack of proof or official evidence of age at which the disease was officially identified; and (iv) lack of awareness about the existence of and ability to apply for a disability certificate and its associated benefit-service package.[141] For comparison, regarding children, only 17 percent of the surveyed SPAS, mostly from larger cities, think there are children in their community eligible for a disability certificate who do not apply. The major access barrier for children is reported to be their parents' low level of education, lack of awareness, or shame in initiating the application.

139 A number of 37 out of the 71 surveyed SPAS, of which 19 from rural areas, 5 small cities, and 13 larger cities. Data from the SPAS survey covering 26 counties, January–February 2021.

140 The average estimates vary between 8 percent in rural areas and 13 percent in larger cities with corresponding standard deviation values lower than averages.

141 These 4 access barriers were selected from a list of 11 options wherefrom the respondents were asked to select the 3 main ones for people in their community. They were elected by 19, 19, 14, and respectively 13 SPAS representatives.

3.3.2. SPAS Operation Models and Practices for Conducting the Social Inquiry

With all the required documents gathered, the applicant makes a second visit to the SPAS, delivers the file, and makes an appointment for the social inquiry.[142] According to the surveyed SPAS, on average, it takes three days in rural areas and seven days in urban areas until the social inquiry is carried out.[143] The SPAS offices use two or all three of the following methods for conducting the social inquiry: home visits, documents, and a combination of documents and telephone, WhatsApp, or Skype interviews.

Table 7: Methods for conducting and average duration of the social inquiry needed for disability assessment, by type of locality

	Rural	Small urban	Large urban	Total SPAS sample
Total number of SPAS in the sample	43	10	18	71
Social inquiry method used by SPAS:				
a. Home visits	43	10	18	71
b. Documents (no home visit)	19	8	5	32
c. Combination of documents and telephone, WhatsApp, or Skype interviews	24	6	14	44
Estimated average number of minutes for …:				
a. Home visits—round trip	46	63	75	56
b. Home visits—interaction with the applicant and his/her family	47	49	47	47
c. Social inquiry based solely on documents (no home visit)	23	24	32	25
d. Social inquiry based on a combination of documents and telephone, WhatsApp, or Skype interviews	24	30	27	26

Source: SPAS survey with responses from 26 counties. The districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January-February 2021.

Notes: If the sum per column is higher than the total shown in the first row of the table, it means that some SPAS offices use a combination of two or three methods for conducting the social inquiry. Regarding the time estimates, only 12 SPAS (from 7 communes and 5 larger cities) reported that they measured those rigorously, the others providing just estimates based on experience. Small urban = small cities up to 20,000 inhabitants as of January 1, 2020; larger cities = cities with >20,000 inhabitants as of January 1, 2020; rural = communes of all types.

Social inquiries based on home visits are conducted in all types of localities, as shown in Table 7. Home visits are used to gather and verify information. They can help SPAS representatives form a better qualitative understanding of an applicant's overall situation. Then, the file is used to cross-check and validate the information. Some SPAS, especially from rural areas, use this method for all disability assessment applicants. However, more often, home visits are used for "new" applicants applying for the first time, and for people who cannot move. In rural areas, home visits involve usually one SPAS caseworker, especially in the underdeveloped and remote communes where the SPAS consists of just one person with social assistance responsibilities (not a professional social worker).[144] On average, a home visit lasts about 90 minutes, out of which half is for the round trip and half is for the interaction with the applicant and his/her family. In urban areas, home visits are usually carried out by a team of two specialists[145] and last over two hours, out of which about 45 minutes are for the interaction with the applicant and his/her family and the rest for the round trip.

142 Only 19 SPAS, out of which 12 communes, 1 small city, and 6 larger cities, report that they conduct home visits for the social inquiry not only after but also before the persons deliver the complete file with documents. Data in this section come from the SPAS survey with responses from 71 administrative-territorial units situated in 26 counties, January-February 2021.

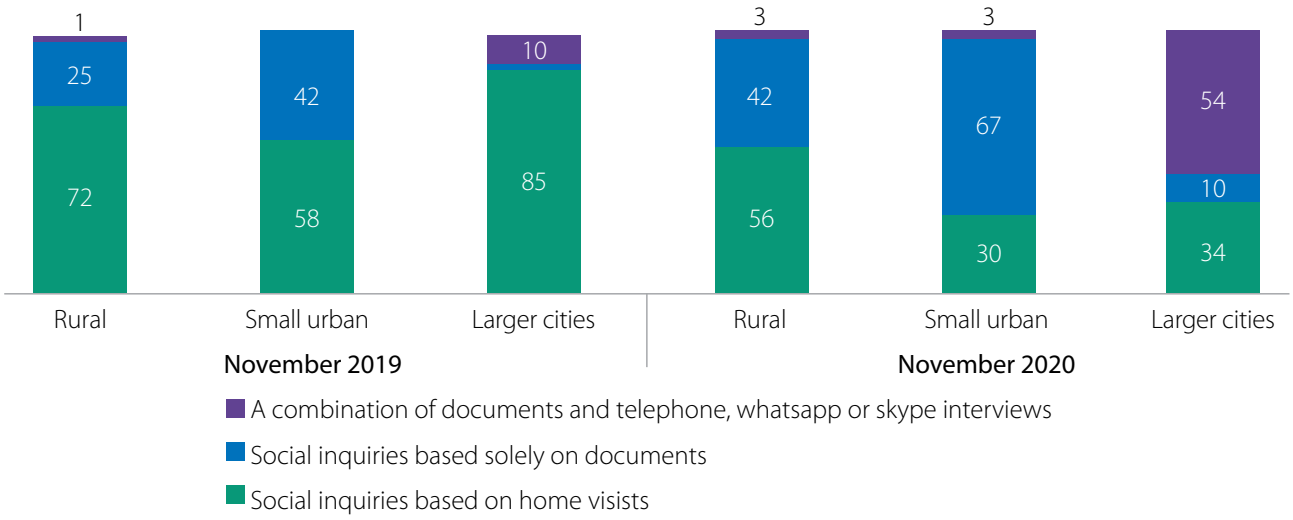
143 The estimates vary between 0 and 15 days in rural communities and 1 and 30 days in urban area.

144 Out of the 43 surveyed SPAS from rural localities, 50 percent report that home visits are done by only one caseworker; 35 percent by two SPAS members; 8 percent by three or more, including a policeman, a community nurse, a Roma mediator, or other community workers besides SPAS (this is the case especially in marginalized areas); and 7 percent did not answer.

145 Out of the 28 surveyed SPAS from urban localities, 25 percent report that home visits are done by only one caseworker; 57 percent by two SPAS members; 15 percent by three or more, including a policeman, a community nurse, a Roma mediator, or other community workers besides SPAS; and 3 percent did not answer.

Social inquiries based solely on the documents gathered and delivered by the applicant are conducted in fewer localities (32 of the 71 in the sample; see Table 7). In all types of localities, this method is used mainly for "old/well-known" cases applying for reassessment, usually people with a medium or marked level of disability (rather than severe), or when the applicant visits SPAS in person and an interview can be also performed.

Figure 8: Distribution of social inquiries according to how they were conducted (% of total)



Source: SPAS survey with responses from 26 counties. The districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January-February 2021.

Note: Small urban = small cities up to 20,000 inhabitants as of January 1, 2020; larger cities = cities with >20,000 inhabitants as of January 1, 2020; rural = communes of all types.

The COVID-19 pandemic led social inquiries to be conducted using a combination of documents and telephone, WhatsApp, or Skype interviews. These methods were particularly adopted for people living in residential centers (public and private), for children and adults under treatment in hospital (including abroad), and for those at high risk of COVID-19 infection. To ensure the accuracy of the information in the social inquiry, an additional working tool—"Declaration on own responsibility"—has been used, through which the applicant ensures the accuracy of the data provided.

Figure 8 shows that in the pre-COVID period (November 2019) most SPAS predominantly used home visits to conduct the social inquiry for adults applying for disability assessment. In contrast, in November 2020, SPAS from small cities considerably increased inquiries based solely on documents, while SPAS from larger cities shifted towards a combination of documents and telephone, WhatsApp, or Skype interviews. A similar change was registered regarding social inquiries for children, but on a smaller magnitude; home visits remained the dominant method.

Regarding adaptations for the inclusion of vulnerable groups, the SPAS survey shows that: (i) in over 75 percent of the surveyed localities, social inquiries based on home visits are conducted for people who cannot move and for people under guardianship or with a trustee; (ii) a few localities (6 out of 71) do not conduct the social inquiry for homeless people, while the majority conduct these social inquiries based solely on documents; (iii) in few localities, SPAS conducts social inquiries for people in detention, usually based on the information collected from that person's family and in cooperation with the social workers from jails; and (iv) only in some localities, SPAS conducts social inquiries for people in residential centers that are located in a different county than the one in which the person officially resides. According to the SPAS representatives, the last issue "requires a legislative regulation to clarify the limits of competence of the administrative structures at least at the local level. It is very difficult to deal with a case in the absence of the persons for whom the disability assessment is requested; all the more difficult to access the disability benefits of the people who live in the territorial area of another locality. The number of people in such a situation is constantly increasing, at least in the case of people living in institutions."[146]

146 Citation from questionnaire Q1_SPAS.

The surveyed SPAS offices do not have an approved procedure, steps, or rules concerning interactions with applicants while conducting the social inquiry.[147] Some interact directly with the applicant, while others interact only with the applicant's family or legal representative. Aside from the standard questions and answers included in the social inquiry, only some take note of what the applicant is saying, recording it under various sections of the instrument. Thus, the recorded data are randomly selected and noted. When the applicant and his/her family or legal representative have a contradictory or conflicting opinion or representation, what the caseworker records within the social inquiry "depends from one case to the other" (in 52 out of the 61 valid responses). Therefore, regardless of the method used to conduct the social inquiry, the interaction with the applicant and how information is selected and recorded vary considerably, not only from one SPAS to another but from social worker to social worker.

"They were nice (the ladies from the social assistance service), they were not bothered by the fact that I did not have too much space, I have a small studio and I had to clear a chair so that they could work, write things down on paper. They were not outraged by all those piles of things. Because I rather use my place for storage and less as an apartment, they were nice, they were kind, they asked me the questions in the questionnaire. According to their question grid, I am autonomous, I can live independently." (Interview with person with disabilities, woman, 60 years old)

"On the one hand, things were made just on paper, usually… it is not a stereotype or…. but that is how things work in villages… in the small counties… the social worker is not necessarily a skilled social worker but someone who was put in that position precisely because there are no other persons to do this activity and, on the other hand, it was also the fact that the person knew my mother. Knew our family and my mother asked her to be discreet about the social inquiry. And all this led to a survey that did not actually take place." (Interview with person with disabilities, woman, 33 years old)

"- [The social inquiry] was conducted at the DGASPC office, not at home. I understand that these are conducted at home in the case of homebound people. of people with more serious problems. But I am not homebound, so it was conducted only with the social worker at the counter, a questionnaire that seems a complete nonsense, yes/no answers, can you walk independently, do you watch TV, do you eat alone… this kind of questions…
- So you filled out the form yourself?
- Yes, yes, by myself, in front of the counter." (Interview with person with disabilities, woman, 24 years old)

The quality of data collected through the social inquiry affects the accuracy of the entire disability assessment. The surveyed SECPAH were asked to provide the research team with examples of "good" and "bad practice" social inquiries as part of the package attached to the institutional Q2A survey. The examples they provided indicate that "bad practice" refers mainly to missing information regarding data on an applicant's children, the network of friends and neighbors, the name of a contact person in case of emergency, income sources, as well as the local offer of services and to what extent they can cover the applicant's needs. Notably, the framework model of social inquiry as provided in the current legislation represents the main source of information for several areas of the disability assessment—education, social and vocational integration, social integration, etc.—but this topic is developed in Chapter 4.

147 Only one SPAS in the sample reported to have it and sent it to the research team.

3.3.3. The Instrument for Social Inquiry

The social inquiry should follow a standard framework model, as per GD no. 430/2008 (Annex 6). For children, the social inquiry should be accompanied by an annex of environmental factors developed from the ICF perspective, for which a standard framework template was issued in Annex 6 of Order no. 1985/1305/5805/2016. According to the SPAS survey, all localities use these two framework models for the social inquiry. Figure 9 shows that most social inquiries are conducted following the framework models, in all types of localities, both in November 2019 (pre-COVID) and in November 2020, to a larger extent for adults than children.

The framework model of social inquiry includes data on the applicant; data on the applicant's legal representative; a section on autonomy highlighting the person's functional status (activities of daily living and instrumental activities of daily living); an evaluation of the person's sensory and psycho-affective status; and a social assessment of the person's housing, family, friends, and neighbor network, and economic situation. Finally, it presents the identified needs and corresponding services, followed by conclusions and recommendations. In the SPAS representatives' perception, the social inquiry they conducted for adults on average scored between 8 and 9, on a scale of 1 to 10, for completeness and accuracy.[148] Thus, the existing social inquiries would allow a "good" or "very good" understanding of an applicant's situation in all spheres of life. The SECPAH practitioners are more critical, giving scores between 5 and 7 for the completeness and accuracy of the information regarding housing, economic situation, and community services.[149] The general score (on a scale of 1 to 10) regarding the extent to which the social inquiry data allow the SECPAH practitioners to accurately assess the applicant's physical and social environment is less than 7 for those conducted by rural SPAS, and less than 8 for those carried out by urban SPAS. The content of the social inquiries is further analyzed in Chapter 4.

However, not all SPAS follow the framework model of social inquiry, as shown in Figure 9. Some localities use a different template that is, according to them, "adapted to the local conditions." The analysis of the sample of "good" and "bad practice" social inquiries[150] provided by SECPAH and SPAS revealed that, most often, the different templates are modified versions of the framework model. First, some of the sections from the framework model are replaced with a narrative essay on the same topic. Second, part of the framework model is deleted. For example, information about the assessment of the individual's sensory and psycho-affective status, relationships with neighbors, as well as the final sections[151] on the assessment results are not recorded. In another example, the social inquiry does not include information about food preparation, household activities, shopping, managing one's own revenues, separate categories for walking within and outside of the house, using transportation, following medical recommendations, participating in leisure activities, or the section on assessment of sensory and psycho-affective status. Third, the first section of the framework model (on Individual Autonomy and Functional Status) is modified, and information is grouped under Types of Occupational Activities, with different categories than those provided in the legislation. Fourth, the framework model is completed with additional notes, observations, or recommendations regarding the services needed by the applicant.

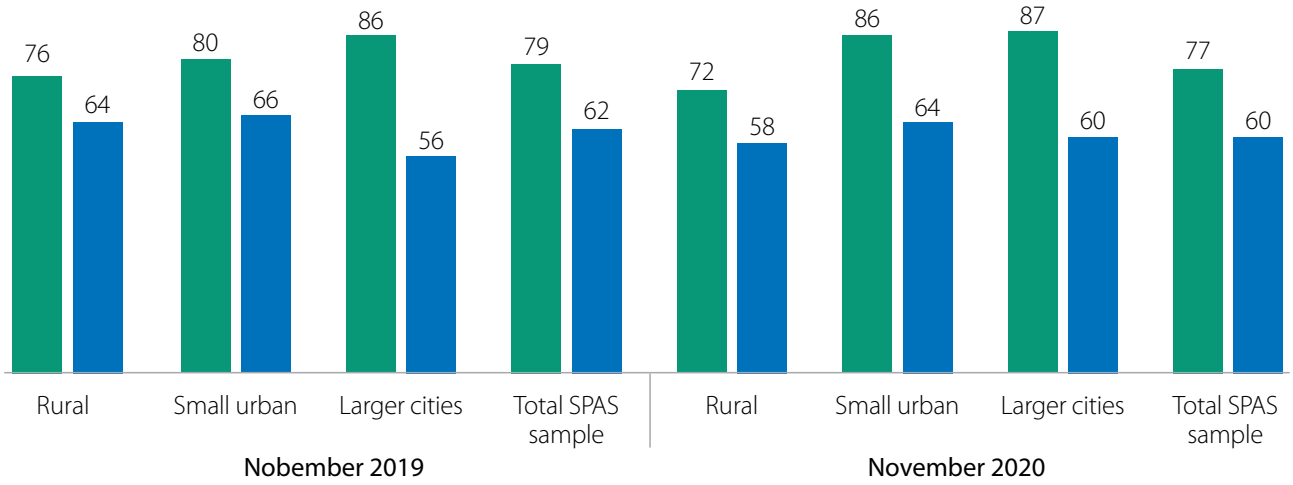
148 The corresponding standard deviation values are between 1 and 2, which indicates very high homogeneity in responses. SPAS survey with valid responses from 65 SPAS, from 26 counties, the districts of Bucharest are not included since the DGASPC also plays the role of SPAS, January–February 2021.

149 The housing information refers to the ability of the person with disabilities to choose where he/she lives, adjustments of his/her dwelling (actual and needed), the support needed by the person with disabilities in obtaining a residence. The information about the economic situation refers to the the income and housing amenities of the person with disabilities, including the cost of disability in that person's family and its impact on a decent lifestyle, as well as the financial aid necessary to allow that person to live together with their family and the community. The information on services regarding the local service offer, the person with disabilities' access to the existing services, and his/her needs in terms of access to health care and rehabilitation services. Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N = 201), January–February 2021, from 39 counties and 6 districts of Bucharest.

150 Sent as part of the attached packages to the Q2A_SECPAH and Q1_SPAS surveys.

151 Namely, if the care and treatment for the individual can be performed in the claimant's home, which are the identified needs, as well as the needs that can be covered by the local offer of services.

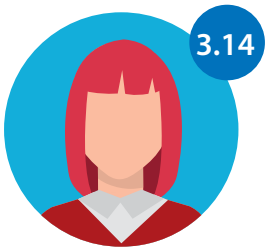
Figure 9: Share of social inquiries for disability assessment carried out for adults and children in compliance with the framework model (% of total social inquiries)



Source: SPAS survey with valid responses from 60 SPAS, from 26 counties. The districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January-February 2021.

Note: Small urban = small cities up to 20,000 inhabitants as of January 1, 2020; larger cities = cities with >20,000 inhabitants as of January 1, 2020; rural = communes of all three types included in the sample.

The main factors that influence the quality of current social inquiries mainly relate to understaffing and insufficient training of SPAS staff, as well as necessary improvements to the framework model. The two main factors are perceived differently by SPAS and SECPAH practitioners. SPAS representatives think the framework model should be adjusted to better capture how persons with disabilities live and how they would want to live. They also emphasize that the quality of social inquiry cannot improve so long as the SPAS compartments are comprised of just one person with social assistance duties, as is the case in many rural communities (see also Section 9.1). In this regard, SECPAH specialists agree. However, they add that some adjustment to the framework model of social inquiry may help, but more importantly, staff at the local level should benefit from training on how to use this instrument, since many of them use it superficially or erroneously.



"The social inquiry – it seemed a bit cold, it seemed standard and less focused on me, as a person with disabilities, and rather focused on. material aspects. It was a kind of review of the living conditions but. somehow from a strictly material perspective. That has not changed much over time in my case. So, I was answering the same questions every year. And it was a bit. I mean. it was not something to be concerned about. because it did not have any annoying content or… but it was not useful either or maybe I did not understand very well why such information was being collected repeatedly since nothing else changed." (Interview with person with disabilities, woman, 30 years old)

"The essential problems of the disease are under no circumstance to be found in that questionnaire and, based on that questionnaire, they establish the type and the degree of disability. … I was not asked if I cooked my own food, if I could do some shopping on my own, I was not asked if I left home alone or if, God forbid, I was home alone, could I manage on my own? These are questions that are not related to... the problems that a person with disabilities faces every day. […] And that is because the questions based on which a patient with health problems is assessed are far too... they do not highlight enough the problems that a patient is really facing. I, at least, tried to tell him that I cannot manage on my own and that I am afraid to be alone at home. I often cannot get dressed on my own and the answer was: these are not important things for our assessment form." (Interview with person with disabilities, woman, 52 years old)

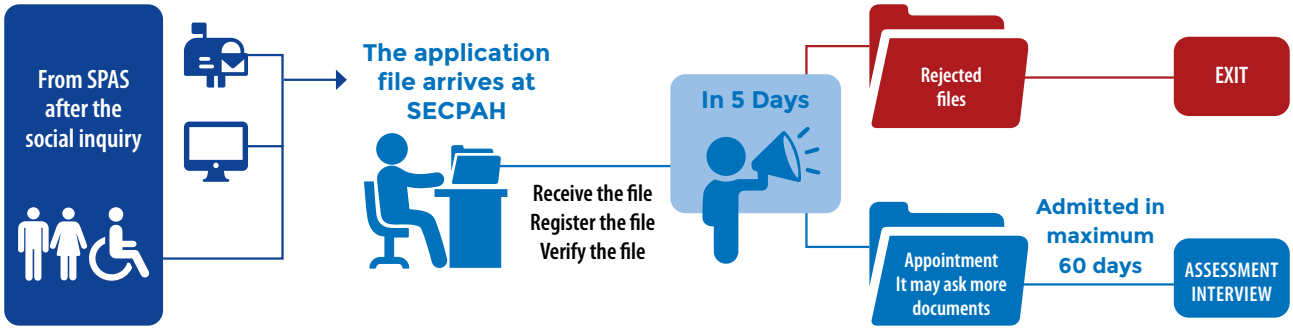
"There were some STANDARD answers to the questions that they asked me, and one could not give a free answer in which to say that, depending on the period… I feel or I do not feel well. That if today I feel very good, I climb the mountain, tomorrow I may not even be able to get out of bed." (Interview with person with disabilities, woman, 25 years old)

A section that should reflect the point of view of the person with disabilities—such as fears, concerns, how he/she would like to live, and what he/she would want to do in the future—was among the improvements more frequently mentioned in interviews. Currently, the framework model is largely focused on support needs, while information on what the person likes and wants, or his/her plans, is very scarce, if available at all. Also, the social inquiry does not record information concerning adjustments to the applicant's dwelling (actual, planned, and needed), the extra-cost of disability and its impact on family life, the applicant's lifestyle (actual, planned, and wanted), family and community resources to help and support the applicant, or the services that the applicant has already benefited from, which would be very useful for the phase on drafting individualized plans (see Chapter 6).

3.4. Registering with SECPAH for disability assessment

Registration is the last step of the second phase of the delivery chain, aimed at efficiently registering the target population and vulnerable groups and accurately recording their information. Registration consists of recording and verifying information. The file containing documents gathered and verified by SPAS during the intake step (discussed in Sections 3.2 and 3.3) represent the inputs to the registration step. The outputs include complete, validated, and verified information on the applicants who have registered. Those outputs feed into the next phase of the delivery chain: the disability assessment, which is analyzed in Chapter 4. The main steps of the registration process (see Flowchart 4) are analyzed in the following sections, which consider the more detailed levels and aspects of implementation, various operating modes developed by SECPAH/DGASPC at the county level, and various stakeholders' opinions and beliefs.

Flowchart 4: Overview of the registration steps



There are big differences between counties concerning the number of assessment requests, as discussed in Section 3.1. First, data presented in this chapter are just estimates done by SECPAH for this research, as most of the counties do not rigorously collect information regarding registration. Second, the number of registered files seeking disability assessment is not significantly correlated with the total number of persons with disabilities officially recorded within the county.

For example, as shown in Figure 10, among the bottom five counties with the lowest total numbers of registered files are county GR, with about 10,600 persons with disabilities, along with county SB with 16,600, as well as county TM with 26,600 persons with disabilities (data for December 2019). This means that a county with a large population of persons with disabilities does not necessarily result in a correspondingly large number of files requesting reassessment, as many of them may hold a permanent disability certificate and hence do not have to register for reassessment every 1–2 years.

Third, the minimum number of registered files in a county (GR) was more than five times smaller than the maximum (in OT), in the pre-COVID period (see Figure 10). The gap between extremes diminished from over 5 to 4 in 2020. Also, the number of applications for disability assessment declined in 2020 as compared with the pre-COVID period, in nearly all counties.[152] Overall, based on the sample of SECPAH from 28 counties and 4 districts of Bucharest, the total number of registered files dropped by over 2,400 (or by 15 percent) in 2020 compared to 2019.[153] This is a result of measures to prevent and combat the effects of the COVID-19 pandemic, in which the procedures for granting disability certificates were temporarily changed.[154] Thus, DGASPC automatically extended, for adults and children, the validity of expiring disability certificates for 90 days after the state of emergency ended,[155] reducing the number of reassessment applications during this period.

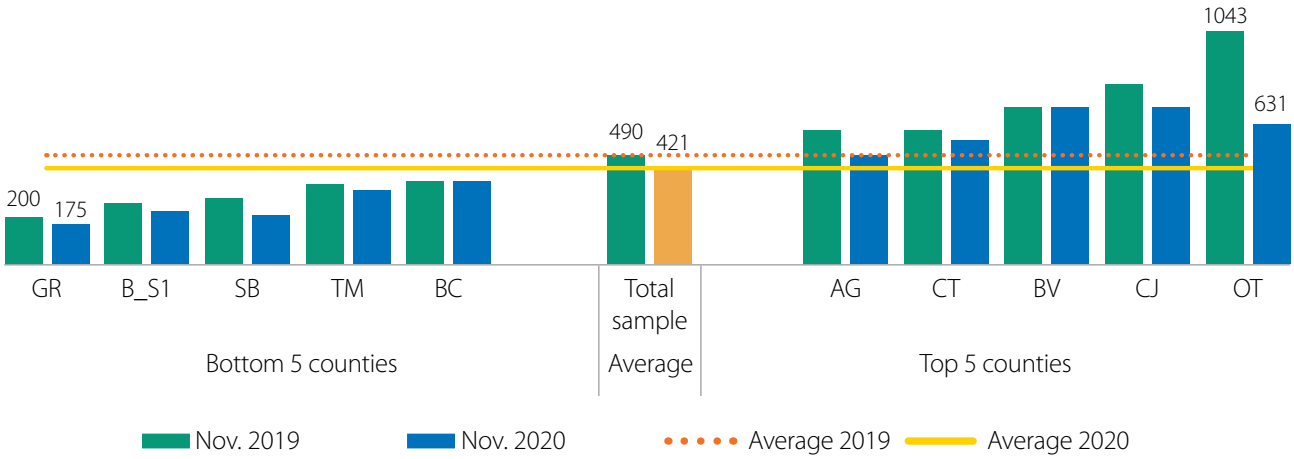
152 In our sample, only three SECPAH reported, for November 2020, a number of registered files larger than that from a typical month (or November 2019), namely MH, SV, and B_S5.

153 In the counties with valid answers, the cumulated number of registered files decreased from almost 15,900 to around 13,500.

154 Law no. 55/2020, Art. 4(5).

155 As per EGO no. 34/2020 amending and supplementing EGO no. 1/1999 on the regime of the state of siege and of the state of emergency.

Figure 10: Total number of files registered for disability assessment in selected counties, in November 2019 vs. November 2020



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 28 counties and 4 districts of Bucharest with valid answers, January-February 2021.

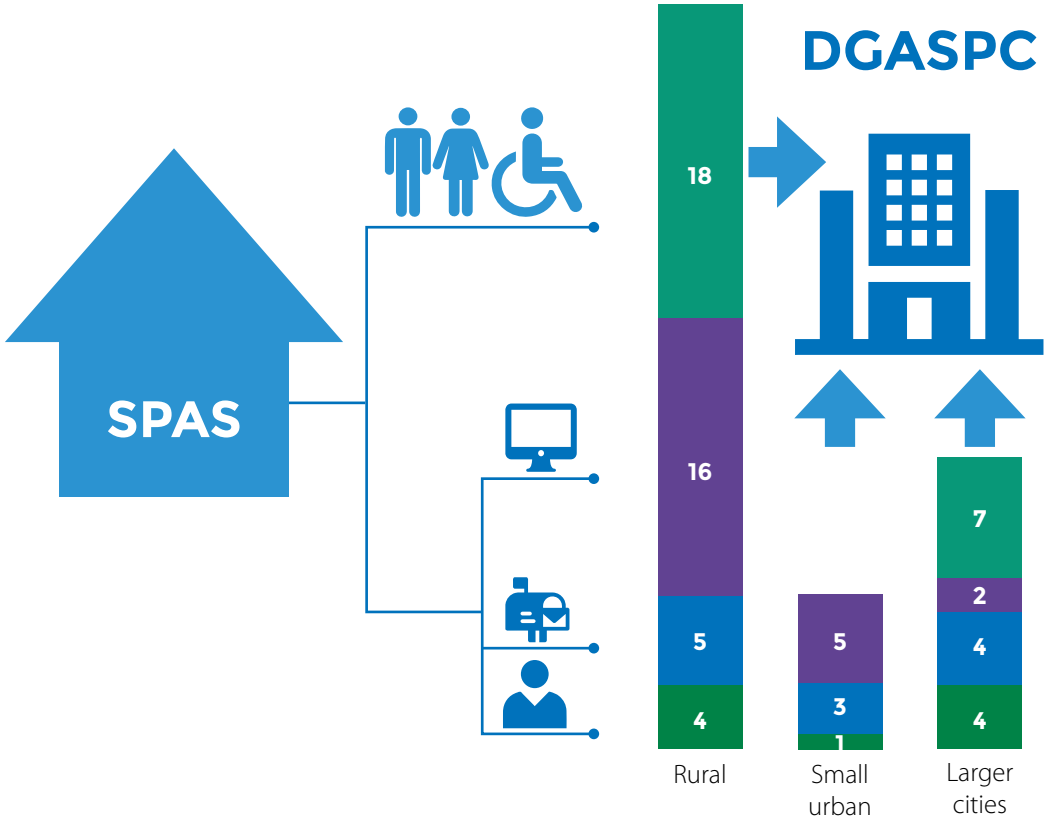
3.4.1. Transferring Application Files from SPAS to SECPAH

There are two main routes through which application files (including documents and the social inquiry) are transferred from SPAS to SECPAH/SECC (within DGASPC), as shown in Flowchart 3 (in Section 3.1) and Figure 11. The first route is followed by most surveyed SPAS (39 out of 69 localities that provided a valid answer) that transfer application files to SECPAH/SECC, mostly via email or mail/courier. Nearly all of these SPAS declared that "most of the time" they manage to observe the statutory term of five business days after registration for delivering files to SECPAH/SECC/DGASPC. In this respect, SECPAH management[156] confirm that most of the urban municipalities successfully complied with the statutory term, whereas regarding the rural SPAS, opinions are more diverse: 12 of 32 counties appreciated that "only some" or "only a small part" of rural municipalities deliver application files for disability assessment within 5 business days following registration.

The rest of SPAS (30 out of 69 localities that provided a valid answer) follow a different route; they do not deliver application files to the SECPAH/SECC, but rather hand them out to applicants, who register them. In a third of these localities, the SPAS hand out the files along with a notification regarding the appointment for the assessment interview, preestablished in cooperation with DGASPC (SECPAH/SECC). The other two-thirds hand out the files and the applicants "go whenever they can/wish, register the file and receive on their own the appointment for the evaluation interview/interaction" from SECPAH/SECC. In these situations, no statutory term is observed by the SPAS.

156 Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties, January-February 2021. The 4 districts of Bucharest that responded with the survey are not considered here because in their case the DGASPC also plays the role of the SPAS.

Figure 11: How application files are transferred from SPAS to SECPAH/SECC/DGASPC, in February 2021 (number of SPAS)



4. The files are handed out to the applicants who carry and register it to SECPAH/SECC/DGASPC
3. The files are delivered by SPAS by electronic mail/a special website
2. The files are delivered by SPAS by mail/courier
1. The files are carried to SECPAH/SECC by a SPAS representative in person

Source: SPAS survey with valid responses from 69 SPAS, from 26 counties. The districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January-February 2021.

Note: Small urban = small cities up to 20,000 inhabitants as of January 1, 2020; large urban = cities with >20,000 inhabitants as of January 1, 2020; rural = communes of all three types included in the sample.

3.4.2. Registering the File at SECPAH and Scheduling an Appointment for the Assessment Interview

There are three possible scenarios by which applicants (18+ years old) can register their files at SECPAH and schedule an appointment for the disability assessment interview, depending on the locality in which they live and the relationship between their hometown SPAS and their county SECPAH.

Based on the data reported by SPAS, it results that in Romania, the registration for disability assessment still involves thousands of people who every month must go to various offices across the country, some of them repeatedly, sometimes traveling for hours, in order to register their application files, despite the available technology. The SECPAH representatives reported similar estimates.[157] Thus, 19 of the 36 surveyed SECPAH estimated that 75 percent of the total application files registered in November 2020 were delivered in person to the institution.[158] In the other 17 counties, the registered application files were more evenly distributed between files submitted in person to the institution and those received via post, email (predominantly), and the Internet.

157 Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January-February 2021.

158 The share varied across counties between 50 percent and 98 percent of the total, with an average of 75 percent and a standard deviation of only 14 percent.

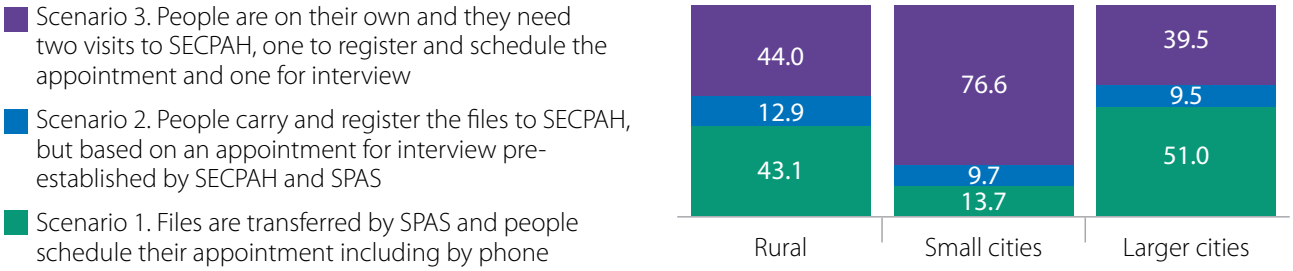
In the first scenario, SPAS transfers the application files to SECPAH, after which the applicants submit a standard application to the registry of SECPAH/DGASPC by post, email, or, in light of COVID-19, by telephone, and schedule an appointment for the assessment interview.[155]

In the second scenario, the files are handed out to applicants who must bring them to the SECPAH/DGASPC registry, where they fill out the standard application form and register the file. However, the SPAS obtains an appointment from SECPAH/DGASPC in advance and notifies the applicants, so as to shorten the waiting time and reduce exposure to any health risks.

In the third scenario, the files are handed out to applicants who need to visit the SECPAH premises twice, first to submit the standard application, register the file, and schedule an appointment, and second for the assessment interview.

The third scenario is the most frequent, as Figure 12 shows based on data about applicants from 66 surveyed localities.

Figure 12: Distribution of applicants for disability assessment, according to scenario used for SECPAH registration (% of total in November 2020)



Source: SPAS survey with valid responses from 66 SPAS, from 26 counties. The districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January-February 2021.

Notes: Estimates determined based on the assumption that a SPAS follows the same procedure for all applicants. This is the dominant pattern, but there are also a few localities in which SPAS proceed differently from one applicant to another. Small urban = small cities up to 20,000 inhabitants as of January 1, 2020; large urban = cities with >20,000 inhabitants as of January 1, 2020; rural = communes of all three types included in the sample.

This is due to the persistent use of paper in the administrative processes, and not only regarding the disability assessment. Although applicants are asked to provide at least some documents in electronic format, and some SPAS and SECPAH[160] (as well as SECC) collect these, "in the end, all files and documents must be also available in paper format."[161] Thus, the available technology is heavily underused, with people being asked to repeatedly gather the same paper documents for each (annual) assessment, which afterward must be stored by SECPAH.

The application files for disability assessment may be delivered and registered both to SECPAH and to the DGASPC Registry, in most counties, as well as to other services or offices within DGASPC,

159 The SECPAH teams indicate that, in exceptional cases, they can also accept documents sent via telephone apps that allow these to be scanned or photographed.

160 Out of the 36 surveyed SECPAH, 20 reported that documents within the application files are both on paper and in electronic format. The other 16 SECPAH have the application files only on paper.

161 Interview with the chief of a SPAS from a large city.

in a few counties. As such, the process for managing and storing files is different from one county to another. In most counties, SECPAH also undertakes these duties on its own or shares them with the CEPAH secretariat. Nonetheless, in counties with a large number of persons with disabilities, the management and storage of files is usually carried out by a different DGASPC service, such as Archive. This is particularly the case in counties with more than 20,000 persons with disabilities.[162] How these duties are assigned affects the workload of the SECPAH practitioners. In counties in which registration, management, and storage are carried out solely by SECPAH, they also have to cover all manual work related to handling and loading the files (from registration to assessment, from assessment to the CEPAH secretariat, from commission to storage, within storage, and so forth).

In line with the legislation, the file can be submitted by the applicant, her/his family, legal representative, personal assistant, professional personal assistant, an NGO of which the applicant is a member, or any other person representing the applicant. With only two exceptions,[163] in all counties, a person under guardianship/curatorship may submit the file by themselves, possibly with the support of someone else. At the same time, in most counties (in 18 counties and 2 districts of Bucharest), a third party may submit the file of a person under guardianship/curatorship even without that person's consent.

In the case of persons requesting reassessment, the file shall be submitted 60 days before the existing disability certificate expires.[164] During the COVID-19 pandemic, disability certificates were extended for both adults and children[165] to ensure the continuity of disability benefits during the crisis. In some counties, the disability certificate was extended automatically, while in other counties it was extended only at the applicant's request.

The documents required for disability assessment are regulated by GD no. 430/2008, Art. 6, and include:

- the standard application form for comprehensive assessment following the model provided in Annex 4 to the decision;
- a copy of the ID (original must be presented on the day of the assessment);
- medical documents requested by SECPAH (see Section 3.2); and
- the social inquiry carried out by the SPAS from the applicant's domicile or residence, following the framework model provided in Annex 6 to the decision (see also Section 3.3).

The service/office that registers the files must transmit those to the SECPAH within 24 hours. This is not a problem, according to the SECPAH chiefs, especially given that, in most counties, SECPAH conducts the registration (or most of it). Once the files arrive at SECPAH, a specialist verifies them for completeness, based on the list provisioned in GD no. 430/2008.[166] In most counties,[167] this initial verification is done by one SECPAH specialist trained to assess the completeness of the file, including medical data. In just four counties, files are directly distributed to the SECPAH team of specialists who go through the file and check the documents specific to each field, while in one district of Bucharest the initial verification is done by untrained, medium-level staff.

The output of the initial verification is to sort the application files into three groups (see Flowchart 4 and Figure 13). The first includes complete files that are registered as admitted for the disability assessment. The second includes files that comply with the disability criteria, but need additional documents. These files are also admitted. The last group includes rejected files. Figure 13 shows how the application files are distributed following the initial verification in the surveyed counties. The dominant practice is to register 80 percent or more of the applications as complete.

162 Out of the counties that took part in the institutional survey Q2A, 7 have between 6,300 and less than 15,000 persons with disabilities, 13 have between 15,000 and less than 20,000, and 12 have 20,000–38,000 (data according to the MMPS Statistical Bulletin, December 2019).

163 Ialomita County and Sector 3 from Bucharest.

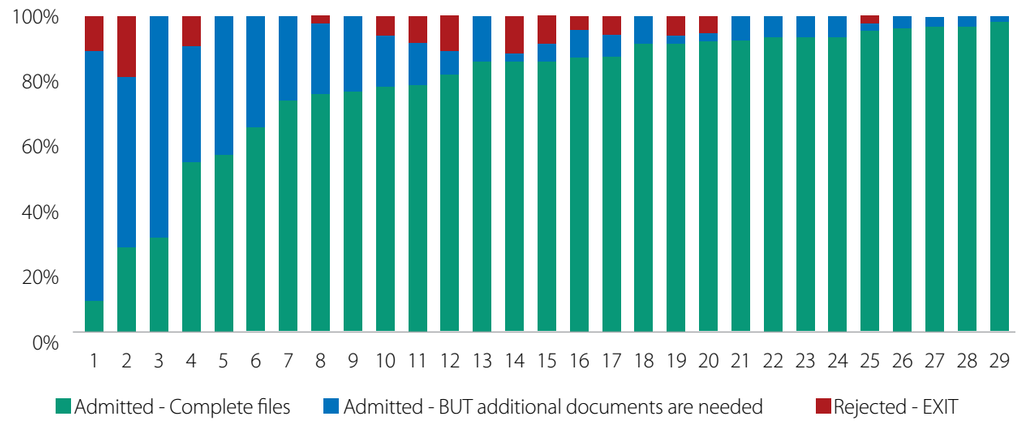
164 GD no. 430/2008, Art. 6, as modified by the Decision no. 927/2016.

165 As per Law no. 55/2020, Art. 4, para. 5.

166 Only 2 counties reported that a DGASPC specialist from a service different than SECPAH conducts the initial verification of the files; and 3 counties did not respond. Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest; January-February 2021.

167 In 28 counties and 3 districts of Bucharest.

Figure 13: The result of the initial verification of application files, admitted and rejected by county, November 2020 (%)



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 25 counties and 4 districts of Bucharest with valid answers, January-February 2021.

Overall, at the sample level, 79 percent of the application files are complete, 18 percent are incomplete, and about 3 percent are rejected and exit the process. Figure 13 shows the considerable differences between counties. In some, the practice is to qualify a lot of the files as incomplete, asking applicants to submit more documents. Thus, the share of incomplete files ranges between 1 percent and 79 percent (or between 2 and 420) per county. At the same time, while in most counties no application file is rejected, there are a few counties in which 1 in every 10 (more often) and even 1 in every 5 files is rejected (up to 70 files per county).

In the case of incomplete files, all SECPAH ask for additional data that usually refer to a new social inquiry, medical documents confirming the onset of disease, and additional psychological evaluations. As the SECPAH practitioners explained in focus groups, a new social inquiry is usually requested in cases that contradict the conclusions of medical documents (for example, if a person who cannot see drives a car, or if a person who cannot move is found cleaning the garden). The medical documents proving the onset of disease refer mainly to additional information for determining the person's medical history. More psychological evaluations are usually requested when the Mini-Mental State Examination (MMSE) for cognitive or intellectual functions and Global Assessment of Functioning Scale (GAFS) test scores are not synchronized with descriptions in the other medical or social documents. However, SECPAH chiefs from 11 counties report that applicants are "only sometimes" informed about the additional information via formats accessible to all persons with disabilities, as it depends on the available materials.

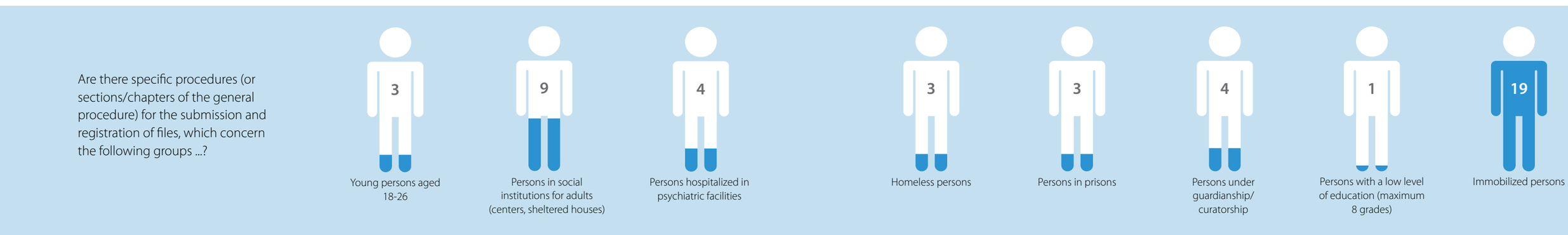
The main reasons to reject a file include: if the applicant's official residence is a different county than the SECPAH where he/she applies; lack of the original identity documents; medical conditions that do not comply with the disability criteria; lack of medical documents or the mandatory social inquiry; as well as "when the applicant is in an advanced state of intoxication."[168] There is a lack of uniformity among counties regarding the accepted document format. Certain counties only accept paper documents, and so might reject a file not because a document is missing but because it is not attached to the file in paper format.

The statutory term for the initial verification is five working days, as per GD no. 430/2008. Within five days, SECPAH must inform the person of the verification results, which happens "in most or all cases," say the SECPAH chiefs. The applicant is either rejected or admitted, with the condition to provide the requested additional documents if the file is considered incomplete. Also, the assessment interview is scheduled, and the applicant gets the appointment. SECPAH must conduct the interview within 60 days.

In nearly all counties, a SECPAH specialist schedules the assessment interviews and informs the applicant, most often via telephone or registered post. Scheduling is done on a specific day and time, but there are also nine counties that provide the applicants with only a specific day, which may result in a longer waiting time in at least some periods. At the time of the Q2A questionnaire, all SECPAH were able to schedule assessment interviews within the mandatory period of 60 days (about half could schedule an applicant to appear for an assessment interview within two weeks). Once the person is informed, the intake and registration phase is finalized, and the disability assessment phase begins.

168 Quotation from the Q2A questionnaire.

Figure 14: Number of SECPAH that adapted their submission and registration procedures for vulnerable groups (number of counties)



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January-February 2021.

3.4.3. Adapting Registration for "Hard to Reach" Population

The procedure for registering the files and scheduling the disability assessment is unitary at the national level, based on the provisions of GD no. 430/2008 and Order no. 2298/2012.[169] Within the intake and registration phase, two-way communication is needed to (i) notify people about intake and registration procedures, locations, and points of contact; (ii) support scheduling appointments; (iii) gather accurate information and documentation; (iv) respond to queries; and (v) facilitate corrections or updates as needed.

Some vulnerable groups mentioned the lack of adapted communication as a barrier to registering for disability assessment. Thus, interviewed persons with disabilities and NGO representatives pointed out that wearing a mask represents a serious communication barrier for people suffering from hearing impairment; many applicants do not have a phone, computer, or Internet, and even fewer have a digital phone, which hinders communication with the institutions; many applicants also suffer from mental impairment "and do not understand easily even if the process is clearly described step by step hence they need accompaniment and not only information;"[170] also, many applicants "are illiterate as they have never been enrolled in education."[171] The risk of miscommunication in this phase is great: people might not know where to go, how or where to register, or what documents and information to provide. Such confusion contributes to inefficient processes and inaccurate information. It can also create bureaucratic hurdles that deter people from registering.

A quarter of the counties that participated in the national survey do not have the physical capacity to receive files and communicate with applicants in a confidential manner.[172] This is an additional barrier to proper communication during the registration step. Overall, the submission and registration procedure has few adaptations for the specific needs and constraints of vulnerable groups. SECPAH has adapted this procedure in more counties (19) only for people who cannot move, as current regulations foresee specific actions for this situation. For all other groups, adaptations to the procedure are available only in a few counties.

169 Order no. 2298/2012: Framework procedure for the assessment of adults for the classification in a degree and type of disability. ANDPDCA told the research team that this regulation is currently under review.

170 Interview with NGO, Bucharest subsidiary.

171 Interview with a national NGO.

172 Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January–February 2021.

Conclusions of Chapter 3

The objective of intake and registration, the second phase of the delivery chain, is to efficiently register the target population and vulnerable groups, and record their information accurately. To efficiently deliver this second chain, several systemic adjustments are needed.

1

First, improvements should be made in the field of data management and institutional procedures. There is a need to have, at the first encounter with the applicant (SPAS), an approved procedure, steps, or rules concerning the interaction. On the one hand, it is essential that SPAS and SECPAH/SECC have access to the national registers and administrative databases, to reduce applicants' efforts to obtain the necessary documents and, at the same time, allow cross-checking by institutions, while reducing the amount of paper used in the process. On the other hand, it is important that SPAS and SECPAH/SECC systematically collect, record, and analyze data about intake and registration, including on the phenomenon of drop-out/refusal during the process in order to identify the dysfunctions of the system that become access barriers to disability assessment.

2

Second, improvements are still needed to reduce barriers for vulnerable groups. Financial and geographical accessibility obstacles are reported in obtaining medical documents. In addition, nearly all SPAS included in the sample require the applicant to gather a large set of documents before conducting the mandatory social inquiry. Further reasons for blockages during the intake phase relate to the lack of support provided by authorities, age when the disease was officially ascertained, lack of adapted communication, and lack of awareness about the existence of and ability to apply for a disability certificate and its associated benefit-service package. Thus, not only does the initial information (discussed in Chapter 2) need improvement, but so does the information and communication during the intake and registration phase. Applicants with sensory or intellectual disabilities reportedly lack accessible information, while information in accessible formats (easy-to-understand language, Braille, mime-gesture language, tactile, etc.) is often unavailable.

3

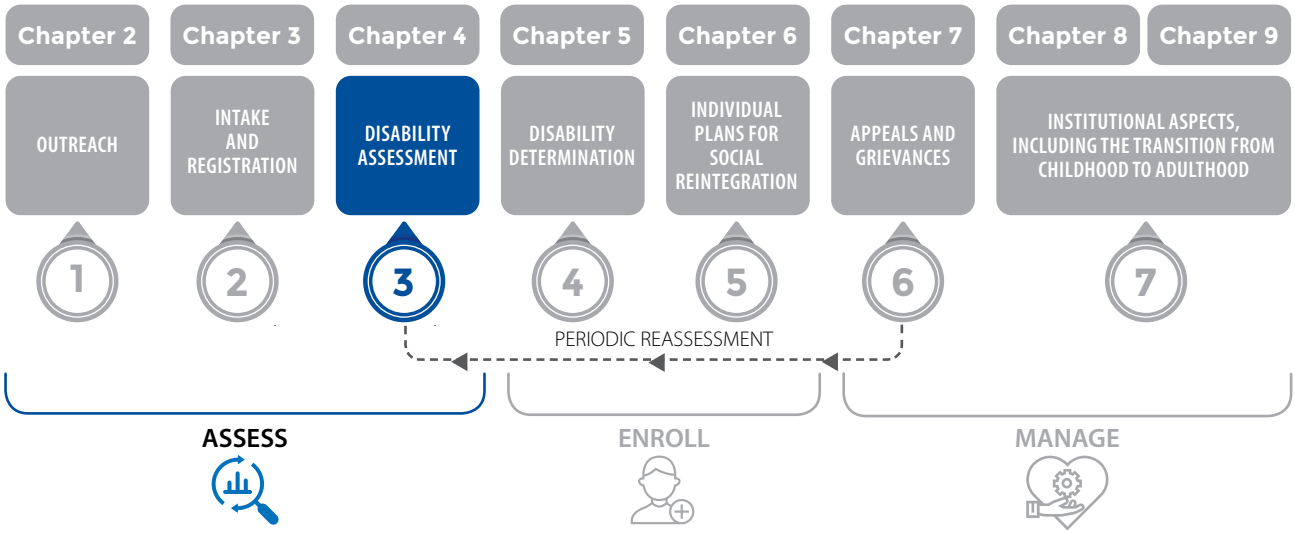
Third, rural public social services particularly need support to build capacity by developing human resources management. The main factors that influence the quality of current social inquiries relate mainly to SPAS understaffing and insufficient training. Additionally, to more accurately reflect the social part of the disability assessment, the framework model of social inquiry needs to be improved.

4

Finally, in Romania, the uptake and registration phase is much more burdensome than in many other countries. International experience shows that most countries have implemented various measures to minimize the number of papers an applicant should submit. In more advanced administrative systems, a person can register electronically for the disability assessment and medical documents are pooled from an e-health system, while a social inquiry (if needed) is obtained through institutional protocols with no involvement, cost, or effort required on the part of the applicant. Romania should strive for this by rethinking the administrative processes to simplify access while avoiding duplication and rent-seeking opportunities.

Thus, the needs of persons with disabilities as applicants in the disability assessment system should be carefully addressed to ensure equal access to intake and registration, and thus improve the disability assessment system's overall efficacy.

4. The disability assessment in Romania



This chapter reviews the third phase of the delivery chain of Romania's disability assessment system, that which classifies an applicant's degree and type of deficiency. This chapter describes and analyzes the processes, tools used, and documentation required by the Service for the Assessment of Adults with Disabilities (SECPAH). Article 88 of Law no. 448/2006 on protecting and promoting the rights of persons with disabilities, republished with subsequent amendments and supplements, states that "in order to carry out the duties of the assessment commission, a service for the comprehensive assessment of adults with disabilities shall be set up within the general directorates for social assistance and child protection of the counties and local districts of Bucharest."

In most countries, the disability assessment (core phase 3) and disability determination (core phase 4) are one step: Assessors carry out the assessment and propose the type and degree of disability and the validity of the certificate, and then an official from the same agency reviews the proposal and makes a formal decision. Romania, however, has separate processes for assessment and determination. SECPAH (a structure within the DGASPC) conducts the assessment for classifying the degree of deficiency, while the Commission for Assessing Adults with Disabilities (CEPAH),

173 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.

a structure under the County Council, decides the classification (determination) of the disability degree. Thus, unlike most countries, Romania's assessment of the disability degree is a two-stage process—the assessment itself and the decision-making. This chapter focuses on the first step of this process.

Along with a general description of the comprehensive assessment stages and the required documentation, this chapter also identifies problems, as reported by SECPAH specialists in interviews, focus groups, and the opinion survey Q2B, as well as by SECPAH chiefs who answered the institutional survey Q2A. In addition, the chapter reviews the assessment tools used for each of the six mandatory areas of assessment (social, medical, psychological, vocational or professional skills, educational level, and social integration level and skills), according to current regulations.[174] These tools are reviewed according to widely recognized scientific requirements for disability assessment, but particularly according to the World Health Organization's (WHO) International Classification of Functioning, Disability and Health (ICF). The chapter concludes with a general summary of the assessment process and the tools SECPAH uses for the comprehensive disability assessment.

4.1. The steps of the comprehensive disability assessment

The regulatory documents governing the SECPAH assessment procedure are GD no. 430/2008 and Order no. 2298/2012.[175] SECPAH is a service within the General Directorate of Social Assistance and Child Protection (DGASPC) and operates in each of the 41 county municipalities in the country, as well as in the 6 districts of Bucharest.

SECPAH's duties are regulated by Art. 50 of GD no. 268/2007 and Art. 5 of Order no. 2298/2012. As stated in Section 1.2.1, SECPAH is responsible for: (i) carrying out the comprehensive assessment/reassessment of an adult with disabilities, either at SECPAH offices or the person's home; (ii) drawing up the comprehensive assessment report for each person who is assessed; (iii) recommending whether or not to classify a person as with disabilities (or to maintain the classification), as well as drafting his/her Individual Social Rehabilitation and Integration Program (PIRIS); (iv) endorsing the Individual Service Plan (PIS), drawn up as required by the case manager; (v) assessing whether conditions have been fulfilled for certification as a professional personal assistant, to draw up the comprehensive assessment report and make recommendations to CEPAH; (vi) recommending protective measures for the adult with disabilities, in accordance with the law; and (vii) performing any other duties provided for by law.

4.1.1. Registering and Verifying Files with SECPAH

The third core implementation phase - disability assessment starts once the second core phase, in which the file is prepared, submitted, and registered, is completed. The steps of intake and registration is discussed in detail in Chapter 3. Once the files arrive at SECPAH, a specialist checks them for completeness, based on the list provided in Art. 6 of GD no. 430/2008.[176] In most counties,[177] this initial check is conducted by a SECPAH representative who is trained to assess the completeness of the documents, including regarding medical data, as shown in Section 3.4.2. When the file is registered with SECPAH, the applicant receives an appointment for the assessment interview.[178] SECPAH specialists then use the documents during the comprehensive assessment phase, when they may request additional paraclinical investigations or medical reports, if necessary. After SECPAH completes the assessment, the whole package of information is forwarded to CEPAH, which decides on classification of the disability degree.

174 GD no. 268/2007, Art. 48.

175 Order no. 2298/2012 on the approval of the framework procedure for the assessment of adults in order to classify the degree and type of handicap.

176 The documents required in the application file are listed in Section 3.4.2.

177 In 28 counties and 3 districts of Bucharest.

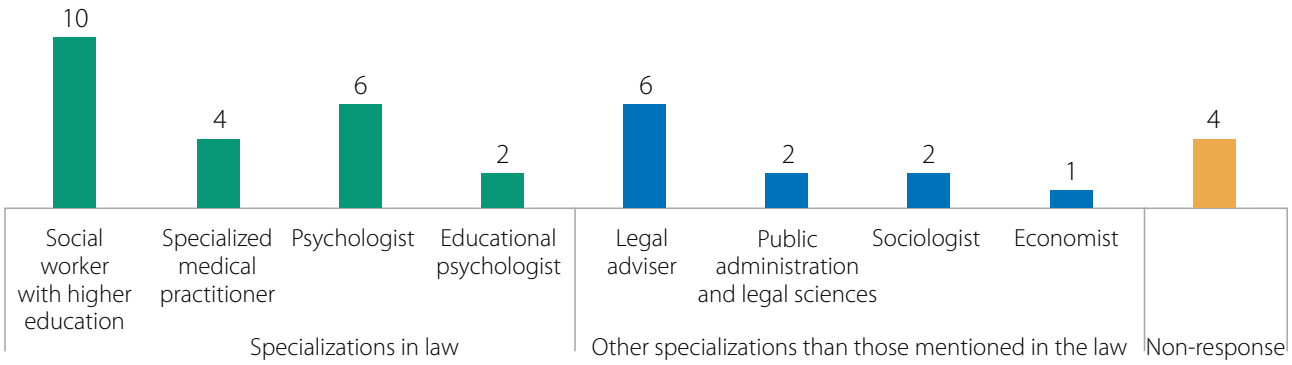
178 The analysis of practices related to file registration and verification is available in subchapter 3.4.

4.1.2 The Comprehensive Assessment Process for Adults

In accordance with GD no. 430/2008 and Order no. 2298/2012, SECPAH carries out the assessment according to two basic criteria: the applicant's state of health and his/her level of functioning. To this end, the legislation stipulates[179] that SECPAH must be composed of at least the following specialists: a social worker with higher education, a specialized medical practitioner, a psychologist, an educational psychologist, a physiotherapist, an education instructor, and a reintegration teacher.

In practice, no county has all these specialists, according to data reported by SECPAH in the institutional survey Q2A. There are, however, some SECPAHs that have employees with specializations other than those mentioned, or even employees who do not meet the legal educational requirements. Most SECPAH comprehensive assessment services consist of a specialized medical practitioner, a social worker, and a psychologist, and sometimes an educational psychologist, with a total of 5–7 members, but with variations between 2 and 22 specialists. Even the SECPAH chiefs have one of the specializations provisioned by the law only in 22 out of 37 SECPAH in the sample (Figure 15). A detailed analysis of the human resources available to SECPAH is available in Subchapter 9.2.

Figure 15: Specializations of the SECPAH chiefs (number of counties)



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 33 counties and 4 districts of Bucharest, January-February 2021.

Note: Two SECPAH (BN and SJ) in the sample did not have a head at the time of the field research.

SECPAH specialists work in multidisciplinary teams, but only 12 (out of 36) SECPAHs that took part in the Q2A institutional survey reported having a specific approved procedure on how to organize and work in multidisciplinary teams (see Figure 16). However, most SECPAHs create teams of three specialists. Only 8 (out of 36) SECPAHs have multidisciplinary teams with a fixed membership. In the other counties and districts of Bucharest, specializations are combined to form multidisciplinary teams depending on the particularities of the case (18 counties) or the specialists available (9 counties).

Most SECPAH chiefs (21 out of 36) report that multidisciplinary teams hold daily consultation meetings on cases and identify the most appropriate recommendations (see Figure 16). However, within the focus groups, SECPAH specialists said that the meetings are ad hoc "meetings among colleagues,"[180] without a clearly defined schedule or agenda. Moreover, in some counties, "we wouldn't even have a place where we could all sit and discuss or organize together; everyone is working on the files assigned to them, by their profession."[181]

Mandatory multidisciplinary team meetings are held in just nine counties, for situations such as disputes or different points of view regarding the proposals in the comprehensive assessment report; unclear, confusing, or inconsistent documents on file; assessment of persons with mental disorders (dementia, autism, schizophrenia); emergency situations, such as assessment of persons brought in from prisons or hospitals; and persons with severe behavioral disorders.[182]

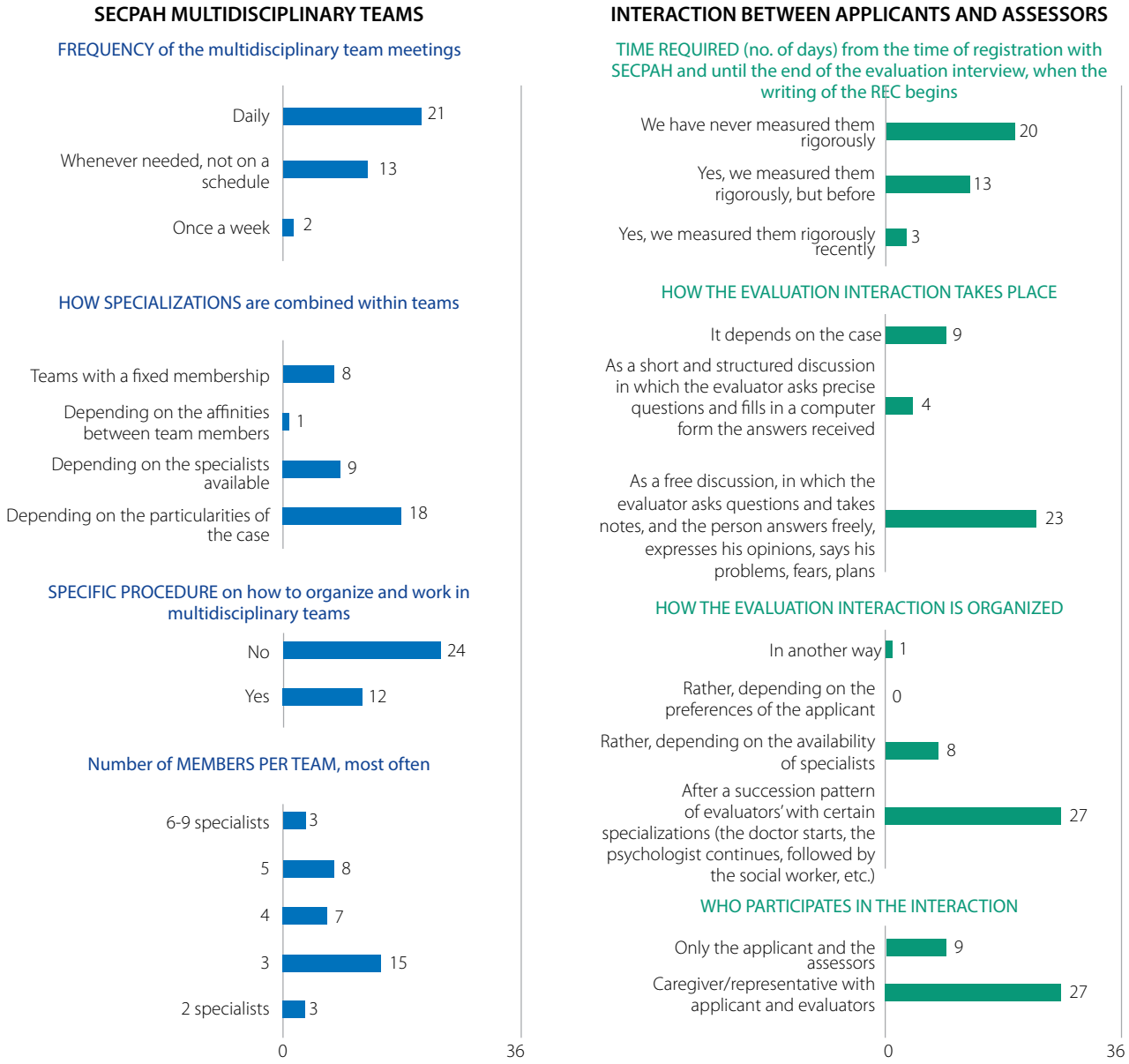
179 Order no. 2298/2012, Art. 5, respectively GD no. 268/2007. Art. 49.

180 To clarify, only 6 (out of 36) SECPAH chiefs gave an estimate of the average time allocated to daily multidisciplinary team meetings (between 15 and 90 minutes), while the others answered "as long as it takes."

181 Focus group SECPAH 1.

182 Quotes from Q2A questionnaires filled in by SECPAH chiefs.

Figure 16: Multidisciplinary teamwork and interaction between assessors and applicants, according to SECPAH chiefs (number of counties)



Source: Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 32 counties and 4 districts of Bucharest, January-February 2021.

According to results of the institutional survey Q2A, there is no uniform procedure by which SECPAH teams should conduct comprehensive assessments, and procedures vary from county to county in several respects. In some counties, the applicant is seen individually by each specialist (physician, psychologist, social worker, educational psychologist) and is interviewed or assessed according to standardized (psychological) testing instruments. In other counties, the person is interviewed collectively by a team of specialists. As the analysis on workload in Section 9.2.1 shows, 72 percent of SECPAH specialists report that the person usually interacts with a team of specialists simultaneously, while 18 percent report that the interaction is sequential, and 10 percent respond that the interaction takes place in other ways; for example, in a dedicated space, the applicant interacts with one specialist who covers all areas of the assessment; or the applicant enters an office with other applicants, and multiple specialist-applicant interactions take place simultaneously in that office, wherein the specialist covers all areas of the assessment.[183]

183 Opinion survey Q2B: Practices and experiences of specialists working within SECPAH (N=182), from 39 counties and 6 districts of Bucharest, January–February 2021.

However, Figure 16 shows that the majority of SECPAH chiefs (27 out of 36) claim that the interaction between assessors and applicant is organized according to a pattern of sequencing of assessors by specialization, with all team members participating (e.g., the social worker starts, the psychologist continues, the physician follows next, etc.). Usually, according to 23 out of 36 SECPAH chiefs, the interaction takes place as a free discussion, where the assessor asks questions and takes notes, and the person responds, expresses their opinions, shares problems, fears, plans, etc. However, the other SECPAHs, predominantly those with a large number of applications per month, organize the interactions according to specialists' availability, and conducts them as short, structured discussions between two people who sit on opposite sides of a desk, with a computer and files between them; the assessor asks precise questions and records the answers on a computer form.

All SECPAH chiefs in the counties that took part in the Q2A institutional survey reported that they had no difficulty meeting the statutory term (of no more than 60 days from the date of file registration at SECPAH) to complete the comprehensive assessment of adult applicants requiring a certificate, as shown in Quote 4.1.[184] Out of the 36 SECPAHs, just 20 have ever conducted a rigorous measurement of the time it takes for an applicant to register their application with SECPAH to the completion of the interaction, when drafting the comprehensive assessment report begins (see Figure 16). Most SECPAH chiefs estimated that on average, around 30 days are needed for the assessment process, both for assessments carried out at SECPAH offices and those at applicants' homes.

"At service level, there are on average 600 assessment files in a month, an average of 30 files/working day, 2 comprehensive assessment teams are organized, which means 15 files per team, with 30 minutes of assessment time allocated to each person. For a good record of the appointments/invitations there is a register in which the date and time of the interview is filled in. It was found that the period of 30 calendar days from the date of submission of the request for assessment is sufficient to examine the file and complete it. The same period of 20 working days is also provided for by Order 2298/2012 in case the person is invited for reassessment. Also, if the person with disabilities does not complete the file by the date of the appointment, he or she has the possibility of another 30 days, until the expiry of the maximum 60 days. There is a possibility that, although the file is complete, the person may not be able to attend on the assessment date due to environmental, climatic, social, medical, etc. factors, which allows SECPAH, together with the person with disabilities, to reschedule the interview appointment." (SECPAH chief, quoted from a Q2A questionnaire)

Usually, SECPAH carries out the comprehensive assessment at its premises. On the day of the assessment, the applicant must be present, possibly accompanied by a legal representative or personal assistant (see Figure 16). Most SECPAHs highlight the problem of inadequate premises for both the assessment process and for archiving and storing documents. In the absence of dedicated premises, in most counties, SECPAH team members conduct interviews with applicants in their own offices. In some counties, SECPAH members are located in different buildings and institutions, making the assessment process difficult for the applicant.

For applicants who cannot travel,[185] based on the medical referral letter and the social inquiry, the comprehensive assessment is carried out at their home/residence, as per Order no. 2298/2012. These types of assessments account for about 12 percent of all adult applicants, on average, in the pre-COVID-19 period, decreasing to 6 percent in 2020.[186] Home assessments are carried out based on

184 Timeframe as laid down in Order no. 2298/2012, Annex, Art. 11.

185 Being unable to travel means that a person is unable to leave their home without difficulty, and, generally does not leave their home. This is usually due to advanced age or illness. These people are eligible to receive special services, including assessment at home.

186 In 2019, the share of the assessment conducted at home in the total assessments ranged from zero to 35 percent – maxim value recorded in the districts of Bucharest, where SECPAH also acts as SPAS. The standard deviation, however, was lower than average, i.e., 10 percent. In 2020, the number of SECPAHs not conducting assessments at home increased from 2, in 2019, to 4. Disparities in conducting assessments between counties also increased nationally.

a schedule, which can cover a period of 1-3 days to 2 months.[187] In 19 counties, SECPAHs only conduct home assessments on certain days of the week; in the other 17 counties, they are conducted daily. Almost all SECPAHs use teams of 2-3 specialists for the home assessment, with a physician, social worker, and psychologist forming the typical team. DGASPC provides transport of the multidisciplinary teams to the applicant's home/residence.

As shown in Table 8 in November 2019 (or a typical pre-COVID-19 month), the majority of the disability assessments were based on face-to-face interviews (93.9 percent). Only 5 SECPAHs were conducting a few assessments solely based on paperwork, possibly through a combination of documents analysis and telephone, WhatsApp, or Skype interviews. But in the context of the COVID-19 pandemic, there has been a dramatic change in how the comprehensive assessment is carried out. Thus, in November 2020, only 30.9 percent of assessments were face-to-face. Most SECPAHs conducted the majority of the assessments based on documents alone, possibly through a combination of paperwork and telephone, WhatsApp, or Skype interviews.[188]

Table 8: Methods for conducting the comprehensive disability assessment

	November 2019	November 2020
Average number of files assessed at SECPAH - Total, of which involved:	506	418
a. face-to-face interaction/interview	93.9 %	30.9 %
b. assessment based on documents only (no interview)	5.5 %	24.6 %
c. assessment carried out through a combination of document analysis and interviews by telephone, WhatsApp, or Skype	0.8 %	41.6 %

Source: Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 27 counties and 4 districts of Bucharest, January–February 2021.

Data reported by SECPAH chiefs in 30 counties and 4 districts of Bucharest (in Q2A), for November 2020, show that a SECPAH assesses, on average, about 21 applicants per county per work day. However, this varies between a minimum of 5 applicants/working day (in IL) and a maximum of around 40 applicants/working day (in IS).

187 According to SECPAH chiefs, of the 36 SECPAHs in the Q2A sample, the planning for field activities covers a period of 1-3 days in 4 counties, one week in 9 counties, two weeks in other 9 counties, one month in 8 counties or more in 2 counties, and 4 counties do not conduct assessments at home.

188 See also Section 9.2.1, analysis of SECPAH staff workload.

Direct interaction between an applicant and the SECPAH team takes, on average, 15–20 minutes, regardless of whether the assessment is carried out at the SECPAH office or the applicant's home. However, for home assessments, the average round trip takes approximately 107 minutes.[189] Accordingly, the interview duration increases from 15–20 minutes to 120–130 minutes, on average, which significantly reduces the number of files that can be assessed during a work day.

4.1.3. Adapting the Assessment Process for "Hard to Reach" Population

In all counties, the comprehensive assessment procedure has some adaptations, depending on disability type. However, in interviews with people with disabilities and NGO representatives, the lack of tailored communication for vulnerable groups was mentioned as a barrier within the comprehensive assessment process. Moreover, most SECPAH chiefs reported in the institutional survey Q2A that the service has not developed specific procedures or sections/chapters of the general procedure to analyze or assess files submitted by persons from groups exposed to various social risks, as shown in Figure 17. Several counties (23) have made adjustments only for immobilized persons, as required by the law.

4.1.4. Transferring Application Files from SECPAH to CEPAH, and Information Management

There is no management information system at SECPAH level. Most activities related to disability assessment are paper-based. The use of technology (phone, email) to communicate with applicants increased considerably in 2020 due to the COVID-19 pandemic, but at the national level, the process still relies heavily on face-to-face interactions and applicants' repeated visits to various counters. All SECPAHs keep copies of the application files, but only a few have transferred and stored these documents electronically,[190] while the others only store them on paper. In most counties, SECPAH (either alone or in cooperation with the CEPAH secretariat) is also in charge of file management and storage, which increases the team's workload in terms of file-handling activities (from registry to assessment, from assessment to CEPAH secretariat, from commission to storage, within the archive, etc.).

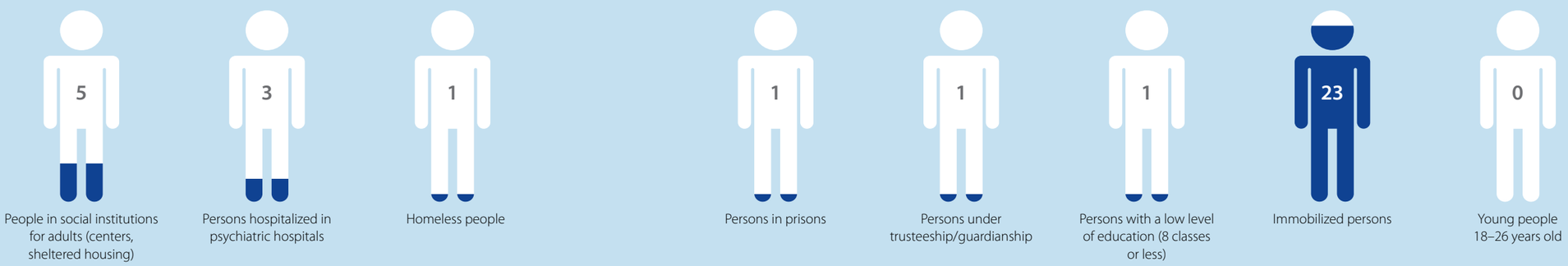
189 With a minimum of 7 minutes, a maximum of 300 minutes and a standard deviation of 84 minutes. Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 25 counties and 2 districts of Bucharest, January–February 2021.

190 One district in Bucharest and 7 counties.

Figure 17: Number of SECPAH that adapted the comprehensive assessment procedure for vulnerable groups (number of counties)

Are there specific procedures or sections/ chapters of the general procedure for the analysis and assessment of the files submitted for the classification of type and degree of disability, which concern the following groups …?

(UNCRPD, Art. 5, 12)



Source: Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 32 counties and 4 districts of Bucharest, January-February 2021.

One district in Bucharest and 22 counties benefit from the use of disability assessment software, namely SeeSoft D-Smart[191] or Assys. Versions of this software vary from county to county, as do the number and type of facilities and modules available (smaller budget counties have purchased more limited versions). The software includes modules for each of the six mandatory assessment areas. The reporting module includes the comprehensive assessment report, the PIS, and the PIRIS, which are generated automatically. However, only some counties have purchased the reporting module. Data is entered manually into the software, and varies from county to county. The data least often recorded in the assessment software relates to applicants' future plans, fears, hopes, or desires. Only five counties enter such information into the software, and the available data is randomly selected (depending on the assessor) and spread across sections of the existing framework model. This data is not analyzed in any county, and it would be very difficult to carry out such an analysis using existing data.

The software is used in the National Electronic Register of Persons with Disabilities. On the one hand, the lack of harmonized data collection, at the level of all Romanian counties, hinders the use of comparative statistics for disability degree assessment. Limited and uneven use of software (such as D-SMART) hinders Romania's ability to conduct qualitative analyses of the service system for people with disabilities. On the other hand, the quarterly statistical bulletins published on the MMPS[192] website do not exploit the full range of information recorded in the disability assessment process. For example, the number of people who underwent a vocational assessment and were referred to county employment services is not highlighted.[193] A detailed analysis of the data management and information system at SECPAH level is provided in Chapter 9, Section 9.2.4.

4.2. The disability assessment procedure in Romania

In Romania, the comprehensive assessment of adults for deficiency degree classification comprises six mandatory areas of assessment: social, medical, psychological, vocational or professional skills, level of education, and social integration level and skills.[194] SECPAH specialists use specific assessment tools for each of these areas, which allow the assessment of physical, functional, and performance parameters as specified in Joint Order no. 762/1.992/2007.[195] This section analyzes these tools, even if some have a minimal or hard-to-determine impact on the assessment decision.

4.2.1. Areas of Comprehensive Disability Assessment

With one exception, all 36 SECPAHs that took part in the institutional study Q2A have an approved procedure for reviewing and assessing files submitted for the classification of degree and type of disability (or a chapter/paragraph in the general procedure). However, only 24 SECPAHs have an assessment procedure that contains all stages and areas of assessment, or one that is complemented by other documents on specific procedures, assessment tools, methodologies, etc.

In fact, a complete assessment covering all mandatory areas, according to the legislation, is available in 23 counties and 3 districts of Bucharest. In the other counties, the comprehensive assessment covers only 5 or 4 areas (in 4 counties and 1 district in Bucharest, respectively in 5 counties). Figure 18 shows that out of the six mandatory areas of assessment, only three—social, medical, and psychological—are carried out by all SECPAHs. The other three types of assessment—for vocational or professional skills, educational level, and social integration level and skills—are only available in some counties (in 29, 30, and 34 counties, respectively).

191 SINGLE MANAGEMENT, ASSESSMENT AND REPORTING TOOL FOR PEOPLE WITH DISABILITIES, version 7.21.01.15(301/2140).

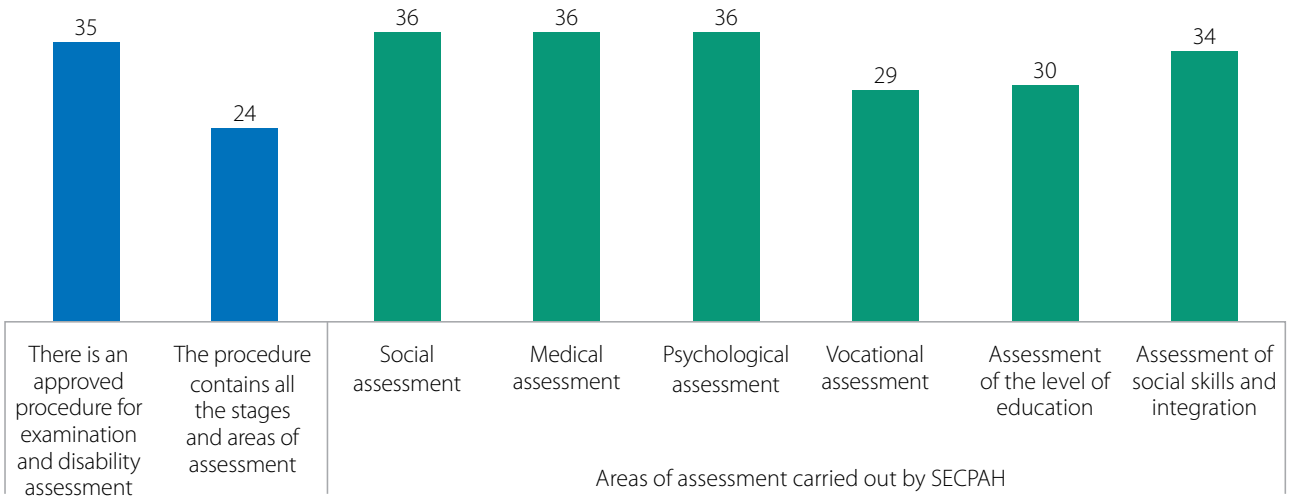
192 MMPS, quarterly statistical bulletin, http://mmuncii.ro/j33/index.php/ro/transparenta/statistici/buletin-statistic.

193 ANOFM collects information on people who have benefited from professional orientation services.

194 GD no. 268/2007, Art. 48, respectively Order no. 2298/2012. Art. 4.

195 Joint Order of the Minister of Labor, Family and Equal Opportunities and the Minister of Public Health no. 762/1.992/2007 approving the medical-psychosocial criteria based on which the degree of disability is determined, with subsequent amendments and supplements.

Figure 18: Areas of comprehensive disability assessment, according to SECPAH chiefs (number of counties)



Source: Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 32 counties and 4 districts of Bucharest, January-February 2021.

4.2.2. Medical Assessment

A specialized medical practitioner from SECPAH carries out the medical assessment for nearly all applicants.[196] The physician assesses the applicant's state of health based on the documents on file, and if clarifications are needed, conducts an interview or requests additional medical documentation. There is a specific approved procedure for medical assessment (or a chapter/paragraph in the general procedure) in 34 of the 36 SECPAHs studied. In all counties, the main data[197] on which the medical assessment is based comes from the medical documents on file, as well as from interviews with the applicant or their family/representative (in 30 of the 36 SECPAHs in the sample). In addition, 10 SECPAH chiefs reported that they also have a tool (or tools) with which to analyze the data available for medical assessment, mentioning documentary/file/referral or standard tools/scales such as MMSE, ADL, IADL, Barthel index, GAFS, Romberg, Optotype, etc.

In most cases, the assessment of the degree of deficiency/impairment/handicap takes into account only one of the applicant's health problems. In cases of co-morbidities—where the applicant has more than one, unrelated health problem (e.g., leg amputation and major depressive disorder)—only one health issue is considered for medical assessment purposes: the one for which there is medical documentation in the applicant's file (or if that deficiency is taken into account in the conditions mentioned in the medical criteria). On the one hand, this goes against the key principles of ICF, as it is very common for people to have two or more health problems at the same time, and for older people, co-morbidity is a very common situation. On the other hand, according to regulations, the medical assessment must be carried out based on the medical documents on file.[198] The problem is that, in many cases, applicants are not informed and/or cannot afford to obtain the necessary

196 Out of 36 SECPAHs participating in the institutional survey Q2A, 2 SECPAH chiefs reported that the medical assessment is provided by specialized medical practitioners only in some cases, while in the other 34 counties this is always the case, according to GD no. 268/2007, Art. 48(b).

197 In accordance with the ANPD instruction of 3.12.2018 on how to complete the comprehensive assessment report, the relevant medical assessment data refers to: (i) main diagnosis with stage of progression; (ii) onset of disease (date and supporting document); (iii) associated diagnoses, each with stage of progression; (iv) imaging investigations; (v) complications; (vi) functional parameters, e.g., AV, VEMS, FMS; (vii) treatment followed; and (viii) recovery programs, other.

198 The ANPD instruction of 3.12.2018 on how to complete the comprehensive assessment report states that the references for the medical assessment can be identified in: the standard medical referral letter from the family physician (only in the case of the first presentation to SECPAH); medical documents according to Art. 6 of GD no. 430/2008 (specialized medical practitioner report, hospital discharge report, etc.); paraclinical investigations requested by SECPAH both in the analysis phase of the file, and in the assessment phase itself; social inquiry—template in Annex 6 to GD no. 430/2008—information from section Assessment of the person's sensory and psycho-emotional status.

documents for each of their conditions. As Section 3.2 demonstrates, there are three main problems related to obtaining medical and psychological documents. The first concerns the financial and geographical accessibility of specialized health services. The second relates to suspected fraud and how it is handled. The third relates to the limited knowledge of many health care professionals about the criteria for disability degree classification.

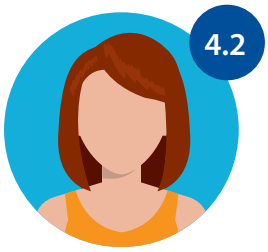
SECPAH physicians who participated in focus groups or the national survey mention frequent situations where medical documents submitted on file are contradictory, unclear, or incomplete. SECPAH chiefs provided similar data in the institutional survey Q2A, namely:

- 29 out of 36 sampled SECPAHs report inconsistencies in medical records.
- The average share of files containing medical documents with vague, unclear, or incomplete conclusions/diagnoses is 9.5 percent of all files assessed in November 2020, with considerable variation at county level, ranging from virtually zero (in 4 counties) to a peak of 30 percent (in 3 counties).[199]
- The average share of files containing medical documents with conflicting conclusions/diagnoses is 7.6 percent of all files assessed in November 2020, with considerable variation at county level, ranging from virtually zero (in 3 counties) to a peak of 40 percent (in 1 county).[200]
- The most common of the above occur in cases of neurological and ophthalmological disorders, dementia, stroke sequelae, psychiatric disorders and intellectual impairment.

However, only 15 SECPAHs (out of the 36 included in Q2A) have a specific approved procedure (or a paragraph/chapter in the general procedure) on these situations. The prevailing practice in such situations does not involve SECPAH physicians interacting with the specialized medical practitioners who prepared the medical reports on file, nor does it involve SECPAH working with specialists from outside SECPAH. Instead, it consists of requesting that the applicant obtain additional medical documents or paraclinical investigations. This practice makes it more difficult for people with disabilities to obtain a certificate.

As a consequence of inconsistencies in medical documents, in 9.4 percent of all files, on average, the assessment in the specialized medical practitioner's report does not correspond to the SECPAH physician's assessment, as estimated by SECPAH chiefs (in Q2A).[201] At one end, in 5 counties and 1 district of Bucharest, SECPAH chiefs report that they have not recorded any such cases of mismatch. At the opposite end, SECPAHs in 5 other counties and 1 district in Bucharest give estimates of between 20 percent and 45 percent of total files assessed.

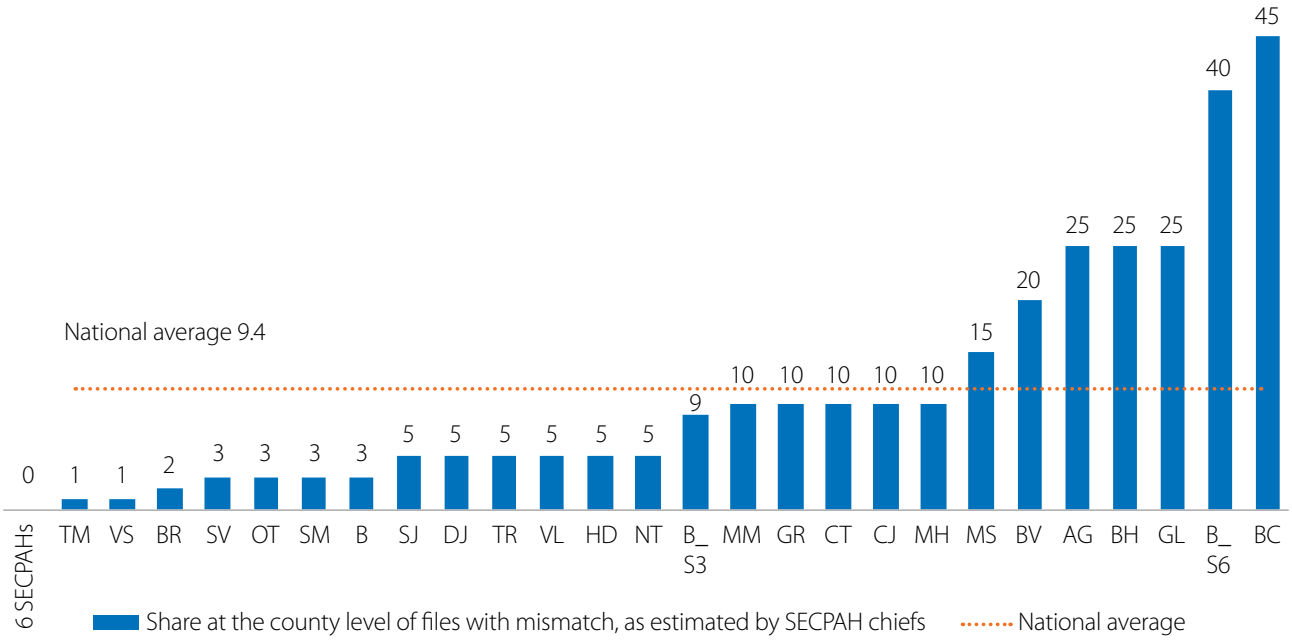
However, only 10 SECPAHs have developed a standardized procedure to deal with situations where discrepancies in medical assessment arise and the actions taken by SECPAH physicians differ. When there is a mismatch, SECPAH specialists typically request the file be completed with results of paraclinical investigations, or that a new medical report be produced by any health care facility/physician of the applicant's choice (in 29 counties), or that additional information be obtained through an in-depth interview with the applicant and/or guardians/caregivers (in 22 counties). Fewer SECPAHs (in 12 counties) require additional medical tests and/or a new report from a specific health care facility/physician, usually a clinic or university hospital. This practice was mentioned in some interviews with people with disabilities and NGOs as a requirement that puts significant pressure on the applicant and his/her family, which is difficult, especially for people who live far from university centers.



"I went and explained to the head of the [assessment] commission that I had made no complaint about these people and that it was a criminal offence what had happened, that they had used my name. However, the persons reported were sent for reassessment to a teaching clinic in Bucharest or in Târgu Mureş, now in the midst of a pandemic. They subjected people to expenses and, above all, to life and death risks based on false claims, as I had already told them. Following reassessment, these people were still given profound disability with the right to have an attendant... These are abuses that should be stopped." (Interview with a national NGO, Bucharest)

199 Standard deviation of 9.5 percent. Estimates for 29 counties and 3 districts of Bucharest.
200 Standard deviation of 7.9 percent. Estimates for 29 counties and 3 districts of Bucharest.
201 Estimates for November 2020, for 28 counties and 4 districts of Bucharest.

Figure 19: Share of files with mismatch between the assessment in the specialized medical practitioner's report and the SECPAH physician's assessment, based on the documents on file, estimates of SECPAH chiefs, November 2020 (% of total files assessed)



Source: Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 28 counties and 4 districts of Bucharest, January-February 2021.

There are also counties with numerous suspicions about the accuracy of medical documents or suspicioned fraud, a subject covered extensively in Section 3.2: Obtaining medical documents. However, on a scale of 1 (none) to 10 (total), the medical documents in the files allow for an accurate assessment of impairment to body structures and functions, at an average level of 8, as well as a comprehensive and sufficiently detailed assessment of the person's activity limitations, at an average level of 7.7, according to the Q2B opinion survey with SECPAH specialists (see Annex 5. Table 1).

4.2.3. Psychological Assessment

In almost all SECPAHs studied, clinical psychologists conduct the psychological assessment for the majority of applicants, as shown in Figure 20.[202] In fact, out of the total number of files assessed in a month, the share of files containing a psychological assessment report/review is about 36 percent, the majority of which (34 percent) being carried out by a clinical psychologist.[203] There is a chapter/paragraph in the general procedure (or, less frequently, a specific approved procedure) for psychological assessment in 32 of the 36 SECPAHs studied (Figure 20).

In accordance with the regulations in force,[204] the main data[205] on which the psychological assessment is based comes from the documents on file, in all counties, and from interviews with the applicant or his/her family/representative (in 33, respectively 30, of the 36 SECPAHs in the sample). In addition, 25

202 SECPAH chiefs in all counties and districts of Bucharest reported that the psychological assessment is provided by psychologists (even if some of them are not clinical psychologists), in accordance with GD no. 268/2007, Art. 48(c).

203 Estimates for November 2020, for 21 counties and 4 districts of Bucharest. The data refers to psychological assessment reports/reviews submitted by the applicant on file, conducted by SECPAH/SEC or both.

204 The ANPD instruction of 3.12.2018, on how to complete the comprehensive assessment report states that the references for the psychological assessment can be identified in: records and/or certificates/assessments /reviews/recommendations issued by the psychologists with the right to practice; medical documents; social inquiry—template in Annex 6 to GD no. 430/2008—information from section Assessment of the person's sensory and psycho-emotional status (behavioral problems).

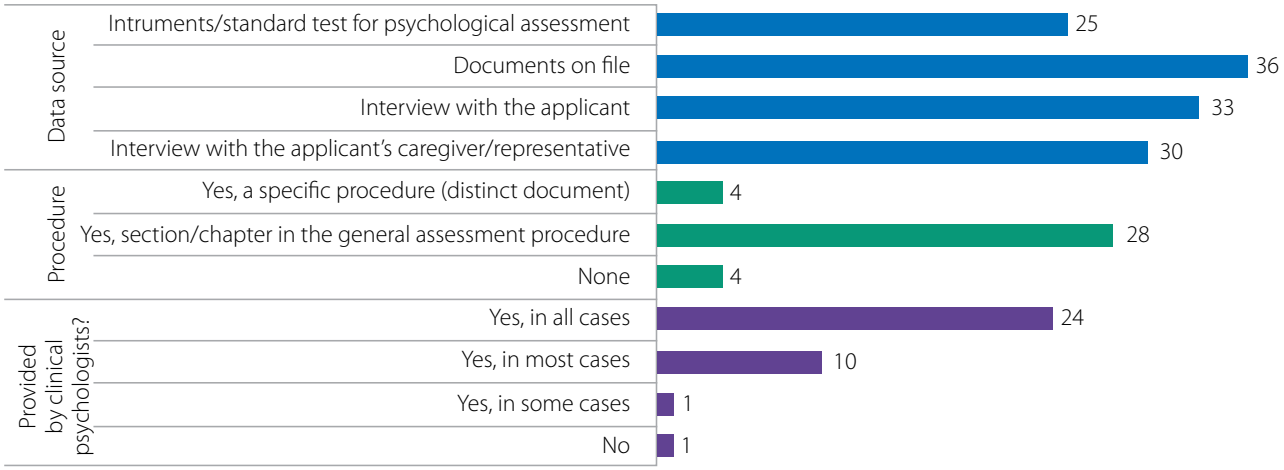
205 In accordance with the ANPD instruction of 3.12.2018 on how to complete the comprehensive assessment report, the relevant psychological assessment data refers to: (i) onset of the condition—date and document of proof; (ii) course of the condition (e.g., frequency of the episodes of decompensation, autolytic attempts); (iii) behavioral problems (aggression, self-harm, exaggerated actions, etc.); and (iv) functional parameters (e.g., as evidenced by GAFS, MMSE scores, etc.).

SECPAHs use standard psychological assessment tools/tests, primarily the MMSE (Standardized Clinical Examination for Cognitive Impairment), and the Global Assessment of Functioning Scale (GAF/EGF).[206] Some counties use tests of standard activities of daily living (ADLs) and instrumental activities of daily living (IADLs), clinical scales that assess the level of functioning, i.e., the ability to perform usual daily activities. The psychological assessment is carried out by reference to the provisions of the medical-psychosocial criteria (Chapter 1 on mental functions).

As in the case of the medical assessment, SECPAH chiefs report an average of 9.2 percent of all cases in which the psychological assessment has vague, unclear, or incomplete conclusions/diagnoses. There is substantial variation between counties, ranging from virtually zero (in 11 counties) to a peak of 75 percent (in 1 county).[207] However, only 12 SECPAHs have developed a procedure to handle such situations. In practice, the SECPAH psychologist may carry out his/her own assessment or may request a second external assessment. Because of the high cost of the psychological assessment provided by a licensed clinical psychologist, some counties accept an assessment conducted at the County Hospital or County Mental Health Center.[208]

For children with disabilities, SECC psychologists state that they cannot always obtain sufficient data from the child psychological assessment form completed by the clinical psychologist, and the recommended tools for completing this data (e.g., neuropsychological assessment battery for children aged 3–12 years, validated on the Romanian population) can only be used by certified psychologists. All psychologists interviewed (SECPAH and SECC) mentioned the need for a unified, specific, and detailed psychological assessment procedure that can be applied to both children and adults, even if the assessment tools are different.

Figure 20: Psychological assessment, according to SECPAH chiefs (number of counties)



Source: Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 32 counties and 4 districts of Bucharest, January-February 2021.

Therefore, on average, for 17.5 percent of all files with a clinical psychological assessment report/review, SECPAH chiefs report (in Q2A) mismatches between the psychologist's assessment (external to SECPAH) and the SECPAH psychologist's assessment.[209] The share of files with mismatched psychological assessment varies significantly, between virtually zero (in 3 counties) and 11 counties with an incidence of over 20 percent, 4 counties with over 40 percent, and 1 county with 65 percent. However, only 13 (out of the 36) SECPAHs have an approved procedure (or a paragraph in the general procedure) for such situations. The most common conditions in which such mismatches occur are mental and intellectual disabilities.

206 Clinical scale that measures the impact of the psychiatric disorders on a person's life and daily functioning abilities, for social behavioral functions.

207 Standard deviation of 17.3 percent. Estimates for November 2020, for 30 counties and 3 districts of Bucharest.

208 See also Section 3.2 on obtaining the medical and psychological documents.

209 Standard deviation of 17.6 percent. Estimates for November 2020, for 24 counties and 3 districts of Bucharest.

In a comprehensive assessment that takes into account the dependency approach, measured by daily activities (the assessment of the person's degree of autonomy/dependence), the available tools are still limited for adequately assessing people with chronic mental health problems. Indeed, some people with this condition can carry out everyday activities, but may require ongoing supervision, which is not yet well-reflected in the assessment tools. In the classic medical approach, it is relatively easier, because the person is diagnosed with a chronic mental illness and the ability or inability to work is assessed. However, in a more comprehensive approach it becomes much more difficult to assess the degree of autonomy or the need for daily support.

Regarding the existence of specific tools used by SECPAH/SECC to assess functioning from a psychosocial perspective (activities and participation), 90 percent of SECC specialists give a positive answer, as opposed to 57 percent of SECPAH specialists.[210] However, in their perception (in Q2B), the documents on file and the current psychological assessment tools also allow for a satisfactory assessment from a psychosocial perspective, with average scores of 7–8, on a scale from 1 (none) to 10 (total) (see Annex 5. Table 2).

4.2.4. Social Assessment

In nearly all SECPAHs (35 out of 36 participating in Q2A), the social assessment is always provided by social workers (in 29 counties) or in most cases (in 6 counties), as required by GD no. 268/2007, Art. 48(a). There is a chapter/paragraph in the general procedure (or, less frequently, a specific approved procedure) for the social assessment in 32 of the 36 SECPAHs studied; the other 4 SECPAHs do not have a procedure for social assessment. In accordance with the regulations in force,[211] the main data on which the social assessment is based comes from the social inquiry on file, in all counties, and from interviews with the applicant or his/her family/representative (in 32 of the 36 SECPAHs in the sample).[212] The social inquiry is drawn up by the social worker or person in charge of social assistance at SPAS level.

According to the SPAS survey (Q1), in all types of localities, most social inquires follow the standard framework template for adults or the standard framework template for ICF-assessed environmental factors for children.[213] The social inquiry framework template for adults includes a wide variety of data on the applicant and the applicant's legal representative; a section on autonomy highlighting the person's functional status (daily activities, independent self-care activities); an assessment of the person's sensory and psycho-emotional state; and a social analysis of the person's housing, family, network of friends, neighbors, and economic situation. Finally, it presents the identified needs and corresponding offer of services to meet these needs, followed by conclusions and recommendations. Much of this information is taken from the ICF as specific elements of activities and participation, as well as environmental factors. A comprehensive analysis of the social inquiries carried out by SPAS can be found in subchapter 3.3.

Regarding the completeness and accuracy of the adult social inquiries, SPAS representatives and SECPAH specialists have different opinions.[214] According to SPAS representatives, the social inquiries they have carried out allow for a "good" or "very good" understanding of the applicant's situation in all areas of life.[215] In contrast, SECPAH specialists rate the completeness and accuracy of the social inquiry information with average scores between 5 and 7 on data about:

- dwellings/housing,
- the applicant's economic situation, and
- community services.

210 Source: Q2B: Practices and experiences of specialists working within the Service for the Comprehensive Assessment of Adults with Disabilities (SECPAH, N=157) and children with disabilities (SECC, N=167), in 39 counties and 6 districts of Bucharest, January–February 2021.

211 ANPD instruction of 3.12.2018 on how to complete the comprehensive assessment report.

212 Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 32 counties and 4 districts of Bucharest, January–February 2021.

213 According to GD no. 430/2008 (Annex 6), for adults, and to Order no. 1985/1305/5805/2016 (Annex 6), for children.

214 The main factors influencing the quality of current social inquiries mainly relate to insufficient staffing and training of SPAS staff, as well as improvements needed to the framework template. For more details, see Section 3.3.3.

215 With average completeness and accuracy scores between 8 and 9 on a scale of 1 to 10, for all dimensions. SPAS survey with valid responses from 65 SPAS, in 26 counties; not including Bucharest districts as district DGASPCs also act as SPAS, January–February 2021.

Thus, in existing social inquires, there is rather unsatisfactory information on the following:[216] the ability of people with disabilities to choose where they live; the adaptation of their housing (current and needed); the support needed by people with disabilities to obtain housing; the income and housing facilities of people with disabilities, including the extra-cost of disability in the person's family and its impact on a decent lifestyle; and the financial support needed to enable them to live with their family and community. In terms of services, the data gaps relate to local service provision, people with disabilities' access to existing services, and their needs for access to health care and recovery/rehabilitation services. The overall score on the extent to which social inquiry data allows SECPAH specialists to accurately assess the applicant's physical and social environment is below 7 (on a scale of 1 to 10) for those conducted by rural SPAS and below 8 for those conducted by urban SPAS.

The SECPAH teams interviewed often mention conflicting information that they find in the SPAS social inquiry, compared to the information presented in the family physician's referral letter or the specialized medical practitioners' report (especially regarding the person's mobility, cognitive, and visual functions, etc.). Besides, also SECPAH teams rarely use tools to assess adaptive behavior; for example, the ABAS-II kit, which is calibrated to the Romanian population.[217] Psychologists interviewed in a separate focus group mentioned the need to supplement the test batteries used in SECPAH with ones that would allow a better assessment of independent living skills.

Also, the social inquiry on file rarely includes complete information about the applicant's living context, support network, daily routine, or lifestyle choices. A section that reflects the applicant's point of view—including their fears, concerns, how they would like to live, and what they would like to do in the future—was among the improvements mentioned more frequently in interviews as needed in the social inquiry framework template. At the same time, during the social inquiry, it would be necessary to analyze the difficulties faced by the person with disabilities, with a focus on contextual and environmental factors that could act as a resource (facilitator) or as a barrier (obstacle)—information that would be useful if it were also included in the PIS/PIRIS as recommendations, to minimize or eliminate barriers and to capitalize on/maximize available resources.

Valuable information in this regard can be requested and taken from psychological assessment reports, which should highlight all aspects related to the resources that a person with disabilities can access, as well as the difficulties they face in their physical, emotional, social, or professional environment, in their daily life. A common database, in which different health care professionals, members of the multidisciplinary team (physician, psychologist, social worker, educational psychologist), based on a specific uniform procedure, would complete the necessary information (both in the assessment reports and in the PIS/PIRIS) would greatly simplify the initiative to improve the comprehensive assessment and intervention process.

4.2.5. Vocational or Professional Skills Assessment

Vocational and professional skills assessment is not available in all counties—only in 25 counties and 4 districts of Bucharest, according to SECPAH chiefs' reports in the institutional survey Q2A. Therefore, 7 counties out of those studied do not provide vocational assessment. Among the 29 SECPAHs that report conducting vocational assessment, about 35 percent of all files assessed over a month contain a vocational assessment. However, the discrepancies between counties are very pronounced Thus, the number of files containing a vocational assessment varies from virtually zero (in 6 counties) to 10–30 files per month (in 5 counties and 1 district in Bucharest) and between 100 and 522 files per month (in 8 counties and 3 districts in Bucharest).[218] A few comments are useful:

- First, the vocational assessment is carried out only at the request of the person with disabilities, based on an application that they submit to the mayor's office of the locality in whose territorial

216 Opinion survey Q2B: Practices and experiences of specialists working within the Service for the Comprehensive Assessment of Adults with Disabilities (SECPAH, N=201), in 39 counties and 6 districts of Bucharest, January-February 2021.

217 As measured by ABAS-II, adaptive skills are defined as: those everyday practical skills that are necessary for the person to function and meet the demands of the environment, including the ability to effectively care for oneself independently, as well as interacting with others. This type of assessment tools is often used in the certification processes of people with disabilities in different countries around the world.

218 A number of 6 SECPAH chiefs did not provide estimates of the number of files containing vocational assessments. Estimates for November 2020, for 25 counties and 4 districts of Bucharest.

area they have their domicile/residence, or to the DGASPC registry office.[219] In the context of this regulation, county practices differ significantly, from counties where vocational assessment is not carried out at all, to counties where it is carried out for all applicants aged 18–26 or, in some counties, 18–45 (and not only on request).

- Second, vocational assessment results in a professional orientation certificate in very few cases. According to the regulations, after SECPAH conducts the vocational assessment, the conclusions and recommendations are recorded in the comprehensive assessment report, which is sent to CEPAH, and the commission issues the professional orientation certificate. According to reports from CEPAH presidents in the institutional survey Q3A, the majority of CEPAHs do not issue professional orientation certificates.[220]
- Third, the entire existing institutional arrangement—SECPAH, CEPAH, county employment agencies (AJOFM/ALOFM)—does not provide real support for people with disabilities to integrate into the labor market. Thus, after CEPAH decides to issue the professional orientation certificate, the CEPAH secretariat sends it to the applicant, but does not send it (automatically) to the public employment services (AJOFM/ALOFM). There are no cooperation protocols between DGASPC and AJOFM/ALOFM for either the assessment or intake of persons with a professional orientation certificate. And within AJOFM/ALOFM, there is no specialist specifically assigned to deal with people with disabilities, providing assistance services to those wishing to enter the labor market in order to find and access the most suitable services from the existing offer. Instead, once the person with disabilities receives the professional orientation certificate, they can go to the AJOFM/ALOFM and must look for training and labor market entry options on their own, possibly with support from family and friends. Only one county (DB) reported an example of good practice—a vocational guidance and training center set up by the DGASPC, as reflected in the following quote.

"The person waits until the professional orientation certificate arrives from the CEPAH secretariat. Once the person obtains the professional orientation certificate, he/she is registered with the vocational guidance and training center of the DGASPC. The person will benefit from assistance and support services, as well as social mediation services, in order to identify training and labor market entry options." (CEPAH members, quotes from Q3B questionnaires)

Closer cooperation with ANOFM/AJOFM would be very useful, especially considering that 20 career counseling centers for people with disabilities have been set up within ANOFM, where many of the career guidance counselors have even been trained in sign language so as to communicate with people with hearing deficiency.

- Fourth, CEPAH presidents state that the number of professional orientation certificates is low either because SECPAHs do not carry out vocational assessment, or because the person's interest in vocational guidance (or other labor market services) is not a subject of systematic analysis for specialists (but is considered proven only by an express request submitted to the mayor's office by the person with disabilities).[221] On the other hand, CEPAH members in the opinion survey Q3B pointed out that, with limited resources and a significant workload, the vocational assessment and the issuing of the professional orientation certificates represent marginal activities because they "overlap with the duties of other related institutions,"[222] i.e., employment services (AJOFM/ALOFM).
- Fifth, in other countries, vocational assessment is not part of the disability assessment, but part of the needs assessment of persons with disabilities.

219 Only one county (BC) stated that they issue the professional orientation certificate without an express request made by the person concerned, based on the vocational and professional skills assessment carried out by SECPAH (as part of the comprehensive assessment) and the interest expressed by the person concerned during the interview/interaction with SECPAH.

220 See subchapter 5.3, Section on professional orientation certificate.

221 Institutional study Q3A: Factual data and indicators on the activity of the Assessment Commissions for Adults with Disabilities (CEPAH) in 19 counties and 2 districts of Bucharest, January–February 2021.

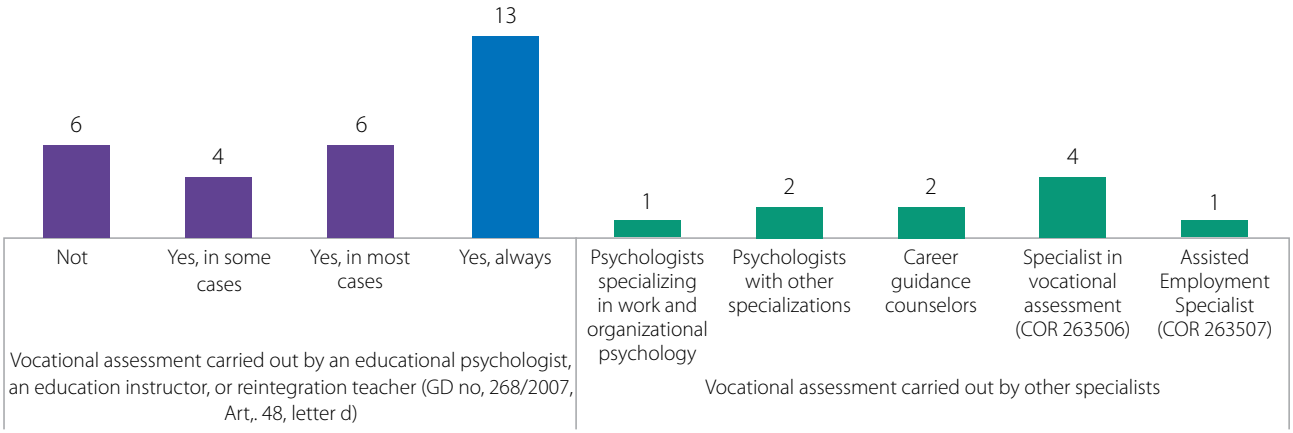
222 Member of CEPAH, quoted from a Q3B questionnaire.

It is therefore carried out by dedicated specialists using specific tools and methodologies, in order to identify all the services that can provide appropriate support for persons with disabilities to enter the labor market. In Romania, the fact that vocational assessment is carried out superficially (or not at all) is also reflected in the PIRIS and PIS. Thus, in most cases, the PIRIS and PIS individualized plans do not adequately reflect the results of the vocational assessment, with the sections on professional (as well as educational) activities being largely incomplete (see analysis in Chapter 6).

- Moreover, the data on vocational assessment and professional orientation certificate are also not systematically recorded, monitored, and analyzed to substantiate and improve employment policies for people with disabilities.

In a few of the studied SECPAHs, vocational assessment is always carried out by the types of specialists stipulated in the legislation,[223] as shown in Figure 21. In most cases, it is carried out by an educational psychologist, but there are also many SECPAHs (10 out of 29) where a significant part of the file is assessed by other types of specialists, shown in Figure 21, and in some counties even by SECPAH members with other specializations (social worker or physician; see also Section 9.2.1).

Figure 21: Who performs vocational or professional skills assessment, according to SECPAH chiefs (number of counties)



Source: Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 25 counties and 4 districts of Bucharest, January-February 2021.

There is a chapter/paragraph in the general procedure (or, less frequently, a specific approved procedure) for vocational assessment in only 19 of the 29 SECPAHs that provide such an assessment. In accordance with the regulations in force,[224] the main data[225] on which the vocational assessment is based comes from the social inquiry carried out by SPAS in 23 (out of 29) counties, and especially from interviews with the applicant or his/her family/representative (in 26 counties). The professional file (skills and professional experience acquired in formal, informal, and non-formal environments) is used by only 7 SECPAHs.

Most SECPAHs do not use specific tools for vocational and professional skills assessment; each specialist uses their own tools. However, DGASPC has the CASPER test batteries, validated on the Romanian population in 2011, and in 2013 specialists from each SECPAH were trained in the use of these tests. However, in the institutional

223 GD no. 268/2007, Art. 48(d).

224 The ANPD instruction of 3.12.2018 on how to complete the comprehensive assessment report states that references for vocational assessment can be identified in: professional qualification sheets/certificates; recommendations issued by authorized institutions; social inquiry—template in Annex 6 to GD no. 430/2008.

225 In accordance with the ANPD instruction of 3.12.2018, on how to complete the comprehensive assessment report, the relevant vocational assessment data refers to: (i) the interests of the person; and (ii) the level of professional qualification. The assessment is aimed at possible recommendations for educational-professional orientation or education reorientation or reskilling contacting the AJOFM for support in finding a job.

survey Q2A, only 6 SECPAH chiefs reported using standard vocational assessment tools/tests, and of these, only two counties mentioned CASPER test batteries. An analysis of the reasons for the under-use of these tools could help improve the way vocational assessment is carried out in the territory.

From a psychosocial perspective, the documents in the file and the tools used for vocational assessment allow for a less than satisfactory assessment, both in terms of activity limitations, participation restrictions, or environmental factors that may act as barriers or facilitators in the area of labor. This is the dominant opinion expressed by SECPAH specialists in the Q2B survey, as shown by available data in Annex 5, Table 3.[226] However, the results of the vocational assessment are generally not included in the final recommendation for classification of degree and type of disability.

4.2.6. Assessment of the Education Level

This is the second type of assessment (after vocational) that has a minor impact on the final recommendation for disability degree and type classification. This is largely because the educational assessment, together with the vocational assessment, are usually (in other countries) components of the needs assessment of persons with disabilities and not of the disability assessment process. Just as the vocational assessment is intended to shed light on the professional/employment pathway and identify the best ways to (re)connect the person to the labor market, the educational assessment focuses on identifying the most appropriate services/activities to support the person achieve their full potential and educational aspirations. Both types of assessment are therefore designed to identify the most appropriate measures to minimize activity limitations and participation restrictions, starting from environmental and personal factors that may act as barriers or facilitators.

In Romania, the educational level assessment is not available in all counties, just in 27 counties and 3 districts of Bucharest, according to SECPAH chiefs' reports in the institutional survey Q2A.[227] Across these 30 SECPAHs, approximately 61 percent of all files evaluated in a month contain an educational assessment, with striking discrepancies between counties. Thus, the number of files containing an educational assessment varies from virtually zero (in 3 counties), to 10–20 files per month (in 3 counties), to between 100 and 631 files per month (in 17 counties and 3 districts in Bucharest).[228]

- However, in most counties, SECPAHs conduct education level assessments for more files than they do for the vocational assessment. One reason is that the educational level assessment is often limited to recording the applicant's completed level of education. Also, unlike the vocational assessment, the education level assessment does not have to end with a school orientation (or educational guidance) certificate or recommendation. Therefore, data on school orientation certificates are not systematically collected.
- Data on young people (aged 18 and over) with special educational needs (SEN) are also not collected. For example, there is no monitoring of the status of young people with SEN who had an school orientation certificate issued by the CJRAE/CMBRAE by the age of 18. Once they turn 18 and transition from childhood to adulthood, young people with SEN can no longer apply to the CJRAE/CMBRAE, but can obtain the educational orientation certificate only on request as part of SECPAH's educational assessment. There are no legal requirements or monitoring mechanisms for any of the following issues: the extent to which young people (aged 18 and over) with SEN are informed and advised to apply for such a certificate; and the extent to which young people with SEN benefit from a special educational needs assessment and receive an educational and professional orientation certificate from SECPAH (see also analysis in Section 8.4).
- According to SECPAH specialists, an educational assessment would be necessary not only for young people with disabilities in pre-university education, but also for those enrolled in university, with an average score of 3.2 on a scale of 1 (not necessary) to 5 (very necessary).[229]

226 Average scores between 4.81 and 6.36 on a scale of 1 to 10. Opinion survey Q2B: Practices and experiences of specialists working within the Service for the Comprehensive Assessment of Adults with Disabilities (SECPAH), in 39 counties and 6 districts of Bucharest, January-February 2021.

227 Therefore, 5 counties and 1 district of Bucharest, out of those studied, do not provide an educational assessment.

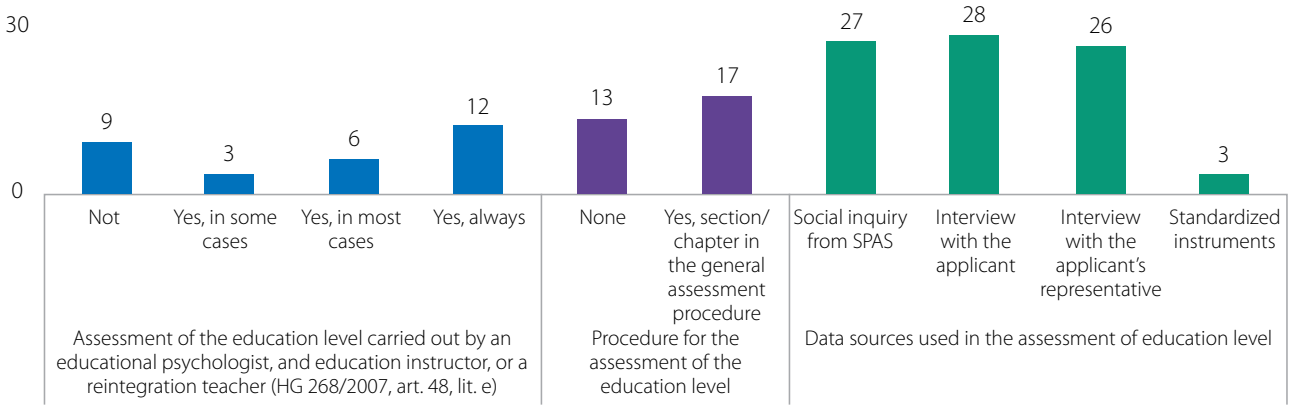
228 A number of 4 SECPAH chiefs did not provide estimates of the number of files containing education level assessments. Estimates for November 2020, for 23 counties and 3 districts of Bucharest.

229 Opinion survey Q2B: Practices and experiences of specialists working within the Service for the Comprehensive Assessment of Adults with Disabilities (SECPAH, N=146), in 39 counties and 6 districts of Bucharest, January–February 2021.

- According to the legal provisions,[230] the conclusions and recommendations of the education level assessment may include: completion of studies, where appropriate; Second Chance ("A doua șansă"); or alternative education programs. However, similar to vocational assessment, the existing institutional arrangement involving SECPAH - CEPAH - County School Inspectorates (ISJ/CJRAE) - educational establishments - AJOFM - training providers does not facilitate the participation of people with disabilities in education. For example, the national Second Chance program for completing compulsory education (primary and secondary school) is available at national level, with the resources needed to organize Second Chance classes being planned from one academic year to the next by the ISJs, according to requests from schools, based on lists of potential beneficiaries (in line with funding per pupil). SECPAH is responsible for carrying out the vocational assessment, but does not draw up a list of potential beneficiaries in time to send to the educational establishments or to the ISJ, so that the planning of Second Chance classes does not take into account and directly registers people with disabilities who wish to participate in this program. The same situation exists for people who would like to take vocational courses: There is no institutional referral mechanism to AJOFM and training providers. In the current context, at best, the applicant obtains the educational and professional orientation certificate and then must search for viable educational options on their own, and then make other files or applications or more trips in order to participate in them. The process is very complex and involves a high level of information, requires the ability to interact with various institutions/organizations, and has costs that only a small number of people with disabilities can afford.
- Finally, in Romania, the assessment of educational level is not based on specific tools or methodologies to identify all the services that can provide adequate support for persons with disabilities to participate in education. The fact that the educational assessment is carried out rather formally (or not at all) is also reflected in the PIRIS and PIS. Thus, in most cases, the PIRIS and PIS do not adequately reflect the results of the educational assessment, with the sections on educational (as well as professional) activities being mostly incomplete (see analysis in Chapter 6).

In a just a few of the SECPAHs studied, educational level assessment is always carried out by the types of specialists stipulated in the legislation,[231] as shown in Figure 22. In most cases, it is carried out by an educational psychologist, but there are also many SECPAHs (12 out of 30) where a significant part of the files are assessed by other types of specialists, especially by psychologists and social workers (see also Section 9.2.1).

Figure 22: Assessment of the education level, according to SECPAH chiefs (number of counties)



Source: Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 27 counties and 3 districts of Bucharest, January–February 2021.

230 ANPD instruction of 3.12.2018 on how to complete the comprehensive assessment report.
231 GD no. 268/2007, Art. 48(e).

There is a chapter/paragraph in the general procedure for educational assessment in only 17 of the 30 SECPAHs that provide such type of assessment (see Figure 22). In accordance with the regulations in force,[232] the main data[233] on which the educational assessment is based comes from the social inquiry carried out by SPAS, in 27 (out of 30) counties, and especially from interviews with the applicant or his/her family/representative. The use of specific standardized tools for educational assessment was mentioned by only 3 SECPAH chiefs, namely the educational psychologist assessment sheet. In general, however, each specialist uses their own tools or does not use any assessment tool at all, but merely records the level of education completed by the applicant.

The data from Annex 5, Table 4 show that, in the opinion of SECPAH specialists, the tools used for the educational assessment allow for a less than satisfactory assessment from a psychosocial perspective, both in terms of activity limitations, participation restrictions, or environmental factors that may act as barriers or facilitators in the area of education.[234]

4.2.7. Assessment of Social Integration Level and Skills (Degree of Dependency)

The assessment of social integration level and skills is the third mandatory area, alongside vocational and education level assessment, with a minor impact on the final recommendation for classification of degree and type of disability. All three types of assessment provide information from a psychosocial perspective, which could influence the classification of disability degree, if it were based on ICF principles and if there was a rigorous methodology for combining this information with the results of the medical and psychological assessment. However, as these two conditions are not met in Romania, these three assessments are components of the needs assessment of persons with disabilities and not the disability assessment. What differentiates the assessment of the social integration level is that in Romania, it plays a significant role in recommending (by SECPAH), and establishing (by CEPAH) the right to a personal assistant and sometimes to other services, such as residential care, day care, or home care.

In Romania, the assessment of social integration level is not available in all counties, just in 30 counties and 4 districts of Bucharest (out of a total of 36), according to SECPAH chiefs' reports in the institutional survey Q2A.[235] In most SECPAHs,[236] the assessment of social integration level is the joint responsibility of 2–4 specialists, usually, the psychologist and social worker. However, there are also counties in which it is carried out by an educational psychologist, a reintegration teacher, and, less frequently, by physicians or other specialists (see also Section 9.2.1).[237] However, a dedicated chapter/paragraph in the general procedure for assessing the level of social integration has been developed by only 18 (out of 34) SECPAHs. In accordance with the regulations in force,[238] the main data underlying the assessment of the level of social integration come from multiple sources, mainly the social inquiry carried out by SPAS, in 33 (out of 34) counties, interviews with the applicant or his/her family/representative (in 33, and 30 counties respectively) and the psychological assessment (in 24 counties).

The regulations[239] stipulate that relevant data for the assessment of social integration level and skills (degree of dependency) shall relate to: (i) the process

232 The ANPD instruction of 3.12.2018 on how to complete the comprehensive assessment report states that references for educational assessment can be identified in: sheets/certificates/recommendations issued by the educational institutions; social inquiry—template in Annex 6 to GD no. 430/2008—section I.

233 In accordance with the ANPD instruction of 3.12.2018, on how to complete the comprehensive assessment report, the relevant educational assessment data refers to: (i) type of education (mainstream/special); (ii) level of education; (iii) education completed or not; and (iv) reason for school drop-out.

234 Average scores between 5.56 and 6.52 on a scale of 1 to 10. Source: Q2B: Practices and experiences of specialists working within the Service for the Comprehensive Assessment of Adults with Disabilities (SECPAH), in 39 counties and 6 districts of Bucharest, January–February 2021.

235 So, 2 counties among those studied stated that they do not provide assessment of the level of social integration.

236 According to GD no. 268/2007, Art. 48(f).

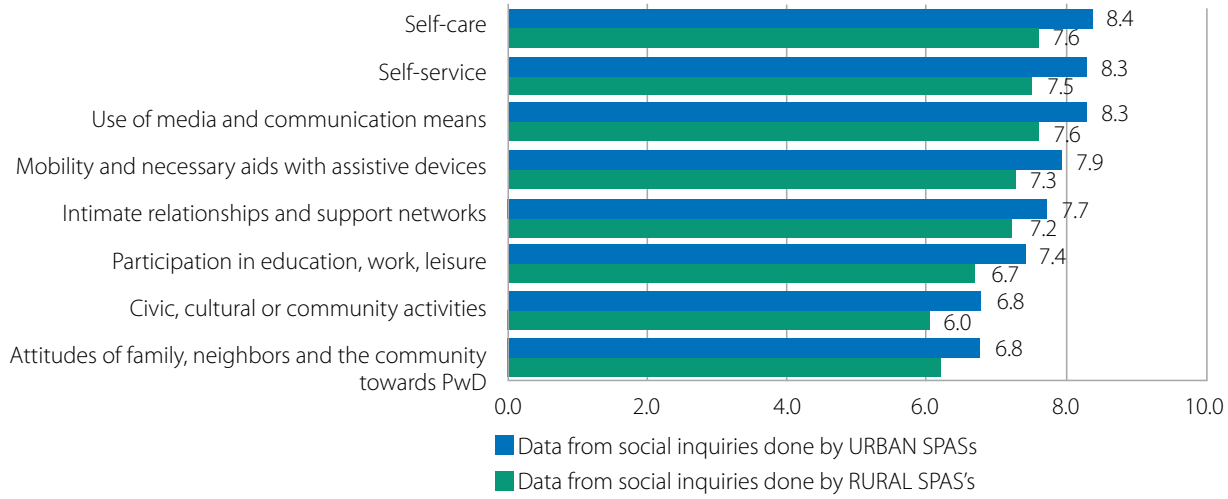
237 In the institutional survey Q2A, of the 34 SECPAHs carrying out the social integration level assessment, 27 chiefs reported that this is provided by psychologists, 21 mentioned social workers, 13 answered educational psychologists, 4 said reintegration teachers, and 2 named other specialists. The data are consistent with those reported by SECPAH chiefs in the SECPAH staff activity participation table which collected information on the specific tasks performed by each employee, where the list of tasks was compiled in accordance with the National Framework Procedure (Annex to Order no. 2298/2012).

238 The ANPD instruction of 3.12.2018 on how to complete the comprehensive assessment report states that references for social integration assessment can be identified in: social inquiry—template in Annex 6 to GD no. 430/2008; other documents.

239 ANPD instruction of 3.12.2018 on how to complete the comprehensive assessment report.

of social integration, defined as the interaction between the individual and the social environment, through which a functional balance of the parties is achieved;[240] (ii) whether the person engages in lucrative activities that involve interaction with other people; (iii) whether the person develops and maintains interpersonal relationships (permanent or occasional): whether the person has relationships with family, friends, and neighbors; and (iv) whether the person belongs to sports/cultural clubs. Out of these relevant data for assessing degree of dependency, only some information from the social inquiries drawn up by SPAS are satisfactory for both rural and urban applicants, according to SECPAH specialists. Figure 23 (and Annex 5. Table 5) shows that the satisfactory information refers to self-care, self-service, use of media and communication means, mobility, intimate relationships, and support networks (average scores above 7, on a scale of 1 to 10). By contrast, information on participation in education, work, leisure, civic, cultural, or community activities, as well as on the attitudes of family, neighbors, and the community towards the applicant, is less satisfactory (average scores below 7, on a scale of 1 to 10).

Figure 23: The extent to which data obtained from social inquiries sent by rural and urban SPASs are sufficient to allow detailed and accurate assessment of social integration level (degree of dependency), according to SECPAH specialists, average values, on a scale of 1 (none) to 10 (total)



Source: Opinion survey Q2B: Practices and experiences of specialists working within the Service for the Comprehensive Assessment of Adults with Disabilities (SECPAH), in 39 counties and 6 districts of Bucharest, January–February 2021.

Note: See also Annex 5. Table 5.

The same ANPD[241] instruction declares that the purpose of the assessment is to make recommendations aimed at identifying a support group, social counseling services, or education programs. It is not clear why findings/recommendations for education programs should be included in the assessment of dependency degree and not in the assessment of education level. But more importantly, in practice, the assessment of social integration level is most often used to establish the right to a personal assistant or a protective measure (admission to residential or day care center, placement with a professional personal assistant, or provision of home care services).

4.2.8. Establishing Conclusions and Recommendations of the Comprehensive Assessment

The previous sections have shown that the comprehensive assessment for disability degree classification covers, in most counties and for most applicants, all six mandatory[242] areas and is carried out by relevant specialists based on

240 Law no. 292/2011 on social assistance, Art. 6(dd).

241 ANPD instruction of 3.12.2018 on how to complete the comprehensive assessment report.

242 As provided for in the legislation, GD no. 268/2007, Art. 48.

an impressive amount of data provided by the applicants in their files. Besides the medical and psychological documents, the main sources of data SECPAH uses are the social inquiry prepared by SPAS and the interview with the applicant and his/her family/representative. However, as shown in Sections 4.2.1–4.2.7, the data have some important limitations, namely:

- Although sometimes marked by inconsistencies or vague or unclear conclusions/diagnoses, the data for the medical and psychological assessment allow for a satisfactory assessment, report SECPAH specialists (see Annex 5), regarding both impairments of body structures and body functions, as well as activity limitations and participation restrictions.
- The data for social assessment are not collected systematically or uniformly, although they come predominantly from social inquiries that are drawn up by most SPAS based on the framework model laid down in the legislation.[243] According to SECPAH specialists, the completeness and accuracy of the information is unsatisfactory, especially regarding dwellings/housing, the person's economic situation, and the community services. Also, the SECPAH teams interviewed often mention conflicting information that they find in the social inquiry compared to the information presented in the family physician's referral letter or the specialized medical practitioners' report (especially regarding the person's mobility, cognitive, and visual functions, etc.). In addition, the social inquiry on file rarely includes comprehensive information about the applicant's living context, daily routine, lifestyle choices, or difficulties faced, with a focus on contextual and environmental factors that might act as a resource (facilitator) or barrier (obstacle). Furthermore, the social inquiry framework model is missing a section that should reflect the point of view of the person with disabilities, such as their fears, concerns, how they would like to live, and plans for the future.
- The data for the vocational assessment, education level assessment, and the social integration level and skills assessment (degree of dependency) are collected sporadically and unevenly, although they are part of the social inquiries based on the framework template. According to SECPAH specialists (see Annex 5), these data allow only for a less than satisfactory assessment from a psychosocial perspective, both in terms of activity limitations, participation restrictions, or environmental factors that may act as barriers or facilitators.

There are no specific tools or methodologies for data analysis, and no clear rules on what data should be used/analyzed for each assessment area.[244] Although the comprehensive assessment is a multi-criteria assessment, there are no specific weights or rules that clearly establish the contribution of each domain to the assessment's final outcome. As a result, the data is used and analyzed differently from one county to another, and, sometimes from one specialist to another, especially as many SECPAHs have not developed specific working procedures in this respect.

Accordingly, the dominant practice is to make the final recommendation for the disability degree classification basically based on quantifiable data, perceived by SECPAH specialists to have the highest level of completeness and accuracy, that is primarily the medical and psychological data. In contrast, "soft" data on a person's level of functioning has, in most counties, limited impact on the final assessment.

SECPAH's comprehensive assessment results in a set of documents that are sent to CEPAH for the final decision on disability degree classification, namely:

1. the comprehensive assessment report containing:
   i. conclusions and recommendations for each assessment area are;
   ii. proposal for classification/non-classification for degree of disability;
   iii. proposal for professional orientation and the Professional Orientation Certificate;
   iv. proposal to take a protective measure;
   v. decision to include the personal assistant service, for those with a severe degree of deficiency
2. the PIRIS and, 3. in some cases, the PIS.

SECPAH recommendations are decided as a team (Table 9). However, 21 of the 36 SECPAH chiefs who responded to the Q2A questionnaire reported that there is one member of the team who contributes more than the others, namely the specialized medical practitioner, in terms of determining the proposal for disability degree

243 GD no. 430/2008, Annex 6.

244 The only guidance available is in the ANPD instruction of 3.12.2018, on how to complete the comprehensive assessment report.

classification/non-classification. All other SECPAH recommendations are team-decided in most but not all counties. For example, 10 SECPAH chiefs state that in their county, the main responsibility for determining the conclusions and recommendations of the comprehensive assessment report lies with the specialized medical practitioner. Also, 16 SECPAH chiefs indicate that in their teams, the proposal for professional orientation and the corresponding certificate are the responsibility of the educational psychologist (in 8 counties), the psychologist (in 5 counties), or another specialist (in 3 counties), which is in line with the regulations. Similarly, in 14 counties, the proposal for a protection measure is the responsibility of a social worker or, less frequently, a physician. Also, 9 SECPAH chiefs indicate that the decision to grant the right to a personal assistant for people with severe deficiencies is mainly taken by a physician (in 6 counties) or a social worker (in 3 counties).

Table 9: How SECPAH recommendations and proposals are determined, according to SECPAH chiefs (number of counties)

In the process of determining the following aspects:	1. Is there a team member (with a particular specialization) who contributes more than others?		2. Is there an area of assessment that "weighs heavier"?	
	Yes	No	Yes	No
Conclusions and recommendations of the comprehensive assessment report	10	25	26	9
Proposal for classification/non-classification for degree of deficiency	21	13	26	9
Proposal for professional orientation and Professional Orientation Certificate	16	20	15	21
The proposal to take a protective measure	14	21	17	19
PIRIS - Individual Rehabilitation and Social Integration Program	2	32	3	30
PIS – Individual Service Plan	2	27	2	27
Decision to include the personal assistant service in PIS for persons with severe deficiencies	9	22	10	21

Source: Institutional study Q2A: Factual data and indicators on the activity of the Services for the Comprehensive Assessment of Adults with Disabilities (SECPAH) in 32 counties and 4 districts of Bucharest, January-February 2021.

Note: The sum of cells per line/question should be 36, which is the total number of SECPAH chiefs who participated in Q2A. In the case of smaller sums, the difference up to 36 represents non-responses or situations where SECPAH does not carry out those activities, as is the case for MTR6 which is only prepared in some counties in the country.

Table 9 also shows that there is an area of assessment that "weighs more heavily" in the decision on certain SECPAH proposals. The conclusions and recommendations in the comprehensive assessment report are predominantly based on the medical assessment in 26 of the 36 SECPAHs studied. Similarly, the proposal to classify/not classify a degree of deficiency is predominantly based on the results of the medical assessment. The professional orientation proposal is mainly based on vocational assessment (in 9 counties), but also on educational (in 4 counties), social (1 county), or even psychological (1 county) assessment.[245] The proposal for a protective measure is also decided according to a specific area of assessment in 17 counties, but this may be social (in 12 counties), medical (in 2 counties), psychological (in 2 counties), or as per social integration level and skills assessment (in 1 county). However, in most counties (19 out of 36), the proposal for a protective measure is made after considering the results of the assessment in several areas. Granting the right to a personal assistant is primarily based on medical (in 7 counties), social (in 1 county), or social integration level and skills (in 2 counties) assessments.

245 In the other 21 of the 36 counties in the sample, the proposal for professional orientation is made based on the findings from several assessment areas.

Therefore: (i) current practices regarding the determination of SECPAH recommendations differ significantly between counties; (ii) the proposal for disability classification/non-classification, which is forwarded to the CEPAH, is primarily made by the specialized medical practitioner; and (iii) the medical assessment provides the key elements in determining the conclusions and recommendations in the comprehensive assessment report. Focus groups with SECPAH specialists confirmed this data reported by SECPAH chiefs in the Q2A questionnaires.

Given the central role of the physician within the SECPAH team, it is important to reiterate the fact that most are either general practitioners or family physicians. As mentioned, the medical assessment is carried out by SECPAH in all counties and districts of Bucharest. Therefore, 100 percent of the applicants receive a medical assessment. However, only about 5 percent of applicants are assessed by a medical practitioner specialized in work capacity (requested by SECPAH or not). And only 5 percent are assessed by a medical practitioner specialized in physical medicine and rehabilitation. Moreover, of the 36 SECPAHs studied, only 4 services collaborate with a medical practitioner specialized in work capacity, within the National House for Public Pensions, and only 1 SECPAH collaborates with a medical practitioner specialized in physical and rehabilitation medicine. Although there is no legal requirement for adult assessment services to employ, collaborate with, or request assessments from physicians with these two specialties, this data is highly relevant from the ICF perspective, because these medical specialties have approaches aligned to the ICF model.

In conclusion, the assessment procedure and tools used in the comprehensive assessment carried out by SECPAH are not aligned with the ICF principles. According to the ICF model of functioning and disability, functioning and disability are the result of the interaction between health condition and personal and environmental factors, as presented in Section 1.5. Correspondingly, the ICF principles require that the disability assessment process should include both medical (impairments of the body's functions and structures) and functional (activity limitations and participation restrictions, depending on environmental and personal factors) components, and that these components should participate in both the definition of assessment criteria and the decision-making process. For this reason, the medical information is essential for assessing the degree of disability, but it is not sufficient. The decisions need to take into account what the person can and cannot do in their environment, not just the medical diagnosis. In contrast, in Romania, given the substantial variation between counties, the different compositions of the SECPAH teams, the different information gathering procedures, and the different approaches to the final decision-making process (the joint decision of the SECPAH team versus a single decision of the physician), it is not possible to estimate at national level whether and to what extent information on the person's functioning and living context plays any procedural role in the comprehensive assessment. In addition, there is no methodology or procedure to ensure that the information on functioning has any impact on the final assessment.

It is absolutely necessary to define and implement new procedures for assessing and classifying the disability degree based on the ICF principles, as the current procedures are not always clear or consistent across counties. It is important to underscore the fact that ensuring uniform tools and procedures at county level is a necessity from a human rights perspective: it is fair and equitable that people in similar situations and with similar levels of disability be assessed in a similar way throughout the country. Any other approach is unfair and discriminatory. This is laid down in all human rights treaties and in the UN Convention on the Rights of Persons with Disabilities. New procedures should be developed in a collaborative process that involves specialists, social workers, international ICF experts, policy makers, and advocates for the rights of persons with disabilities.

4.3. Medical-psychosocial criteria

This subchapter covers the medical-psychosocial criteria on which the classification of disability degree is based. The first section provides an overview of the criteria, while the second section analyzes the criteria from the perspective of the ICF.[246]

246 More details on the ICF are available in subchapter 1.5.

4.3.1. Overview of the Medical-Psychosocial Criteria

In Romania, the comprehensive assessment of adults for disability degree classification is based on medical-psychosocial criteria, defined by Joint Order no. 762/1.992/2007.[247] From a technical point of view, at the heart of the medical-psychosocial criteria is an assessment based on scales.[248] A Baremic assessment method is an arbitrary ordinal scale that attaches percentage values, degrees, or other qualifiers (mild, moderate, severe, profound) to different levels of disability based on the degree of impairment of various parts of the body. Scores based on scales are widely used around the world and associate certain percentages of deficiencies or impairments of organs or functions with degrees of disability. Almost every country in the world that has a formal disability assessment procedure has at some point used or continues to use some form of the scales-based system.

Frequently, the degree of severity of a disease or organ disorder (or other diagnosed abnormality) is identified by standard tests or other tools (e.g., dioptric autorefractometer for visual acuity impairment, blood pressure measurement, exercise tolerance test, mean corpuscular hemoglobin concentration, etc.). These instruments measure the body's "functional parameters." This means that in terms of diagnosis, the medical-psychosocial criteria are well-founded in clinical medicine.

Unlike traditional Baremic tools—such as the most influential modern scaling tool, the American Medical Association's Guides to the Evaluation of Permanent Impairment—the Romanian medical-psychosocial assessment criteria were designed to perform several additional functions, presumably to align them with the terminology used in the ICF, at the very least. The medical-psychosocial criteria are therefore a complex working tool, both as structure and through its internal components.

Joint Order no. 762/1.992/2007 approving the medical-psychosocial criteria has undergone a number of amendments and supplements over time.[249] It is organized into eight chapters and is based on the model of classification of body functions described by the ICF. Each of these chapters is subdivided into assessment domains based on major groups of conditions, which are in turn organized into major diseases, injuries, or syndromes and associated impairments.

Chapters		Areas of assessment (examples) For example, Chapter 2 is subdivided into:
1. Mental functions 2. Sensory functions 3. Phonatory functions and verbal communication; Assessment of the degree of disability in voice impairment	1	pct. I Assessment for classifying into a degree of deficiency of persons with impaired visual functions
4. Functions of the cardiovascular, hematological, immune and respiratory systems 5. Functions of the digestive, metabolic, and endocrine system	2	pct. II Assessment for classifying into a degree of deficiency of persons with impaired hearing functions
6. Urogenital functions 7. Neuro-musculoskeletal functions and related movements 8. Skin functions	3	pct. III Assessment for classifying into a degree of deficiency of persons with impaired vestibular functions

247 Joint Order of the Minister of Labor, Family and Equal Opportunities and the Minister of Public Health no. 762/1.992/2007 approving the medical-psychosocial criteria based on which the degree of disability is determined, with subsequent amendments and supplements.

248 The scales method was named after the 17th century French mathematician Francois Barrème who devised a table of ordered percentage values for different types and degrees of severity of bodily damage to compensate for war-related injuries.

249 They are: Order no. 692/982/2013 amending Chap. 1 Mental functions; Order no. 707/538/2014 amending Chap. 2 Sensory functions and Chap. 7 Neuro-musculoskeletal functions and related movements; Order no. 131/90/2015 on the amendment of Chap. 4 point A.II. Assessment of the degree of disability in the impairment of functions of arteries related to blood flow; Order no. 874/554/2016 on the amendment of Chap. 8 Assessment of persons with major sequelae of complex burns in order to classify the degree of disability; Order no. 1070/403/2018 Chap. 4 Functions of the cardiovascular, hematological, immune and respiratory systems, Chap. 5 Functions of the digestive, metabolic and endocrine system, Chap. 7 Neuro-musculoskeletal functions and related movements; Chap. 8 Skin functions; Order no. 741/577/2019 on the amendment of Chap. 2 Sensory functions, Chap. 7 Neuro-musculoskeletal functions and related movements.

The medical-psychosocial criteria is a Baremic-based tool that provides an assessment of the degree of disability in terms of diagnosis or impairment/deficiency. As a Baremic-style assessment tool, its main function is to link diagnostic categories or impairments to a particular degree of disability ("handicap"). This is done by classifying the degree of impairment/deficiency/handicap into four or five points (minor, medium, marked, and severe with or without personal assistant), based on a description of the results of the diagnostic test or examination. Box 6 shows an example of how this appears in the medical-psychosocial criteria.

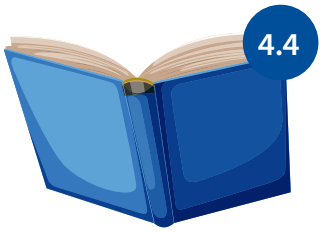
BOX 6

Example of disability degree classification

FUNCTIONAL PARAMETERS		Subjective liminal tone audiometry, speech audiometry, early auditory evoked potentials, impedancemetry and acoustic otoemissions.
MODERATE IMPAIRMENT	MEDIUM HANDICAP	Bilateral hearing loss between 41–70 dB, prosthetic.
SEVERE IMPAIRMENT	MARKED HANDICAP	Hard-to-protect hearing loss above 70 dB, associated with mental and language disorders. Congenital deafness or deafness acquired before language acquisition accompanied by mutism (deaf-blindness with poor/no demutism), with loss above 90 dB (profound deafness and cofosis).

Source: Chap. 2 Sensory functions, Point. II Assessment of persons with impaired hearing functions for disability degree classification

Although predominantly based on Baremic scales, the medical-psychosocial criteria are adjusted to include two additional components, namely functional parameters, as well as activities–limitations and participation–needs. Thus, for each major group of conditions (or more often, for each condition), the medical-psychosocial criteria also provide functional parameters that summarize the results of diagnostic tests or clinical examinations used for diagnosis. This is a valuable component of this working tool, as it helps to standardize the assessment criteria for each condition. The quote 4.4 offers an example of functional parameters.



Orthopedic examination, radiological examination: blunt; overlying joint, contralateral, spine, depending on location, to assess consequences of locomotor disability; blunt testing, prosthesis and limb/limbs functionality testing, Oscillometric indices, biometric testing specific to the affected structure, joint mobility testing, muscle testing, spine mobility testing, neurological examination, in some cases, autonomy assessment scales: ADL, IADL, SOS, etc. (Chap. 7 Neuro-musculoskeletal functions and related movements, point III. Assessment of persons with motor function impairment (of statics and mobility - locomotion and/or gestures) for disability degree classification, 1. Amputations from Order No. 707/538/2014 amending and supplementing Order No. 762/1.992/2007)

The last additional component of the medical-psychosocial criteria relates to activities–limitations and participation–needs. This was added with the clear intention of alignment with the ICF, as it extends the standard Baremic scales approach to more closely follow the ICF model. Thus, for each health problem, after the degree of impairment/deficiency/handicap is presented in a table, another table presents the presumed impact of each degree of "disability" on the types of activities and on areas of participation. However, unlike the ICF, which covers all areas of activity and social participation, the Romanian medical-psychosocial criteria deal mainly with activities associated with work and employment.

Under the heading Activities–Limitations, the tables list a combination of activities and general descriptions of the type of occupation, profession, and job that a person with the specified degree of disability could perform. Under the heading Participation–Needs are descriptions of prerequisites for being able to work in an occupation, profession, or job—such as an assistive technology that can facilitate access to a job, social services, and other requirements. Box 7 shows an example of this component.

In fact, this component is an assessment of the needs in order to carry out a professional activity. In some cases, the specification of job capacity (including examples of job types) and job needs are extremely detailed (Box 8).

Together, the degree of impairment/deficiency/handicap and the assessment of the person's activities–limitations and participation–needs create a single comprehensive assessment tool, allowing for two separate assessments: one to determine the degree of disability and the other to identify work-related needs, as well as adaptive capacity, self-care, and self-service (degree of autonomy). Other countries use two separate assessment tools and procedures to make these two very different assessments: a disability assessment supports the summary decision on the degree of disability to qualify for benefits, and a needs assessment identifies the resources a person needs to carry out daily activities and participate in the community.

BOX 7

Examples of Activities–Limitations/ Participation–Needs component

	ACTIVITIES–LIMITATIONS	PARTICIPATION–NEEDS
MEDIUM HANDICAP	Activities involving the safety of other people—driving heavy vehicles, buses, minibuses, airplanes, trains, etc.—or operational activities in professions requiring hearing standards—police, army, air force, etc.—are not recommended.	Hearing aid
MARKED HANDICAP	Activities involving the safety of other people—driving heavy vehicles, buses, minibuses, airplanes, trains, etc.—or operational activities in professions requiring hearing standards—police, army, air force, public communication activities, telecommunication, etc.—are not recommended.	Providing optical signaling systems to replace audible ones Hearing aid Provision of sign language interpreters in public institutions

Source: Chap. 2 Sensory functions, Point. II Assessment of persons with impaired hearing functions for disability degree classification

4.3.2. Medical-Psychosocial Criteria from the ICF Perspective

Romania's current legislation provides that the assessment of the disability degree is based on a "medical-psychosocial model," which is aligned with the WHO's ICF, meaning that the degree of deficiency (minor, medium, marked, severe) is determined according to: (i) medically established functional parameters; (ii) activity limitations; and (iii) participation restrictions. However, this section proposes a more in-depth analysis of the disability degree classification criteria used in Romania, on two dimensions:[250] scientific substantiation as assessment tools and alignment with the ICF.

From a medical point of view, it can be generally assumed that the medical-psychosocial criteria used in Romania are scientifically sound. In interviews and focus groups, SECPAH and CEPAH specialists mentioned the lack of some diagnoses in the medical-psychosocial criteria (especially for older adults) or other specific aspects for which they could be considered somewhat outdated. Nonetheless, in general, there is no reason to consider the medical-psychosocial criteria medically deficient. However, two changes to the medical-psychosocial criteria would be welcome, namely:

i. In their current form, the medical-psychosocial criteria cannot adequately assess co-morbidities; for example, in the common situation where a person has several conditions that may interact and have combined effects on their level of functioning. A specific methodology or algorithm that takes into account the person's co-morbidities for the purpose of disability degree classification would add value to the disability degree classification assessment.
ii. In the future, Romania could benefit from a more robust electronic system for collecting health care information, whereby information on health and functioning can be collected in a standard way and reported in a comparable manner nationally and internationally. This will require a standardized terminology and coding capability to ensure interoperability. The ICF provides such an information infrastructure for data related to functioning. However, as far as medical information is concerned, the medical-psychosocial criteria will need to be reviewed and, over time, updated to align with the latest version of the International Classification of Diseases, ICD-11; this updating of criteria will only be possible once the Ministry of Health has adopted ICD-11.[251]

From the point of view of scientific standards, within the medical-psychosocial criteria, the way of determining the degree of disability is rather arbitrary and empirical. The medical-psychosocial criteria classify the severity of conditions and impairments and provide medical descriptions of each level of severity. The rationale underlying the classification of a medical condition as minor, medium, marked, and severe is assumed to be a clinical judgement supported by consensus validation. However, the severity of the medical condition is not identical to the degree of disability. In Romania, there are no studies based on scientific standards testing the relationship between the severity of the condition and the degree of disability. Thus, even if it has apparent clinical validity, the degree of disability is determined in the absence of a scientifically sound methodology—either evidence-based, or a methodologically robust form of consensus. Furthermore, as shown in Subchapter 4.2, most of the tools used in four of the six mandatory assessment fields—social, vocational or professional skills, educational, social integration level and skills—are not scientifically validated for the disability degree assessment.

From the point of view of alignment with the ICF bio-psychosocial integrative model,[252] the medical-psychosocial criteria aim to assess

250 The scientific basis of an assessment tool is assessed depending on the measurement methodology it uses and its suitability for the purpose for which the tool was created. The measurement methodology can be quantitative or qualitative. If the methodology is quantitative, the scale used by the tool makes the difference. With regard to the disability degree classification, a tool based on a continuous scale would allow a numerical degree to be determined, e.g. a degree of functional impairment of 10 percent, 50 percent, etc. On a category scale, the degree that can be determined is a category such as minor, medium, marked, severe (as in Romania). A tool with a dichotomous (yes/no type) scale could only signal the presence/absence of the disability, but the degree of disability cannot be determined. A tool based on a qualitative methodology might be adequate to describe the types of problems a person faces, but it cannot determine the extent of the problem. Regardless of the type of measurement methodology, a "good" tool has the basic psychometric properties of validity and reliability.

251 Romania currently uses ICD-10.

252 ICF is primarily a common coding system for the functioning dimensions and the determinants of the degree of functioning. It is important that, although the ICF manual provides a method with a scale of severity of five qualifiers, the ICF was never intended by WHO to be used independently, much less as a standard assessment tool. ICF is primarily a data dictionary for epidemiological purposes and is used as a standard worldwide. The ICF, more than a classification, is a model for assessing functioning and disability, and it is this feature of the ICF that the Romanian government refers to in its objective of "alignment."

the ICF domains concerning "activities" and "participation," but this information is neither quantifiable nor sufficiently used to determine the degree of disability. The regulation[253] containing the medical-psychosocial criteria uses ICF terminology in the way the chapters are organized, at the level of classification options and within the "activities/participation" component. But the mere use of ICF terminology does not mean that the current criteria integrate the ICF model of functioning and disability. The ICF bio-psychosocial model considers that functioning and disability are phenomena determined by both a person's level of intrinsic *capacity* to perform an action, depending on his/her health status, and by the level of *performance* of an action in his/her real environment. Disability assessment therefore involves assessing both the person's capacity in terms of their health *and* their environment, which together determine their level of performance (i.e., their degree of disability).

In this respect, alignment with the ICF requires compliance with the following principles: (i) disability is not directly or exclusively a health problem of a person; (ii) disability is not a disease, injury, or other impairment of health, nor does it simply consist of one or more impairments that result directly from an existing condition; (iii) disability is experienced by a person in the context of real life, which affects the actions, tasks, and social roles a person can perform; (iv) disability can only be understood in terms of the impact of the environment on a person's ability to perform actions, tasks, and social roles, simple or comprehensive; and (v) assessing disability in a manner aligned with the ICF requires both an assessment of the applicant's health status and of the impact on the person's activities, taking into account the person's environment and living context.

The medical-psychosocial criteria are basically a standardized tool based on the Baremic method,[254] which has been extended to include the domains "activities" and "participation," as well as professional skills. In addition, in their current form, the medical-psychosocial criteria include functional parameters. These are important because they provide a standardized medical assessment of symptoms and risk factors. The problem is that, as shown in subchapter 4.2, the comprehensive assessment carried out by SECPAH is predominantly based on medical criteria and, in the absence of quantifiable psychosocial criteria, cannot accurately capture either the person's needs or participation restrictions or activity limitations (functional assessment). For example, in focus groups with specialists, but also with NGOs, it was stressed that simply diagnosing dementia cannot capture the reality of the experience of living with dementia, as this experience is often shaped by the environmental demands and context in which the applicant lives. The existing criteria, therefore, do not reflect the understanding and operationalization of disability promoted by the ICF.

Moreover, in the ICF-based conceptual model, key elements include a partnership between the person and the service provider. Thus, regardless of the person's age or health status, the service provider takes into account the person's routines/lifestyle, concerns, fears, and plans with reference to all areas of life (health, education, work, and social activities). From the ICF perspective, most of the tools used in Romania both for assessing and determining disability, and for assessing service needs, are still too focused on medical aspects; they are insufficiently participatory and based on models that need to be revised to include the person's resources, the way he/she wants to live, and environmental factors, in addition to the needs identified by the assessment. Interviews with people with disabilities have repeatedly emphasized the need to fully and thoroughly consider how their health problems affect their daily lives.

In conclusion, Romania's comprehensive disability assessment is designed in the regulatory documents to cover two very different types of assessment from a theoretical point of view: disability assessment and assessment of the needs of people with disabilities. Countries with developed systems carry out these two assessments as separate steps involving different specialists and structures. Thus, the modernization of Romania's assessment and classification system implies, first of all, a shift from "handicap" (medical approach) to "disability" (integrative bio-psychosocial approach). To this end, the disability assessment must be clearly separated from the needs assessment, and the two types of assessments should be applied in a standard and uniform manner in all counties.

253 Joint Order of the Minister of Labor, Family and Equal Opportunities and the Minister of Public Health no. 762/1.992/2007 approving the medical-psychosocial criteria based on which the degree of disability is determined, with subsequent amendments and supplements.

254 The Baremic method consists of using reference scales, to which values or percentages are attached, to define disability, according to the Council of Europe (2002: 13). In general, the scales-based approach is not consistent with the model of functioning and disability presented in the ICF.

i. **The disability assessment must be aligned with the ICF principles.** To this end, the first necessary reform is to collect information from a psychosocial perspective in a consistent, standardized way across counties and in a scientifically-based manner. Second, this information must have the same real, transparent, and quantifiable impact on the final disability degree classification assessment in all cases and in all counties. Instead of six areas of comprehensive assessment, the system should collect information on functioning, in a uniform manner, using a single standardized psychometric tool. This tool must be scientifically appropriate to enable a global or total score of the person's disability to be obtained, preferably based on a full scale. Such a tool can provide a functioning score, which could be systematically integrated into the medical assessment to establish the final results of the assessment in order to classify the degree and type of disability. This substantial change of tools will, of course, require changes in the responsibilities and procedures used by both SECPAH and CEPAH.

ii. **The needs assessment of people with disabilities should be aligned with UNCRPD and, to every extent possible, with the ICF.** Depending on the services that exist or are planned, each country conducts the needs assessment differently, but with the common goal of promoting greater autonomy for people with disabilities, so they can enjoy their rights and participate fully in social and economic life. For example, countries may consider services to integrate people with disabilities into the labor market, educational services, medical services (including assistive devices and technologies), or various social services (from residential or day care centers, to habilitation/rehabilitation, recovery, personal assistant, home care, etc.). For each, the needs assessment involves specific tools and methodologies based on which to identify, in a person-centered manner, the most appropriate services/activities/measures to support the person's recovery and achievement of their maximum potential, according to their own routines, expectations, concerns, and lifestyle choices. The development and implementation of the needs assessment will require provision of the necessary resources to the structures that will have this task, as well as clarification of the responsibilities in relation to SECPAH and CEPAH. In the medium and long term, it will be necessary to create a referral system, strengthen cooperation between institutions from different sectors (social, health, education), and, at different levels (central, county, local), strengthen case management for adults with disabilities, and above all, develop and diversify services for people with disabilities.

iii. **Disability assessment and needs assessment should be applied in a standardized and consistent manner in all counties.**

Also, the medical-psychosocial criteria require constant updating in line with progress in the field of medicine, but also a continuous approach to the concept of disability, so that the assessment process can establish people's real need for support and functional potential.

BOX 8

Examples of Activities–Limitations/ Participation–Needs used to provide a very detailed description of work capacity and workplace needs

MINOR HANDICAP

ACTIVITIES–LIMITATIONS

Any professional activity without limitations, except for those requiring fine, precise gestures

PARTICIPATION–NEEDS

Unrestricted participation

Requires change of job in some occupations (e.g., pianist, violinist, etc.)

MEDIUM HANDICAP

ACTIVITIES–LIMITATIONS

Any profession, except for those that require:

- orthostasis and prolonged postural movements;
- manual dexterity of both hands.

PARTICIPATION–NEEDS

Professional orientation towards an accessible job

Vocational training and guidance according to the age of the people who have lost their manual dexterity, with reference to manual labor - unskilled

Provision of prostheses, orthoses, differentiated aesthetic prostheses in order to activate in social life without restrictions

MARKED HANDICAP

ACTIVITIES–LIMITATIONS

- Jobs with no physical demands, no movements and postural and/ or gestural variants, depending on morpho-functional impairments

Note:

In developing recovery programs, consideration will be given to:

- location and level of the amputation;
- the causes that produced it;
- the effectiveness of the prosthesis;
- age;
- general and vocational training depending on which it is recommended: change of job or vocational training for static jobs, accessible to postural or/and gestural disability.

PARTICIPATION–NEEDS

Provision of prosthetic means, adaptation of machinery, reorganization of work when needed

For people with postural locomotor deficiencies:

In addition to adequate prosthesis and adaptation to the workplace so as not to require a posture that cannot be achieved, it is recommended to facilitate this by additional means of support (ergonomically adapted chairs) or to easily allow postural changes required by the work, by handrails or support handles.

Transferring some machine controls from foot to hand or automating those controls

For people with physical disabilities with impaired gestures:

It is possible, where appropriate, to use prosthetic or orthotic devices, possibly work prostheses adapted to the work sequences (clamps, hooks, etc.), to change the laterality and to adapt the machine, e.g. transferring the controls from one hand to the other, or from the hand to the foot, changing the lever system of the controls to reduce physical effort.

SEVERE HANDICAP

ACTIVITIES–LIMITATIONS

Idem marked disability

Can work at home or in adapted workplaces.

The social inquiry has a major role in determining the degree of autonomy and functional remnant, with the possibility of adapting to prostheses and making the environment accessible, so that care and self-service activities can be carried out independently or with partial help, for limited periods of the day.

PARTICIPATION–NEEDS

Idem marked disability

After prosthesis, adaptation to prostheses/orthoses:

- provision of means of travel for people with postural deficiency (crutches or frame for those with unilateral amputations, wheelchairs for those with bilateral amputations);
- providing means of self-service and/or work for those with bilateral loss of gestures;
- full or partial support for care and everyday self-support activities.

Depending on the outcome of the comprehensive assessment, the person may be classified as person with profound disability with the right to a personal assistant, if they have completely lost the ability to self-service, self-care and self-support and require permanent support, or as a person with profound disability without the right to a personal assistant, when they require partial support for some daily activities.

Source: Chap. 7 Neuro-musculoskeletal functions and related movements, point III. Assessment of persons with motor function impairment (of statics and mobility - locomotion and/or gestures) for disability degree classification, 1. Amputations from Order no. 707/538/2014 amending and supplementing Order no. 762/1.992/2007)

Conclusions of Chapter 4

1

Unlike in other countries, Romania's disability assessment and disability determination (disability degree classification) are separate processes carried out by separate structures, i.e., adult assessment services (SECPAH) and assessment commissions (CEPAH). Most SECPAHs do not have all the specialists required by the legislation[255] to carry out the comprehensive assessment, which consists of a specialized medical practitioner, a social worker, and a psychologist, sometimes a physiotherapist, with a total of 5–7 members most often, but with variations between 2 and 22 specialists.

2

In Romania, the comprehensive assessment of adults for disability degree classification comprises six mandatory areas of assessment: social, medical, psychological, vocational or professional skills, level of education, as well as social integration level and skills (degree of dependency).[256] According to data reported by SECPAH chiefs, the comprehensive disability assessment covers all six mandatory areas in most (but not all) counties and for most applicants, and is carried out by relevant specialists, based on an impressive amount of data provided by the applicant in the application file. But some of the data are marked by inconsistencies, including not being collected systematically or uniformly. Furthermore, there are no specific tools or methodologies for data analysis, and no clear rules on what data should be used/analyzed for each assessment area.[257] Although the comprehensive assessment is a multi-criteria assessment, there are no specific weights or rules that clearly establish the contribution of each field to the final outcome of the assessment. As a result, the data is inconsistently used and analyzed from one county to another, and even from one specialist to another, especially as a large number of SECPAHs have not developed specific working procedures in this respect.

3

The dominant practice is to primarily base the final recommendation for disability degree classification on quantifiable data (basically medical and psychological data), which SECPAH specialists regard as most complete and accurate. Current practices regarding the determination of SECPAH recommendations differ significantly between counties, but in most of them, the proposal for disability degree classification/non-classification (which is forwarded to the CEPAH) is primarily made by the specialized medical practitioner, and the medical assessment provides the key elements for determining the conclusions and recommendations in the comprehensive assessment report.

255 GD no. 430/2008 and by Order no. 2298/2012 on the approval of the framework procedure for the assessment of adults in order to classify the degree and type of disability.

256 GD no. 268/2007, Art. 48, respectively Order no. 2298/2012, Art. 4.

257 The only guidance available is in the ANPD instruction of 3.12.2018, on how to complete the comprehensive assessment report.

4

The assessment procedure and tools used in SECPAH's comprehensive disability assessment are not aligned with the ICF functioning and disability model, precisely because the psychosocial data (on activity limitations and participation restrictions, depending on environmental and personal factors) have, in most counties, a limited impact on the final assessment. In fact, in Romania, given the substantial variation between counties, the different compositions of the SECPAH teams, the incongruent information-gathering procedures, and the various approaches to the final decision-making process (a joint decision of the SECPAH team versus a single decision of the physician), it is not possible to estimate at national level whether and to what extent the information on the person's functioning and living context plays any procedural role in the comprehensive assessment. In addition, there is no methodology or procedure to ensure that the information on functioning has any impact on the final assessment.

5

Moreover, in the ICF-based conceptual model, key elements include a partnership between the person and the service provider. Thus, regardless of the person's age or health status, the service provider takes into account the person's routines/lifestyle, concerns, fears, and plans with reference to all areas of life (health, education, work and social activities). From the ICF perspective, most of the tools used in Romania for both assessing and determining disability, and for assessing service needs, are still too focused on medical aspects, are insufficiently participatory, and based on models that need to be revised to include the person's resources, the way he/she wants to live, and environmental factors, in addition to needs identified by the assessment.

6

It is absolutely necessary to define and implement new procedures for assessing and classifying disability degree, based on the ICF principles. The current assessment procedures are not always clear or consistent across counties. It is important to underscore that ensuring uniform tools and procedures at county level is a necessity from a human rights perspective: it is fair and equitable that people in similar situations and with similar levels of disability are assessed in a similar way throughout the country. Any other approach is unfair and discriminatory. This is laid down in all human rights treaties and in the UN Convention on the Rights of Persons with Disabilities. The new procedures should be developed in a collaborative process that involves specialists, social workers, international ICF experts, policy makers, and activists for the rights of persons with disabilities.

7

In Romania, the comprehensive assessment of adults for disability degree classification is based on medical-psychosocial criteria, defined by Joint Order no. 762/1.992/2007. From the point of view of scientific standards, within the medical-psychosocial criteria, the way of determining the degree of disability is rather arbitrary and empirical. Although the medical-psychosocial criteria have apparent clinical validity, the degree of disability is determined in the absence of a scientifically sound methodology—either evidence-based or a methodologically robust form of consensus.

8

The medical-psychosocial criteria are basically a standardized tool based on the Baremic-scales method,[258] which has been extended to include the fields "activities" and "participation," as well as professional skills. In addition, in their current form, the medical-psychosocial criteria include functional parameters, which are important because they provide a standardized medical assessment of symptoms and risk factors. The problem is that the comprehensive assessment carried out by SECPAH is predominantly based on medical criteria and, in the absence of quantifiable psychosocial criteria, cannot accurately capture either the person's needs or participation restrictions or activity limitations (functional assessment).

9

The comprehensive assessment in Romania is by regulation designed to cover two very different types of assessment from a theoretical point of view: disability assessment and assessment of the needs of people with disabilities. Countries with developed systems carry out these two types of assessment as separate steps involving different specialists and structures. Thus, modernizing Romania's disability assessment and classification system implies, first of all, a shift from "handicap" (medical approach) to "disability" (integrative bio-psychosocial approach). To this end, the disability assessment must be clearly separated from the needs assessment, and the two assessments should be applied in a standardized and uniform manner in all counties.

10

Disability assessment must be aligned with the ICF principles. To this end, the first necessary reform is to collect information from a psychosocial perspective in a consistent, standardized way across counties and in a scientifically-based manner. Second, this information must have the same real, transparent, and quantifiable impact on the final assessment for the disability degree classification in all cases and in all counties. Instead of six comprehensive assessment fields, the system should collect information on functioning, in a uniform manner, using a single standardized psychometric tool. This tool must be scientifically appropriate to enable a global or total score of the person's disability to be obtained, preferably, based on a full scale. Such a tool can provide a functioning score, which could be systematically integrated into the medical assessment to establish the final assessment results. This substantial change of tools will, of course, require changes in the responsibilities and procedures used by both SECPAH and CEPAH.

11

The needs assessment of people with disabilities should be aligned with UNCRPD and, to every extent possible, with the ICF. Depending on the services for people with disabilities that exist or are planned, each country conducts the needs assessment differently, but has the common goal of promoting greater autonomy for people with disabilities, so that they can enjoy their rights and fully participate in social and economic life. For example, countries may consider services that integrate people with disabilities into the labor market, educational services, medical services (including assistive devices and technologies), or various social services (from residential or day care centers, to habilitation/rehabilitation, recovery, personal assistant, at-home care, etc.). For each, the needs assessment involves specific tools and methodologies based on which to identify, in a person-centered manner, the most appropriate services/activities/measures to support the person's recovery and achieve their maximum potential, according to their own routines, expectations,

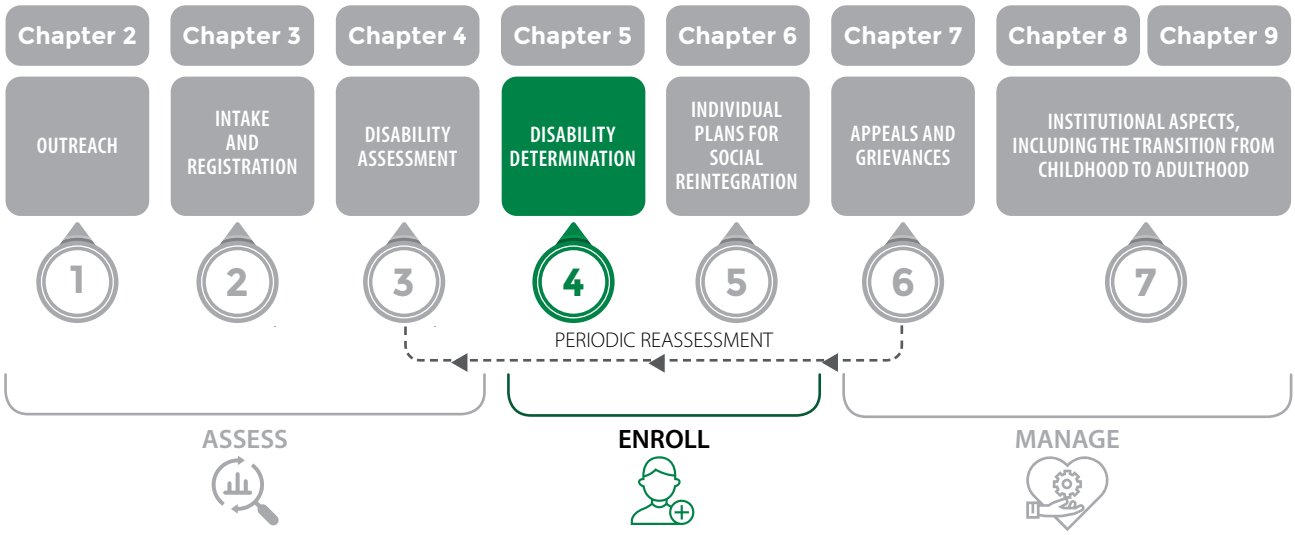
258 The scales method consists of using reference scales, to which values or percentages are attached, to define disability, according to the Council of Europe (2002: 13). In general, the scales-based approach is not consistent with the model of functioning and disability presented in the ICF.

concerns, and lifestyle choices. The development and implementation of the needs assessment will require provision of the necessary resources to the structures that will have this task, as well as clarifying responsibilities in relation to SECPAH and CEPAH. In the medium and long term, it will be necessary to create a referral system, strengthen cooperation between institutions from different sectors (social, health, education), and at different levels (central, county, local), strengthen case management for adults with disabilities, and, above all, develop and diversify services for people with disabilities.

12

Also, the medical-psychosocial criteria for classification into degree and type of disability require constant updating in line with progress in the field of medicine, but also a continuous approach to the concept of disability, so that the assessment process can establish people's real need for support and functional potential.

5. The disability determination in Romania



This chapter is dedicated to the fourth core implementation phase of the delivery chain of Romania's disability assessment system, namely the disability determination, that is classification of the degree and type of deficiency. The objective of this chapter is to describe and to analyze the procedures, tools and practices used by the Commission for Assessing Adults with Disabilities (CEPAH), that is responsible for classifying in a degree and type of deficiency and promoting the rights of people with disabilities.[260]

Romania implements a multidisciplinary procedure for disability degree classification. Unlike most countries, Romania has separate processes for assessing disability (core phase 3) and determining disability (core phase 4). Thus, the disability assessment is carried out by SECPAH, a structure within DGASPC, as presented in Chapter 4. Then, the decision on the disability degree classification (determination) is taken by CEPAH, a structure subordinated to the County Council, respectively to the Local Councils for the districts of Bucharest. The

259 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.

260 Art. 85, para. 3 of Law No. 448/2006 on the protection and promotion of the rights of people with disabilities, republished, as subsequently amended and supplemented.

determination phase is the subject of this chapter. People with disabilities are entitled to the rights provided for by the law[261] based on the classification of the disability degree, in relation to the deficiency degree. Thus, this chapter presents the process and the methodology applied to determine the eligibility for granting the rights and benefits for people with disabilities in Romania.

Along with a general description of the steps in the process for the classification in a deficiency degree undertaken by CEPAH, this chapter also identifies the problems with the approach, as reported by CEPAH specialists in focus groups and the opinion survey Q3B, as well as by CEPAH presidents who answered to the institutional survey Q3A. The analysis relates to the legislative requirements, but also to the requirements of the Convention on the Rights of Persons with Disabilities (UNCRPD) and the World Health Organization's (WHO) International Classification of Functioning, Disability and Health (ICF).

5.1. The steps of the disability determination

The CEPAH is a specialized body of the County Council, or, of the Local Council of the district of Bucharest, with decision-making activity in matters of classification of adults in degree and type of deficiency. Such commissions operate in each of the 41 county municipalities in the country, as well as in the 6 districts of Bucharest.

The key duties of CEPAH, as outlined also in Section 1.2.1, are as follows:[262] (i) determines the degree and type of disability and the term of validity of the certificate, where applicable, the date of onset of the disability, the professional orientation of the adult with disabilities, based on the SECPAH comprehensive assessment report; (ii) establishes the protective measures of the adult with disabilities, in accordance with the law; (iii) revokes or replaces the protection measure established, in accordance with the law, if the circumstances that led to its establishment have changed; (iv) settles the applications for the issuance of the certificate of professional personal assistant; (v) informs the adult with disabilities or his/her legal representative of the protective measures established and the obligations incumbent on them; (vi) promotes the rights of persons with disabilities in all activities that they undertake; performs any other duties provided by the law.

5.1.1. Sending the Files from SECPAH to CEPAH

Core phase 4 of the classification in a degree of deficiency (disability determination) begins with the completion of core phase 3 of the comprehensive assessment conducted by SECPAH. The steps of phase 3 are discussed in detail in Chapter 4. Once SECPAH completes the assessment, the applicant's file is forwarded to the CEPAH secretariat. SECPAH delivers the files accompanied by the results of the comprehensive assessment, namely the comprehensive assessment report (which also includes the recommendation for classification or non-classification in a degree and type of deficiency), the Individual Social Rehabilitation and Integration Program (PIRIS) and sometimes the Individual Service Plan (ISP).

The secretariat registers the application in its own Register of Records, ensures that the files are complete and sends them to the assessment commission, in order to establish the classification/non-classification in a degree and type of deficiency.[263] The file transmission system differs from one county to another. Most files are submitted on paper, while some counties submit the data (at least some of the data) in electronic format. The CEPAH secretariat is provided by the staff that is part of the DGASPC structure.[264] More details on the activities of CEPAH secretariat can be found in Chapter 9, Section 9.3.3. How are the data managed and archived at the level of CEPAH is further analyzed in Section 9.3.5. It is to be noted that the practices regarding the information management differ considerably among counties.

261 Law no. 448/2006, Art. 85, para. 1.
262 Law no. 448/2006, Art. 87, para. 1.
263 GD no. 430/2008, Art. 15, para. (1).
264 Law no. 448/2006, Art. 85, para. 9.

5.1.2 The Process for the Classification of Adults in a Disability Degree

The organization and operation of CEPAH are regulated by Law no. 448/2006 (Art. 85), respectively GD no. 430/2008. According to these regulations, CEPAH consists of 5 members with the following specializations: a) president - a specialist in medical expertise of work capacity, internal medicine, family medicine or a general practitioner; b) a medical practitioner specialized in the medical expertise of work capacity, family medicine or a general practitioner, proposed by the county, respectively of the Bucharest public health directorate; c) a representative appointed by non-governmental organizations working for the benefit of the persons with disabilities; d) a psychologist; e) a social worker. The nominal composition of the assessment commissions is approved by decision by the County Councils or, as the case may be, by the Local Councils of the districts of the Bucharest, with the approval of ANDPDCA. Among the members of CEPAH, only the president is part of the staff of DGASPC, without being a civil servant. Most of the CEPAHs studied comply with these regulations, being composed of 5 members with the specializations mentioned above.[265] A comprehensive analysis of the human resources of CEPAH is available in subchapter 9.3.

Highly relevant for the way in which the decision-making process of classification in a degree and type of deficiency at county level is carried out, is the fact that CEPAHs are made up of stable teams. The data provided by the CEPAH presidents in the institutional survey Q3A indicate an average member experience of approximately 7 years within CEPAH.[266] Also, of the 24 CEPAHs that participated in the Q3A survey, 17 commissions underwent changes in the nominal composition over the last four years (2017-2020), as follows: 8 CEPAHs changed their composition only once (one or more members), 5 commissions changed their composition twice, and 4 changed their composition three times, by a decision of the County Council, respectively the Local Council of one district of Bucharest.[267] Therefore, at the national level, changes in the composition of the CEPAH were few and did not follow a certain pattern (for example, every year or every two years).

CEPAH carries out its activity in ordinary or extraordinary meetings, when convened by the president. Most CEPAHs (17 of the 24 that responded to Q3A) hold ordinary meetings once a week, every week, without exception, according to the regulations.[268] The other (6) CEPAHs meet in ordinary meetings in most weeks.[269] However, the average number of ordinary CEPAH meetings per year is 65 (higher than the number of 52 weeks per year),[270] but with significant variations at county level, from a minimum of 41 to a maximum of 224 (in 2020).[271] The number of extraordinary meetings is even more unequal between counties. On average, about 50 extraordinary meetings are organized per year,[272] but while 3 counties report zero such meetings, 7 counties reported over 52 (between 56 and 185), both in the pre-COVID period (2019), and in 2020. Therefore, the practices regarding the organization of meetings differ significantly between counties.

- The estimates regarding the total number of meetings (ordinary and extraordinary) per year or per month is very high and with considerable discrepancies between counties.[273] With a number of 10-11 meetings, on average, per month, it means that CEPAHs meet every two working days (or 2-3 times a week).

265 In the Q3A study, 19 counties and one district of Bucharest provided data on CEPAH members. Of these 20 CEPAHs, 2 commissions have 6 members (AG and MM), while one has 4 members.

266 The average experience within CEPAH is 82 months, with a standard deviation of 62 months.

267 According to GD no. 430/2008, art. 8, para. (2).

268 GD no. 430/2008, art. 9, para. (2).

269 One CEPAH (out of 24) did not respond.

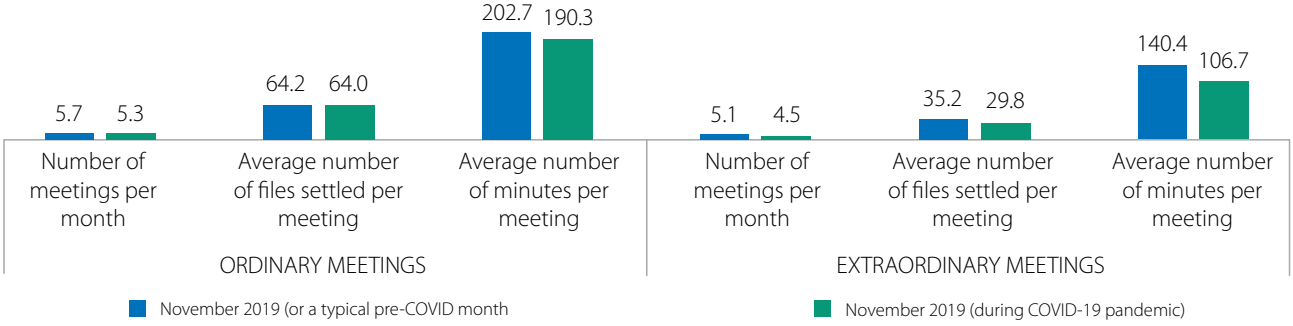
270 Standard deviation of 36, in 2019, respectively 40 ordinary meetings, in 2020.

271 Estimates provided by the CEPAH presidents in the Q3A questionnaires, regarding the years 2019 and 2020. Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 19 counties and 2 districts of Bucharest, January-February 2021.

272 With an average value of 58 extraordinary meetings, standard deviation of 60, in 2019, respectively an average of 49 and a standard deviation of 59, in 2020.

273 At the level of one month, the total number of meetings reported at county level was between 4 and 21, in November 2020. Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 16 counties and 1 district of Bucharest, January-February 2021.

Figure 24: Change of practices in the organization of CEPAH meetings, during the COVID-19 pandemic, by type of meetings, according to the estimates provided by CEPAH presidents (number of meetings/files/minutes)



Source: Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 15 counties and 4 districts of Bucharest, January-February 2021.

- Figure 24 shows how CEPAH's practices regarding the organization of meetings during the pandemic changed, with the introduction of new measures of social distancing and the interruption of interactions with the applicants. The estimates of the CEPAH presidents indicate a slight decrease in the number of meetings in 2020 compared to the pre-COVID period (2019), from the total number of meetings (ordinary and extraordinary) of 127 to 115, on average, per year.[274] Also, if the average total time for CEPAH meetings in November 2019 was about 31 hours/month, in November 2020 it was reduced to 25 hours/month.
- Therefore, the typical ordinary meeting lasts over 3 hours in which the commission settles 64 cases, while the typical extraordinary meeting has around 2 hours in which 30-35 cases are analyzed, as can be seen in the figure below. Also, typically, an assessment commission for adults gathers in 5-6 ordinary meetings and 4-5 extraordinary meetings, per month.
- The analysis of non-responses provides an indication that many CEPAHs do not systematically monitor their own activity. Thus, 24 CEPAHs responded to the Q3A questionnaire. Of these, 23 said whether they complied with the regulation on the obligation to meet weekly or not. The answers go down to 20-22 for the number of ordinary meetings, and 18-19 for the number of extraordinary meetings. And, the number is reduced to 15 when we refer to the CEPAHs that reported both the number of meetings and the number of cases that were settled (in order to calculate, for example, the workload).
- There is no statistically significant correlation between the average duration of a meeting (in minutes) and the number of cases settled per meeting. For example, in November 2019, while one CEPAH reports that in a typical 120-minute meeting it settled 100 cases, on average, another CEPAH reports that it reviewed the classification for 25 cases in 180 minutes. Of course, the level of complexity may differ among cases, but the lack of correlation remains noteworthy.
- The analysis of the workload of CEPAH members, presented in Section 9.3.1 shows that: (i) there is no correlation between the total number of CEPAH meetings (ordinary and extraordinary) and the total number of cases settled, which means that the number of meetings is randomly increased in some counties; (ii) the random increase in the number of CEPAH meetings held per month does not compensate for, but rather widens the existing discrepancies between counties with regard to the monthly payments granted to CEPAH members as meeting allowance.[275]
- Apart from ordinary and extraordinary meetings, only in 2 counties and one district in Bucharest,[276] CEPAH also organizes consultation meetings attended by all members (or most of them). They are organized "sometimes, when possible", last between 10 and 30 minutes and, usually, deal

274 Standard deviations of 60, in 2019, respectively 61 meetings, in 2020.

275 The members of CEPAH (including the president) are entitled to a meeting allowance equivalent to 1 percent of the allowance of the President of the County Council and of the Mayors of the districts of Bucharest. Law no. 136/2012 approving EGO no. 84/2010 supplementing and amending Law no. 448/2006.

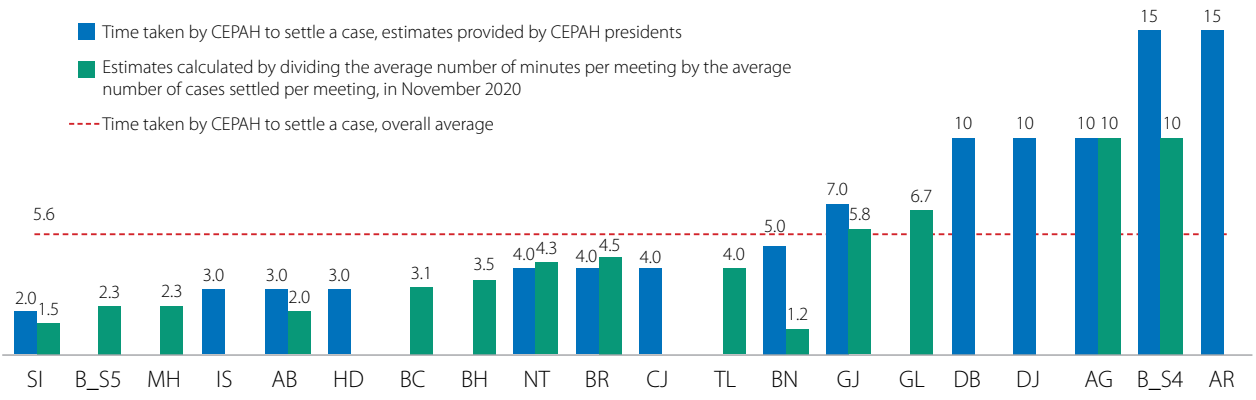
276 These are AG, IS and B_S4.

with topics such as making teamwork more efficient or drafting statements of defense or explanatory statements/substantiation of the CEPAH decision for the courts.

Decision-making process in CEPAH is not participatory, with little or no interaction with the applicants. The law allows the applicants and their representatives to participate in the works of the commission, with the agreement of the president.[277] In reality, a very small number of applicants benefited from this provision. Out of 19 CEPAHs that provided data (in Q3A), only 3 commission presidents responded that 2-3 applicants (or representative) were invited to attend 2-4 meetings per month. And this was the pre-COVID situation in November 2019. In 2020, all interaction was cut off, not just physically, but also online. The members of the commission see no point in the persons with disabilities participation, stating in focus groups that they have no reason to interact with the applicants, as either commissions` meetings are not public, or the applicants have already been assessed and seen by SECPAH. Consequently, none of the CEPAHs studied has a specific approved procedure (or paragraph in the general procedure) for the participation of applicants in CEPAH meetings. Under these circumstances, it is obvious that a legal provision such as the one in Art. 89 (para. 1 and 2) of Law no. 448/2006, according to which CEPAH has the obligation to draw up the PIRIS in collaboration with the person with disabilities or his/her legal representative, is not respected.[278]

The decision on the classification/non-classification into a deficiency type and degree is taken in too short a time to be thorough. With regard to the average time taken by CEPAH to settle a case, we made three types of estimates. The first one is based on estimates provided by CEPAH presidents in the institutional survey Q3A, according to which the average time allocated per file is 7.3 minutes.[279] The second type of estimate is based on the data provided on the average number of minutes per meeting and the average number of cases settled per meeting, for November 2019 (pre-COVID) compared to November 2020 (during the pandemic). In both reference periods, the results indicate about 3 minutes per file (less than half the time estimated by the CEPAH presidents). The results of these estimates are shown in Figure 25 and indicate an average time per file of between 2 and 15 minutes with large differences between counties.

Figure 25: Average time spent by the Commission on each case, in minutes



Source: Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 18 counties and 2 districts of Bucharest, who reported the necessary data, January-February 2021.

Finally, the third estimate used a theoretical time available to CEPAH members (based on their employment contracts) and the total number of cases settled per month.[280] According to this third type of estimation, the average time allocated per file is 3.5 minutes. Under these circumstances, it is reasonable to consider that CEPAH makes the determination in a case (including the degree, type,

277 GD no. 430/2008, as subsequently amended and supplemented, art 9, para. (3).

278 In practice, SECPAHs have taken on the task of developing PIRIS, but not necessarily in collaboration with the person with disabilities or his/her legal representative, as discussed in subchapter 6.2.

279 Standard deviation of 4.8 minutes. Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 14 counties and 1 district of Bucharest, January-February 2021.

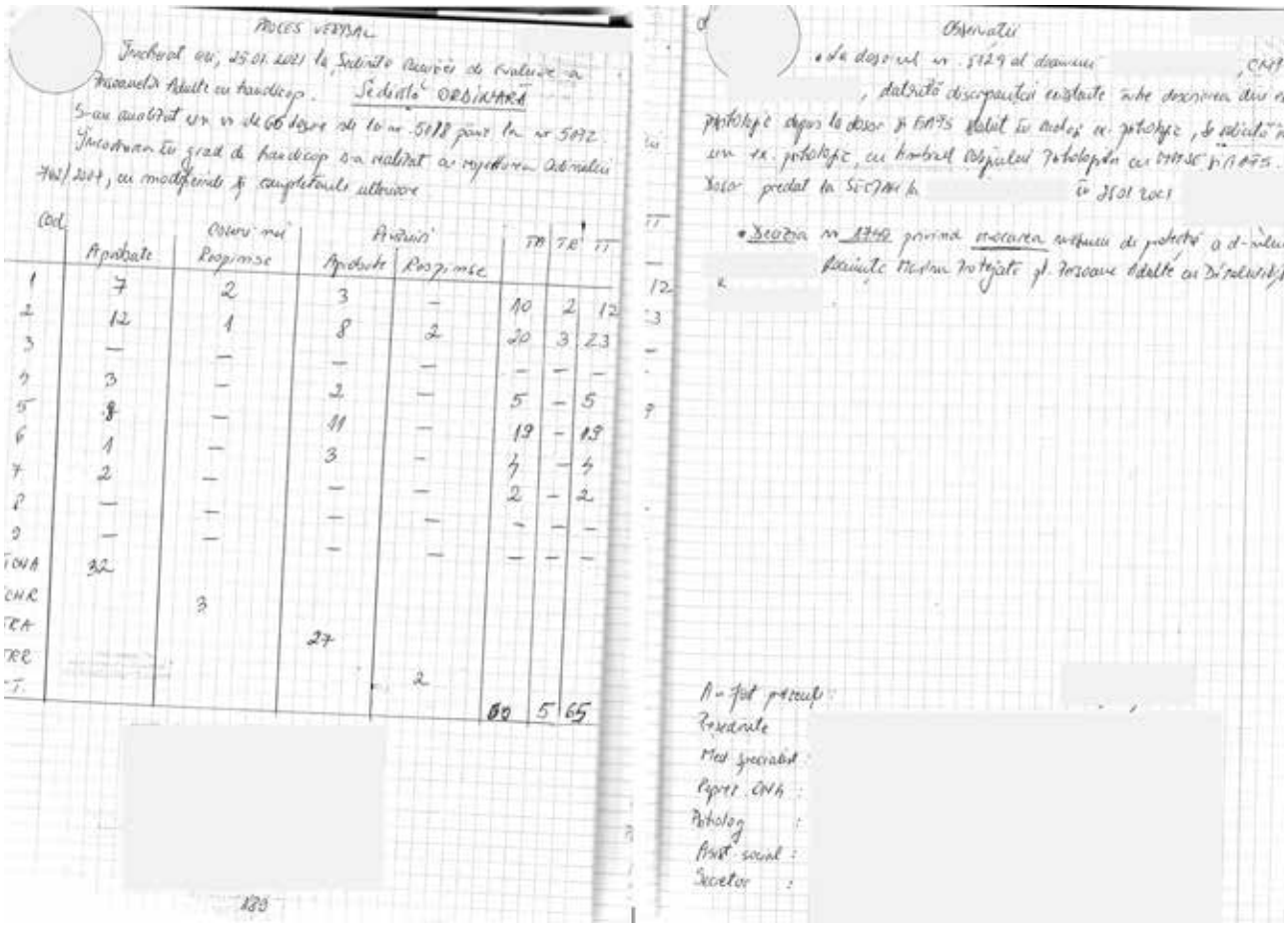
280 This estimate is developed in Chapter 9, Section 9.3.1 CEPAH workload.

PIRIS, etc.) in about 5-6 minutes (see also Figure 25). Given the large number of documents on file, the complexity of the procedure for the classification of the deficiency degree and type, and the fact that the decision should be collective, it is obvious that a duration of about 5 minutes is too short for a sound decision.

The decision-making process is strictly confidential and only authorized personnel have access to the applicants` data. In about half of the counties (11 out of 23 in the Q3A sample), there are no formal procedures in place to ensure the protection of applicants` personal data (Figure 29 in Section 5.2.2). However, despite the lack of procedures, according to the CEPAH opinion survey (Q3B) and interviews, data confidentiality and respect for privacy in the process of submission and assessment of the files are always fully respected, in line with Art. 31 of the UNCRPD (at an average level of 8.8, on a scale of 1-not at all to 10-total).[281]

The absence of guidance procedures or rules is accompanied by the absence of a substantiation accompanying the disability certificate explaining the reasons for the classification/non-classification decisions and how the degree of deficiency was determined (see also Chapter 7). The main tool provided for in the current legislation for recording in detail the decision-making process within the CEPAH is the minutes of the meeting. The CEPAH secretariat should draw up the minutes of the meeting and keep a record of these minutes. The institutional survey Q3A asked the CEPAH presidents to provide anonymized minutes of the last two CEPAH meetings, as part of the response package. Eight counties responded to this request; a typical example of CEPAH minutes is provided in Figure 26.

Figure 26: Minutes of a 3-hour CEPAH meeting involving decisions for 65 people with disabilities



281 Standard deviation of 1.6. Opinion survey Q3B: Practices and experiences of CEPAH members (N=49), from 24 counties and 2 districts of Bucharest, January-February 2021.

The analysis of the collected sample of meeting minutes showed that, most often, the minutes are handwritten[282] and tend to focus on procedural aspects, such as the introduction of the commission members and president, their signatures, the agenda of the meeting, the number of files; the decision for the classification of the disability degree and type in aggregate format (on the model in Figure 26) or a list of all certificates. The comments section (if any) is empty or provides information on other types of decisions, such as suspension of a protective measure, cancellation of a certificate due to the death of the person or specific references to the completion of certain files. The voice of people with disabilities is completely missing, no dialogue or discussion is recorded, no events are described, all decisions seem to be taken unanimously, and there is no substantiation for the decisions. Under these circumstances, the drafting of the expert opinions requested by the courts is technically deficient (see also Chapter 7). In general, such a non-transparent approach can open the door to unwanted interference, political manipulation and corruption.

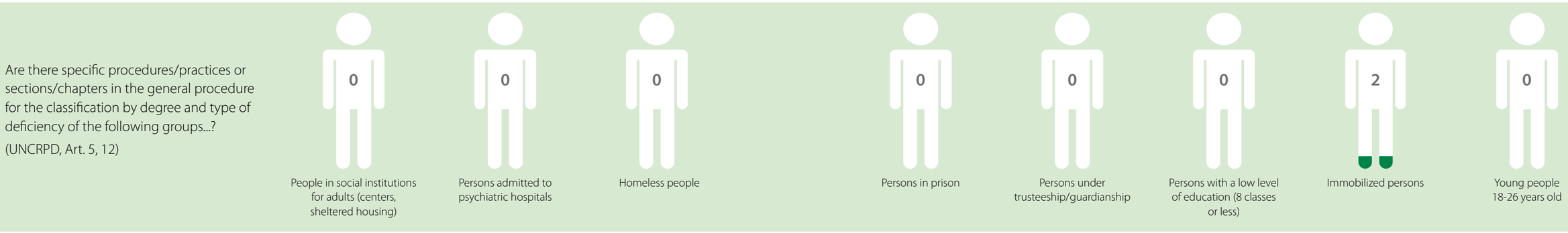
So, the decision-making process within CEPAH is not transparent. Including a legal adviser in the membership of SECPAH/CEPAH could bring value in the transparency of the decision-making process for disability degree classification. The legal adviser`s responsibilities could include: drafting the explanatory statements/ substantiations for the CEPAH decisions, ensuring the quality of the minutes of the CEPAH meetings, informing and advising persons challenging the certificate, coordinating the grievance redress mechanism related to the disability assessment and determination (if such a mechanism were to be set up), liaising with the Higher Commission on requests for methodological coordination (case-by-case clarifications, organization and functioning of SECPAH/CEPAH, interpretation of legislation, etc.) or providing expert opinions for the courts in cases where the certificate is challenged.

5.1.3. Adapting the Determination Process for "Hard to Reach" Population

The procedure for classifying in a deficiency degree and type does not benefit from adaptations in any county. Only two CEPAH presidents (out of 20 who answered the question) reported having specific procedures/practices or sections/chapters of the general procedure by which the classification of immobilized people is carried out (Figure 27). But, the lack of tailored communication for vulnerable groups was mentioned as a barrier, both in interviews with people with disabilities and with NGOs, regarding this phase of the certification process as in all previous phases. Therefore, the approach to determining disability in Romania does not comply with the requirements of UNCRPD, all the more so after the start of the COVID-19 pandemic, following which people`s interaction with the assessment commission and their already limited participation in the approach were completely interrupted.

282 Of the eight counties that provided minutes of the CEPAH meetings, only one uses a standard electronic format extracted from D-Smart, and another has a combination of a standard electronic page and the rest is handwritten.

Figure 27: Number of CEPAH that adapted for vulnerable groups the procedure for classifying adults in degree and type of deficiency (number of counties)



Source: Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH), January-February 2021.

5.1.4. Communication of the Result and Delivery of Documents to Beneficiaries

At the meetings, the assessment commission makes the final decisions on (1) classification or non-classification in a degree of disability; (2) the professional orientation certificate, for persons requesting this type of assessment; and (3) the services/actions recommended in PIRIS, including protective measures, such as personal assistant/professional personal assistant or social assistance through residential or day care centers, public or private.[283] Finally, the CEPAH secretariat notifies individuals of the issuance of the certificate and sends the approved documents by mail.[284]

All CEPAH presidents in the counties that took part in the Q3A institutional survey reported that they had no difficulty in meeting, for 99 percent of applicants, the deadline of a maximum of 15 working days from the date of referral of the file by SECPAH, to complete the disability determination. In fact, the representatives of the CEPAH secretariats reported that the time from the registration of the file in the Register of Records to the communication of the result (by mail) to persons with disabilities is, on average, 7-8 days, at the sample level.[285] Furthermore, according to the information recorded in the Register of minutes, almost all CEPAH secretariats (23 out of 27 that participated in the institutional survey Q3C) reported that they always[286] manage to meet the legal deadlines, namely, to:

i. draw up the disability certificates and the professional orientation certificates, no later than 3 working days after the date of the CEPAH meeting;[287]
ii. notify by mail, with acknowledgement of receipt, to the person with disabilities or, where applicable, his/her parents/legal guardian, personal assistant or professional personal assistant, within 5 working days of the date set for drafting the documents approved by the assessment commission;[288]
iii. the person may choose to collect the documents in person from the CEPAH secretariat or to receive the documents by other means than by post, with acknowledgement of receipt, as required by the law.

283 GD no. 430/2008, Art. 2.
284 GD no. 430/2008, Art. 13.
285 The variation across counties is between 2 and 30 days. Institutional study Q3C: The outcome indicators of the disability determination process for the CEPAH Secretariat, in 22 counties and 2 districts of Bucharest, January-February 2021.
286 The other 4 counties manage to meet the legal requirements "in most cases" (3 counties) or "sometimes" (1 county), and the person cannot opt for other ways of sending the documents than by post, with acknowledgement of receipt, as mentioned in GD no. 430/2008.
287 GD no. 430/2008, Art. 15, para. (2e).
288 GD no. 430/2008, Art. 15, para. (3).

5.2. The disability determination procedure in Romania

In Romania, the classification of adults in a degree and type of deficiency is based on the assessment of six mandatory areas[289] and is carried out based on the medical-psychosocial criteria,[290] analyzed in Chapter 4. This subchapter looks at how the assessment commissions carry out the process of classifying in a degree and type of disability, how they analyze the file, how they use the criteria, how they determine the final resolutions, and how they manage the risk of error in the decision-making process.

5.2.1. Entries from SECPAH

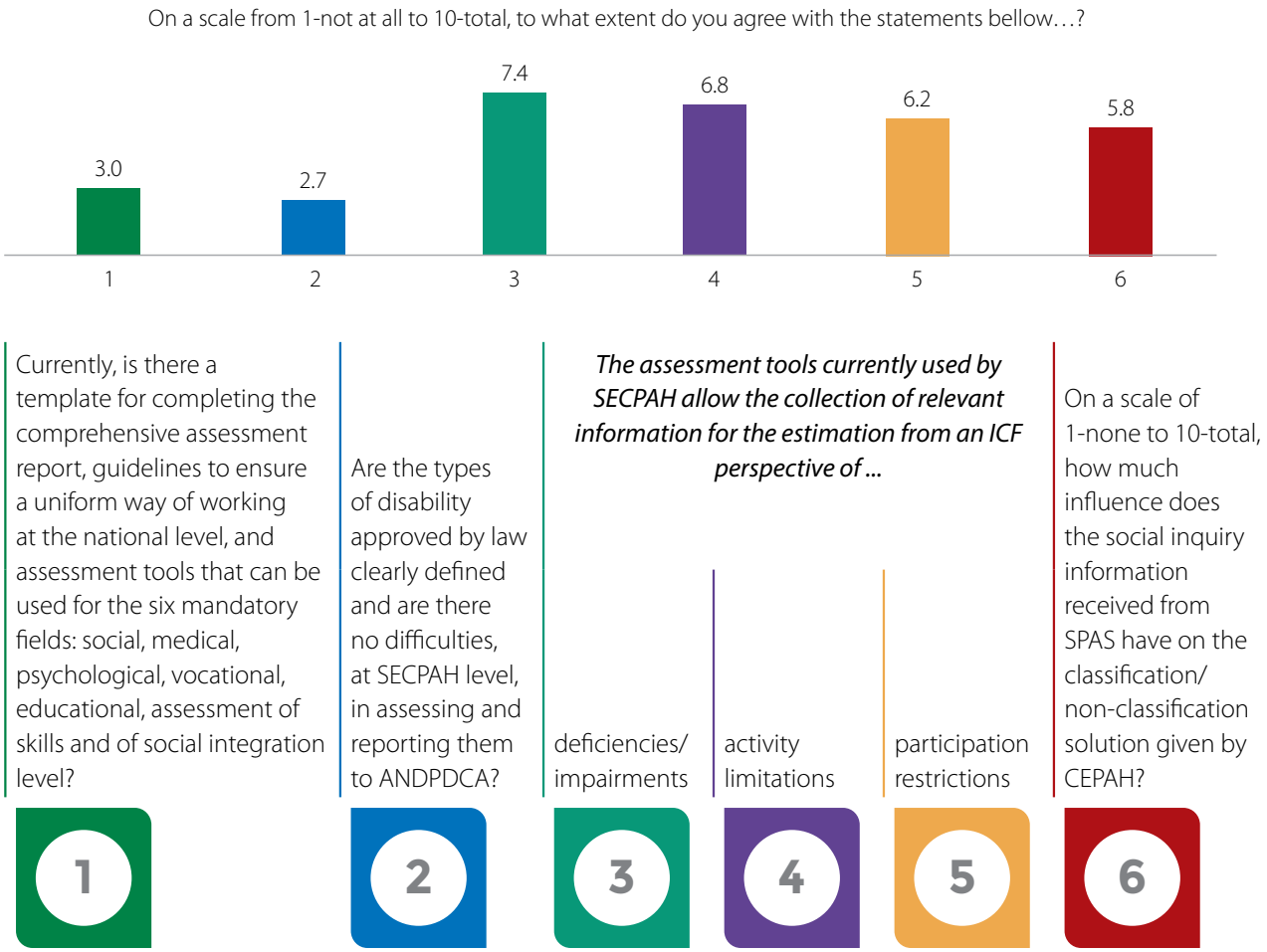
The file prepared by SECPAH is registered and checked by the secretariat of the assessment commission. In some counties (5 of the 27 in the Q3C sample), the CEPAH secretariat may refuse the submission/registration of SECPAH files, if they are not complete. Yet, only one county (AG) states in the Q3C institutional survey that it has a specific procedure for such situations. However, in all counties, the secretariat forwards the files to the commission which is responsible for reviewing the files for classification in a disability degree and type.

If, from the analysis of the file and the comprehensive assessment report (drawn up by SECPAH), the assessment commission finds that the information is insufficient to take a decision, it sends back the documents to SECPAH for reconsideration and possible completion.[291] Such situations are very rare. According to the reports of the CEPAH presidents in the Q3A questionnaires, the share of files sent back to SECPAH represents 1 percent of the total number of files forwarded to the commission.

Regarding the quality of the information provided by SECPAH, the CEPAH members participating in the opinion survey Q3B (Figure 28) indicate that (medical) information on impairments/deficiencies is satisfactory (with an average score of 7.4, on a scale of 1-not at all, 10-total). Instead, in their opinion, the methodology for establishing the types of disability needs to be revised, especially with regard to the mental and psychic types. In this regard, CEPAH members expressed a similar opinion in the survey Q3B, because "for adults there has not been legislative continuity" and "there is a need for an analysis of the necessity of the types reported, so that their number is not too high, but to help policy planning in the field".[292]

289 Assessment of social, medical, psychological, vocational or professional skills, level of education, as well as skills and level of social integration, according to GD no. 268/2007, art. 48, respectively Order no. 2298/2012, art. 4.
290 Joint Order of the Minister of Labor, Family and Equal Opportunities and the Minister of Public Health No. 762/1.992/2007 approving the medical-psychosocial criteria based on which the degree of disability is determined, with subsequent amendments and supplements.
291 GD no. 430/2008, Art. 3, para. (2).
292 Quotes from Q3B questionnaires.

Figure 28: Opinions of CEPAH members on the comprehensive assessment tools used by SECPAH (average scores on a scale from 1-none to 10-total)



Source: Opinion survey Q3B: Practices and experiences of CEPAH members (N=43), from 24 counties and 2 districts of Bucharest, January-February 2021.

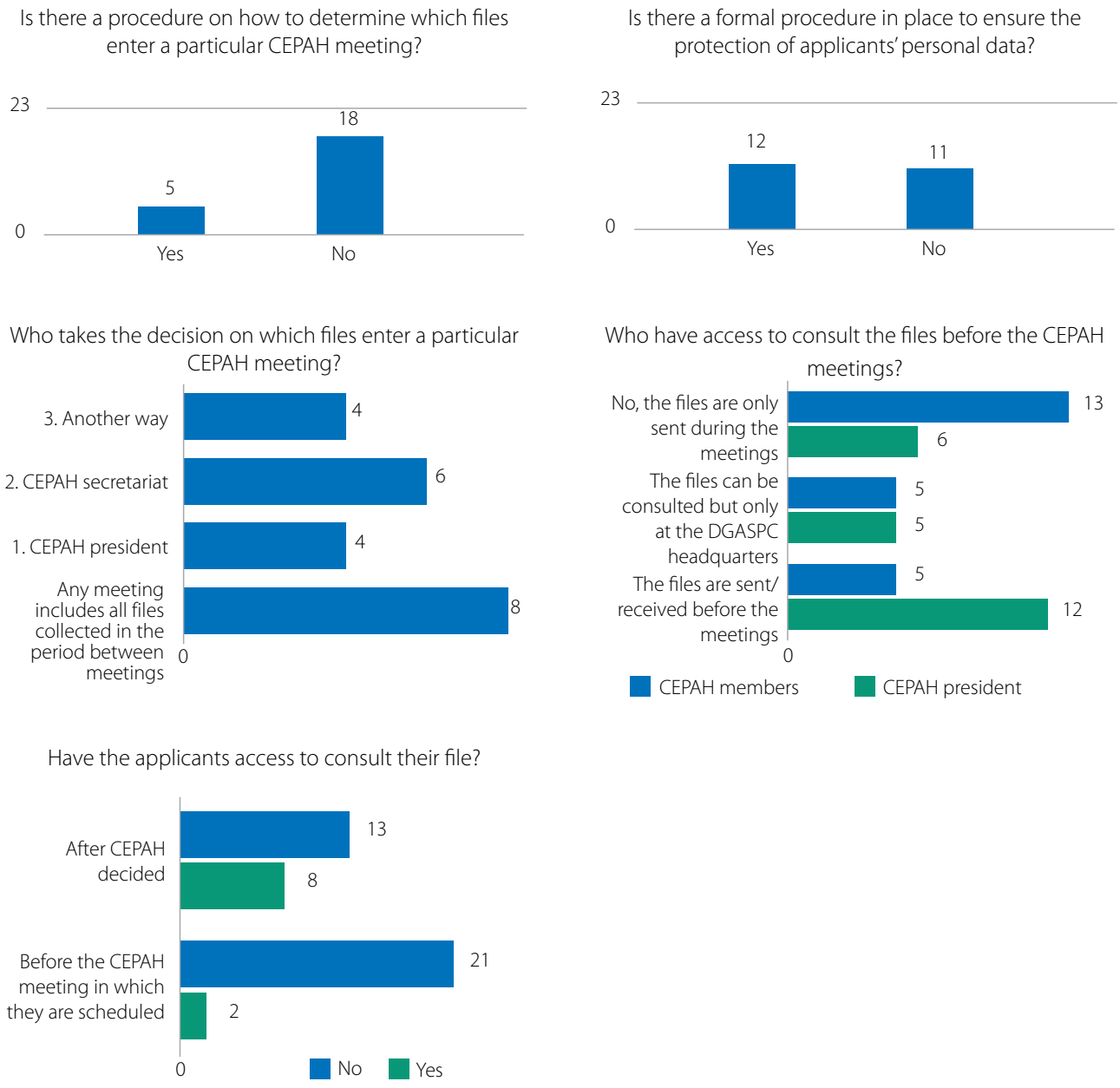
Another major shortcoming is the lack of scientifically based tools, and the CEPAH members mention mainly tools for vocational assessment, education level assessment and social integration level assessment (also highlighted in the analysis in Chapter 4). That is why, according to CEPAH members, the assessment of participation restrictions and the estimation of the possibility of social (re)integration can be considered deficient.

5.2.2. How the Assessment Commissions Work

The CEPAH secretariat sends the agenda and the date of the meeting to the members of the assessment commission based on the convening notice signed by its president.[293] In the majority of the counties (18 out of 23) there is no approved procedure/paragraph in the general procedure on how to determine which files enter a particular CEPAH meeting, as shown in Figure 29. The decision on which files are selected for classification per CEPAH meeting is made in different ways from county to county. Either all files collected in the period between the previous meeting and this meeting are entered (in 8 counties), or they are decided by the commission secretariat (in 6 counties) or by the CEPAH president (in 4 counties) or in other ways (in 4 other counties), e.g., they are selected by SECPAH.

293 GD no. 430/2008, Art. 15, para. (4) and (2b).

Figure 29: Management of files during the phase of disability determination, according to CEPAH presidents (number)

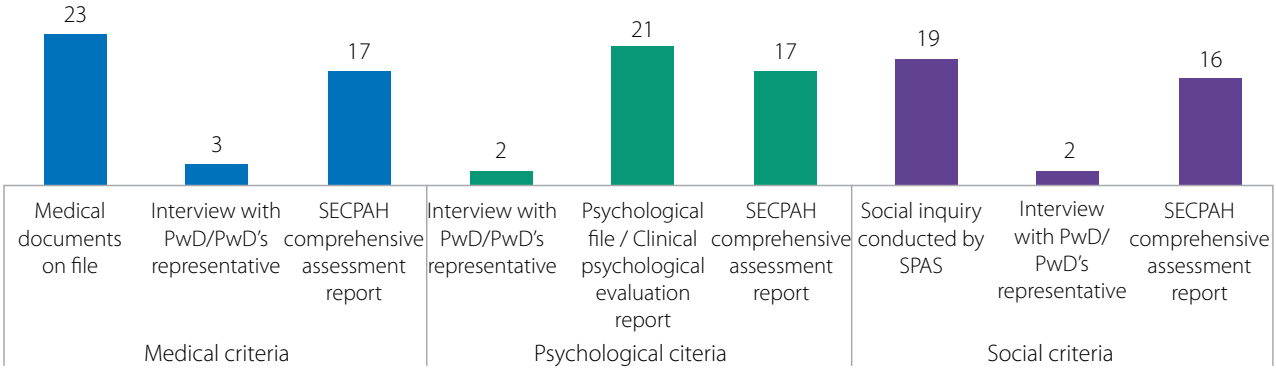


Source: Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 21 counties and 2 districts of Bucharest, who reported the necessary data, January-February 2021.

The applicants can consult their file prior to the meeting in which they are scheduled for classification in only two counties (IS and OT), that have also declared that they have a special place for this purpose. Alongside these, another 6 CEPAH presidents report that files become available to beneficiaries, for consultation, after the commission makes the classification decision. However, these counties do not have a special place for this purpose.

Practices regarding access to files by members of assessment commissions differ between counties. Before the CEPAH meetings, the presidents of the commissions have access to the files, in most counties (Figure 29); in 12 (out of 23) counties, the secretariat sends the files to the presidents, and in 5 counties the presidents can consult the files only at the DGASPC office. The other members of the commissions have much less access to the files, before the meetings; in 5 counties the files are sent to them by the secretariat, and in 5 counties they can only consult them at the DGASPC office.

Figure 30: Main sources of information for verifying the medical-psychosocial criteria for the classification of the deficiency degree and type, according to CEPAH presidents (number)



Source: Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 21 counties and 2 districts of Bucharest, who reported the necessary data, January-February 2021.

Notes: Multiple choice question, which is why the sum of the bars for each type of criteria may exceed 23, i.e. the number of CEPAH presidents who answered these questions in the Q3A questionnaire.

In fact, the 24 CEPAHs studied (in the Q3A) can be classified into four groups with different practices.[294] Thus, the first group includes 5 CEPAHs where both the president and the other members receive the files for examination before the meetings. The second group consists of 7 commissions in which only the president has access to the files before the meetings, while the other members only see them during the meetings. The third group includes 5 CEPAHs which provide access to files to the president and to the members before the meetings, but only if consulted at the DGASPC office, while the fourth group of 6 CEPAHs only have access to the files during the meetings.

In other words, the prevailing practice at the national level is that only the president of the CEPAH can consult the files before the meetings. The other members, as a rule, have access to the files only during the meetings. Therefore, the typical situation in the adult assessment commissions can be described as follows: a group of 5 specialists get together to make decisions that affect the lives of other people, and 4 of them receive the files only during the meetings, while in a meeting of 190-200 minutes solutions have to be decided for 64 cases with situations ranging from mild to very complex.[295]

Once they receive the files, the commissions analyze them and establish the solutions for classifying the degree and type of deficiency based on the medical-psychosocial criteria, as provided by the law. Figure 30 shows which are the main sources of information, i.e. the documents that the commissions consult most often, to support their decisions. As reported by the CEPAH presidents in the Q3A questionnaires, the dominant practice is to review/corroborate the medical/psychological documents[296] with the comprehensive assessment report prepared by SECPAH, in order to verify the medical/psychological criteria. Similarly, both the social inquiry and the comprehensive assessment report are used to check the social criteria. Most likely, this is the working method of the CEPAH presidents who have access to the files before the meetings. Such a verification algorithm applied to 64 cases within 190-200 minutes would be very difficult for any specialist, especially as the files are paper-based, in most cases, and do not allow for a quick or targeted search.

As outlined in Section 5.1.2, decisions are based on document analysis, interviews with the applicants and/or their representatives are rarely used (Figure 30). Besides, there would not even be enough time to conduct interviews/interactions with all applicants (or more numerous categories of applicants) during the meetings.

The quality of the information in the medical/psychological documents is assessed positively by the CEPAH presidents (in the Q3A questionnaires). It rarely happens that the medical documents have

294 One assessment commission did not answer the question.

295 See also section 5.1.2.

296 Including the report of the specialized medical practitioner, the family physician's referral letter, medical tests and investigations, hospital discharge reports.

conclusions/ diagnoses that are either vague or unclear, conflicting,[297] potentially erroneous or even fraudulent.[298] Such situations are reported to be more common in relation to neurological, ophthalmological and psychiatric disorders. Correlated, only 4 CEPAHs (out of 24 in the sample) have an approved procedure (or paragraph in the general procedure) for such situations. Also, according to CEPAH presidents, there are rare cases of inconsistency between the CEPAH physicians' assessment (based on the documents on file) and the assessment made in the report of the specialized medical practitioner. Very rarely is there a disparity between the CEPAH physician`s assessment and the SECPAH physician`s assessment (from the comprehensive assessment report).[299] Consequently, only 3 CEPAHs (out of 24) have a specific procedure for resolving inconsistencies between medical opinions. The practice used in such situations by all commissions is to request the completion of the file with the results of paraclinical investigations or a new medical report, carried out at any health care facility/physician of the applicant`s choice. Furthermore:

- the president of the commission consults with the SECPAH`s physician (in 14 counties),
- the commission requires tests to be carried out and/or a new medical report from a specific medical establishment/physician to be obtained (in 10 counties)
- the commission requests additional information from the guardians/caregivers of the person concerned (in 7 counties)
- the commission conducts an in-depth interview with the applicant (in 4 counties)
- the president of the commission consults/ communicates with the specialized medical practitioner who made the initial assessment (in 2 counties).

The situation is largely similar with regard to the data used for the psychological assessment. The clinical assessment report and the SECPAH comprehensive assessment report are used to apply the psychological assessment criteria. As with the medical assessments, CEPAH psychological assessments correspond to the SECPAH psychological assessment in the comprehensive assessment report. In the event of a discrepancy, the following measures are usually taken: i) the commission recommends a psychological assessment to be carried out by a third party, ii) another report is requested from a psychologist at a university clinic/psychiatric hospital, iii) the psychologist of the commission conducts an interview with the person concerned and decides on classification scores (usually, GAFS and MMSE scores).

The social inquiry, although used by most CEPAHs as the main source for the social assessment, has little influence on the solution for the classification/non-classification in a disability degree, as shown in Figure 28 (bar 6) in Section 5.2.1. The reason given was that most social inquiries do not provide an adequate basis for decision-making, because they often provide random and insufficient information for a good understanding of people`s performance in their living environment (including environmental factors), a perception that is consistent with the findings of the analysis in subchapter 3.3. And in order to remedy this situation, first of all, the social inquiry framework model needs to be improved (according to 55 percent of CEPAH members), local social workers should be trained on the rights of people with disabilities and the ICF (46 percent), and SPASs should hire professional social workers to draw up social inquiry and not people with social assistance responsibilities (42 percent).[300] Opinions aside, the fact is that the lack of clear criteria on how to use the information presented in the social inquiry hinders its use in the disability determination process. There is a lack of connection between the information in the social inquiry (information that predominantly refers to the person`s limitations in activity and participation, his or her living context and environmental factors) and the classification of the disability degree and type. The social inquiries drawn up by SPAS rarely provide consistent information on the degree of autonomy and social integration of the person. Instead, the conclusions of the social inquiry are often missing or formulated in an incomplete or vague way, such as: "it is recommended to classify the person in a degree of disability".

297 When two or more medical reports from different specialized medical practitioners are requested or provided.

298 Average values equal to 2, on a scale from 1-very rarely to 5-very often.

299 Average values equal to 1.5, on a scale from 1-very rarely to 5-very often.

300 Multiple choice question. Opinion survey Q3B: Practices and experiences of CEPAH members (N=45), from 24 counties and 2 districts of Bucharest, January-February 2021.

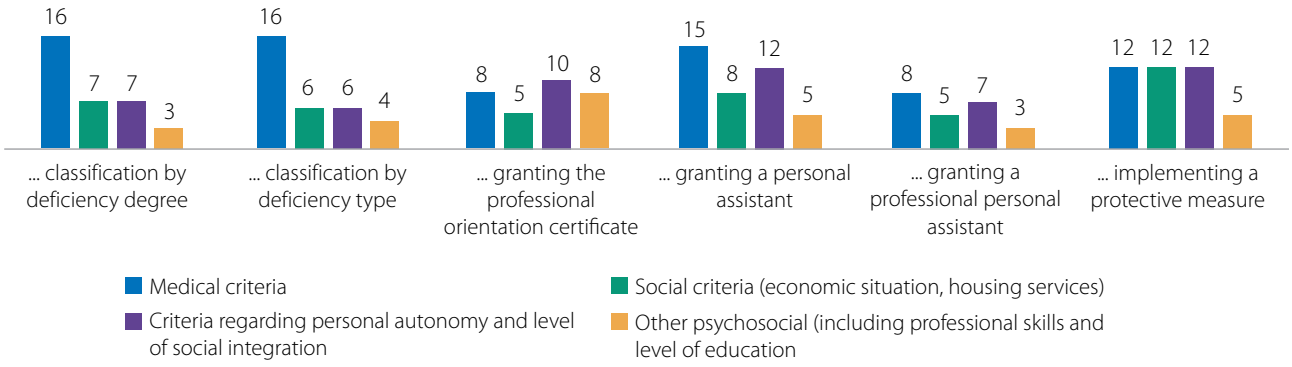
"We have 400 files/month, we meet 2-3 times/week. All files are reviewed by the president and we discuss only the very complicated cases with the members of the commission. The problem with SECPAH, there are many situations where the real situation is different from what appears in the papers and colleagues tell me and point out to me where the problem is. When the papers are overstated compared to the reality on the ground, I always ask for information, because such cases have the potential to end up in court. When I have concerns, I call the mayor`s office and ask the social worker to go to that person`s house again and check. For example, he/she finds out from the village shop that X went shopping at the village shop two days ago, even though it says in the social inquiry that he/she is bedridden!" (Focus group CEPAH 1)

As the assessment of participation restrictions and the estimation of the possibility of social (re)integration are considered deficient by the majority of the CEPAH members, we asked in the opinion survey Q3B, whether the introduction of a self-assessment of the people with disabilities own situation, as a new working tool, could help the commission in the process of deciding on the solution for disability degree classification/non-classification. The answer was a resounding no from 96 percent of respondents. The explanation given by the CEPAH members was that the people with disabilities would be subjective, would not tell the truth, would not know the law and/or would strategically manipulate the opportunity to exaggerate their own situation. In other words, the area of participation restrictions is perceived as the most unsatisfactory area assessed by the specialists, but the partnership with the people assessed is not considered as a possible solution to adjust the approach.

5.2.3. How Are the Solutions for the Disability Degree Classification/Non-classification Determined

The general picture of the medico-psychosocial criteria that the assessment commissions predominantly use to fulfill their main tasks is given in Figure 31. For the majority of CEPAHs (16 out of 24 in the sample), the medical criteria are the key determinants in establishing the classification/non-classification in a degree and type of deficiency, as well as in granting the right to a personal assistant (15 out of 24), according to the presidents of these commissions. The main justification for the preference for the medical criteria, also frequently mentioned in the focus groups, is the belief that: "The medical conditions are easier to identify and can be more easily quantified by approved tests".[301]

Figure 31: Medical-psychosocial criteria predominantly used by CEPAH, according to CEPAH presidents (number)



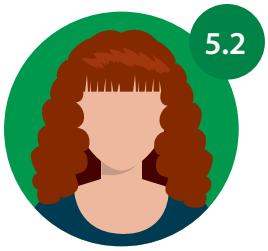
Source: Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 22 counties and 2 districts of Bucharest, who reported the necessary data, January-February 2021.

Note: Multiple choice question, which is why the sum of the bars for each CEPAH task may exceed 24, i.e. the number of CEPAH presidents who answered these questions in the Q3A questionnaire.

301 Focus group CEPAH 2.

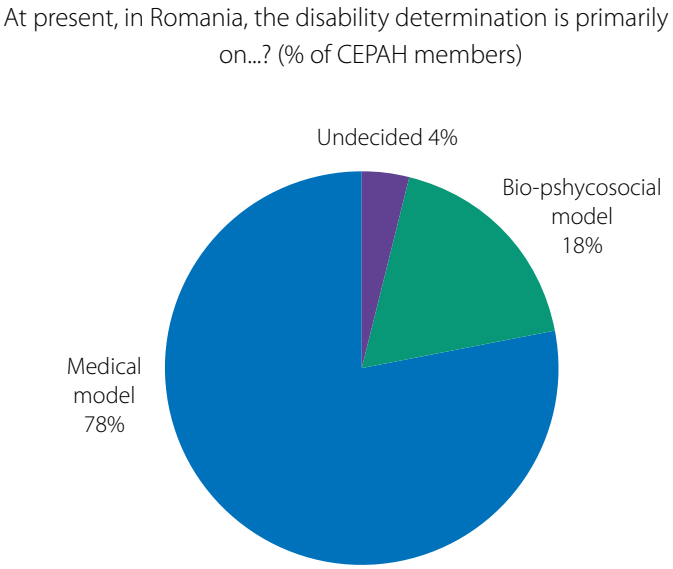
The criteria relating to the level of social integration (degree of dependency) play a dominant role in commission decisions on entitlement to a personal assistant and professional orientation. The only multi-disciplinary decision taken in a large number of counties (half of the counties studied), taking into account the medical, social criteria and the degree of dependency, is that related to the approval of the protective measures.

Only a third of the CEPAH members consider the current medico-psychosocial criteria to be sufficiently inclusive, i.e. all people whose functioning is impaired can meet the criteria. The other 66 percent of the total Q3B sample believe that the criteria are not inclusive enough, because there are some incomplete or dysfunctional criteria and, therefore, they need to be revised, and they mention a long list of conditions or situations for which they had difficulties in classification. Among these, the following were mentioned by several respondents:



"various medical diagnoses which, although affecting social functioning, cannot be classified";
"people with oncological conditions during chemotherapy"; "for oncological conditions there is no dedicated chapter"; "the conditions for neoplasms must be changed";
"the criteria are not appropriate for some rare diseases causing disability"; "genetic diseases and rare diseases cause disability difficult to assess according to the criteria";
"Oxygen dependence is not classifiable";
"post-traumatic conditions in adulthood may not meet the criteria";
"persons severely affected in one eye";
"personality disorder over the age of 26";
"ankylosing gonarthrosis";
"mental retardation and schizophrenia over the age of 35";
"people with irreversible mental disorders, who do not fall into the category of under 26 or under 35";
"criteria for cognitive impairment (dementia), functional parameters are unclear, permissive";
"the criteria for ophthalmological conditions, regarding visual acuity and visual field, are permissive";
"the possibility of classifying plegic deficit regardless of damage, whereas paretic deficit can only be classified as a result of a stroke or cardiovascular disease"
"persons with disabling conditions, but without early onset"; "the age at which the degree and type of disability can be classified for some conditions is not clearly specified. Youthful onset is a vague term";
"where a person has multiple diagnoses, which taken separately do not fit or fit to a lesser degree than the actual need given by the complex situation";
"there are cases where applying the criteria results in a lower degree than the real needs identified, and dependence on other people cannot be fully taken into account";
"an elderly person with a degenerative disease of old age, who carried out lucrative activities, has been socially involved, is classified as a person with disabilities based on the biological age deterioration (diagnosed by the psychiatrist as mixed dementia), is entitled to rights and facilities and may also receive an invalidity pension. And a middle-aged person with no income, no health insurance, with an osteoarticular condition from adolescence, but without a medical document to prove it, does not qualify as person with disabilities";
"the social component loosely represented in those who are conditional on being classified as having no income, e.g. some psychiatric conditions".
(Quotes from Q3B questionnaires)

Figure 32: However, according to the dominant opinion among CEPAH members, currently, the medical model is still dominant in classifying the degree and type of disability for adults



Source: Opinion survey Q3B: Practices and experiences of CEPAH members (N=46), from 24 counties and 2 districts of Bucharest, January-February 2021.

The decisions of CEPAH are taken as a team, during the meetings, with a majority vote, according to Art. 9 (para. 7) of GD no. 430/2008. However, Table 10 shows that half of the 36 SECPAH presidents who responded to the Q3A questionnaire reported that, there is one member of the commission who contributes more than the others. Namely the specialized medical practitioner has a larger contribution to the decisions for classification/non-classification into a deficiency degree and type. Specifically, the president of the commission, who is a physician and who has access to the files before the meetings, has more time to consult the files and contributes more to those decisions, based on the medical assessment. All other CEPAH decisions are made as a team, in most counties, but the team does not necessarily include all five members of the commission, but may vary in composition from one type of decision to another and from one county to another.

For example, 6 CEPAH presidents indicate that the decision on the approval of a protective measure, such as admission in a residential center, may be taken mainly by the following types of groups:

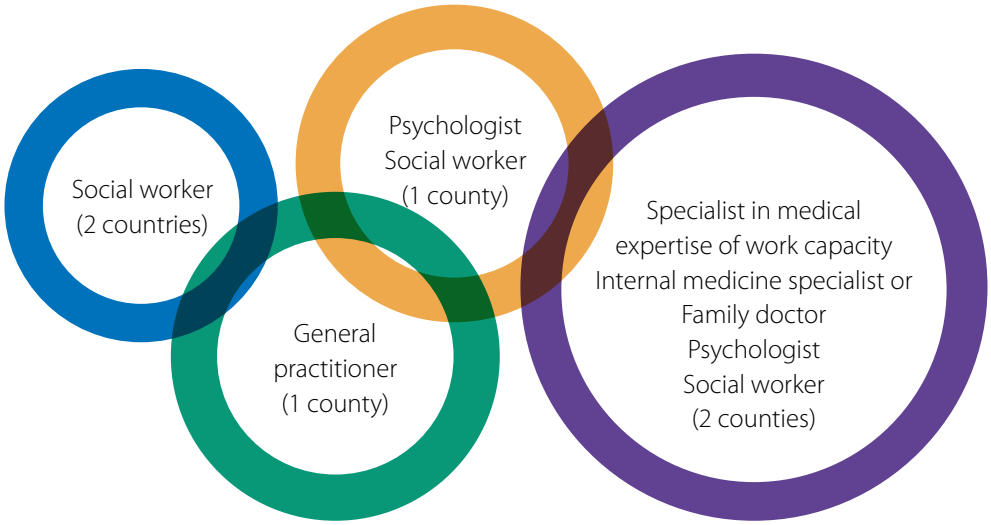


Table 10: How are CEPAH decisions determined, according to CEPAH presidents (number)

In the process to determine ...	Is there a team member of the commission (with a particular specialization) who contributes more than others? Yes	No
Classification or non-classification (granting of the certificate)	9 (Physician)	9
Deficiency type	8 (Physician)	10
Deficiency degree	5 (Physician)	13
Granting of the Professional Orientation Certificate	3	15
Taking a protective measure/institutionalization	6	12
PIRIS	5	13
Granting a personal assistant for the person with severe deficiencies	5	13
Granting a professional personal assistant for the person with severe deficiencies	2	14

Source: Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 17 counties and 1 district of Bucharest, who reported the necessary data, January-February 2021.

Note: The sum of cells per line should be 18, which is the total number of CEPAH presidents who answered to these questions from Q3A. For smaller amounts, the difference up to 18 represents non-responses.

The situations of disagreement among CEPAH members about the classification of the deficiency degree and type for a case are reported to be very rare (20 counties) or rare (3 counties), according to the CEPAH presidents (in Q3A). And when they arise, majority voting is the way to settle the differences. Correspondingly, only 3 CEPAHs have developed a specific approved procedure (a paragraph in the general procedure) for handling these situations. However, in the opinion survey Q3B, CEPAH members gave a very high average score of 4.5 on a scale of 1 to 5, for the usefulness of such a procedure for the current activity of the commission.[302]

5.2.4. Exclusion Errors and Inclusion Errors

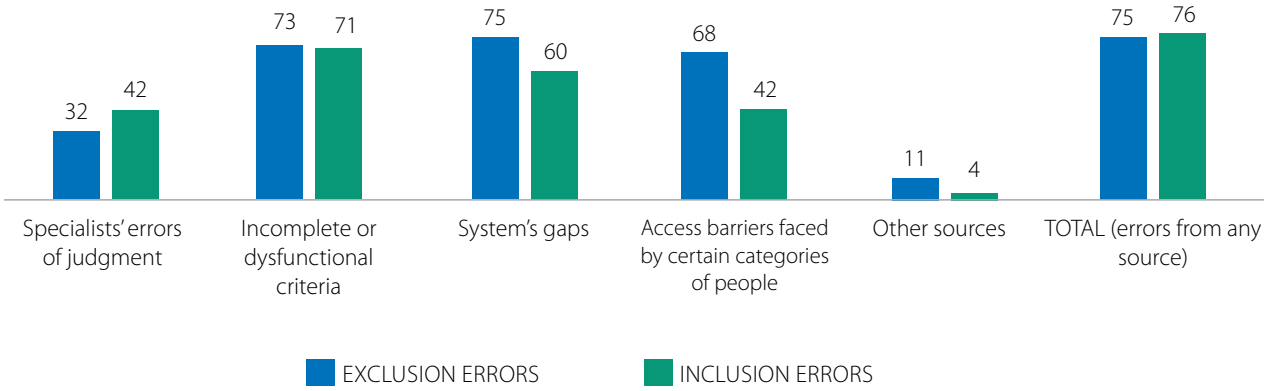
The exclusion errors refer to cases where the person`s functioning is impaired to a significant degree, but individuals do not receive a disability degree classification. In contrast, the inclusion errors relate to situations of people who are classified in a disability degree and type, but whose functioning is not impaired to a significant degree. Three quarters of CEPAH members confirm the existence of both exclusion and inclusion errors, in the process for the classification of the disability type and degree (Figure 33). Incomplete or dysfunctional criteria are perceived to be the main source of errors (of both types), as outlined in the previous section. The system's gaps follow, such as: physicians issuing medical documents with vague/unclear diagnoses; the fact that the disability assessment "is carried out based on documents, not the actual assessment of the person" (see also Section 5.2.2); "mismatch between the criteria for children and adults" due to which "situations frequently arise where the child (under 18) is classified in a disability degree and, on transition to adults, suddenly, changes to a lower degree, although the person`s needs and limitations remain the same" (see also Chapter 8).[303]

Access barriers faced by certain categories of people are more frequently cited as a source of exclusion errors, particularly with regard to people with no income, no health insurance, in isolated communities or without a family and support network (see also subchapter 3.2). The specialists' errors of judgment are less frequently mentioned, but it is relevant that 42 percent of the CEPAH members perceive them as a source of inclusion errors in the disability determination.

302 See also Section 9.3.4.

303 Quotes from Q3B questionnaires.

Figure 33: The share of CEPAH members confirming the existence of exclusion and inclusion errors within the process of disability determination, by type of error source (%)



Source: Opinion survey Q3B: Practices and experiences of CEPAH members (N=45), from 24 counties and 2 districts of Bucharest, January-February 2021.

However, say over 90 percent of CEPAH members, regardless of source and type, classification errors are only isolated cases, not associated with certain types of deficiencies/impairments. Moreover, 92 percent of them believe that court decisions are not evidence of exclusion or inclusion errors, as court decisions are "subjective", made mainly based on "subjective" criteria (see also Chapter 7, especially Section 7.4.4).

"The medical criteria are still the most important, because they have a higher degree of objectivity. Social criteria are more subjective and interpretable. We leave it to the courts to decide on these cases. In our country, the Legal Department of the County Council represents us in court, we just make reports for these legal advisers. But they are not good at defending these cases. And they lose a lot of cases, ... about 10 per month" (Focus group CEPAH 2)

The measures that would be needed to prevent the exclusion/inclusion errors in disability determination, recommended by CEPAH members (in Q3B), include, first of all, clarifying the criteria and completing them, as "for several conditions, classification is made without taking into account the impairment of functioning",[304] plus applying them uniformly at the national level. Secondly, "there should be a procedure for consulting the data, the specialists in the field and the representatives of the people with disabilities, in order to continually assess the situation and correct the errors observed". And thirdly, there should be more effective mechanisms to deal with the situations of suspected fraud or intentional distortion of reality by the applicants. Preferably, these mechanisms would also include the direct interaction with the applicant or even the possibility of an actual assessment, possibly in collaboration with the specialists in the condition concerned. And, with regard to the misjudgments of the specialists, some CEPAH representatives propose to "re-establish the Higher Commission, in order to confirm/report some unclear diagnoses". Instead, the introduction of an external auditing system would not be useful because it would not improve the performance of the assessment commission, according to more than three quarters of the CEPAH members participating in the opinion survey Q3B.

5.2.5. The Feedback Loop of the Decision-Making Process within CEPAH

The decision-making process within CEPAH does not incorporate a feedback mechanism, which violates the principle of "nothing for us, without us", especially as there is no interaction between the assessed person and the assessor and the approach does not include a self-assessment of the applicant. Only 7 CEPAH presidents (out of 24

304 The quotes in this paragraph are taken from the Q3B questionnaires.

who responded to the question, in Q3A) reported that they systematically record feedback from people applying for the classification of disability degree and type. The reactions of the applicants are "different, good and bad", but mostly "challenges, according to Law no. 554/2004" or "we directly receive the verbal expressions of dissatisfaction with regard to the classification of the disability degree, the financial precariousness of the allowances, etc. It is true, we also receive thanks when they present themselves at the assessment or when they pick up the certificate". And measures to improve the way of working based on the feedback received are usually limited to "trying to solve the request, within the limits of the law and the budget".[305] More generally, in Romania, the whole disability assessment system lacks a grievance redress mechanism[306] that complements (not replaces) the formal legal channels for managing grievances, such as the judicial system or the organizational audit mechanism. But this subject is dealt with extensively in Chapter 7.

In the perception of CEPAH members:[307](i) applicants and their guardians/representatives are only to a small extent involved in CEPAH`s process of settling the case; (ii) and the information (including preferences, fears, etc.) provided by the applicants and their guardians/representatives has very little influence on the classification/non-classification solution given by CEPAH (with an average score of 4.6, on a scale of 1-none to 10-total); (ii) but the person or their accompanying guardians/representatives are informed of the explanatory statement/substantiation for the solution;[308] (iv) and the assessment commission is perceived satisfactorily by the applicants (with an average score of 6.9, on a scale from 1-very negative to 10-very positive).[309]

The main difficulties encountered in interacting with applicants and their guardians/representatives are that "people do not understand the difference between illness and deficiency" and therefore "do not accept that certain illnesses do not classify in a degree of deficiency". In addition, the difficulties of explaining the solutions are mentioned, all the more so as "the applicants are frequently unwilling to develop/improve their remaining skills". Only a few CEPAH members mention the lack of direct interaction, counseling or integrated services, given the complex needs of the applicants` families.[310]

5.3. The results of the disability determination

Typically, CEPAHs examine a very large number of files over the course of a year. For example, in 2019, before the pandemic, the maximum number of cases examined by a commission was 12,807,[311] which means an average of 1,067 cases per month, while the minimum number was 2,700 cases,[312] with a monthly average of 225. During the pandemic, the number of cases fell drastically. Across the sample of 23 CEPAHs, the average number of files per county decreased from 2019 to 2020 from over 6,100 to 4,800 files per year. So, at the national level, the SECPAH and CEPAH have to analyze and to classify in degree and type of disability a large number of files that vary significantly both between counties and over time.

- In 2019 (pre-COVID), 19 counties and 2 districts of Bucharest assessed a total of over 116 thousand

305 Quotes from Q3A questionnaires completed by CEPAH presidents.

306 According to UNDP (2017: 1), the grievance redress mechanism is defined as a system of organizational procedures and resources established by national/county/local government agencies to receive and address grievances, complaints, or concerns about the impact of their policies, programs, and operations on external stakeholders.

307 Opinion survey Q3B: Practices and experiences of CEPAH members (N=42), from 24 counties and 2 districts of Bucharest, January-February 2021.

308 In this respect, Section 7.4.4 proves that the lack of the explanatory statement/substantiation for the solution in the disability certificate is one of the two main elements that the courts take into account when they rule in favor of the claimants, persons with disabilities. Moreover, an explanatory statement/substantiation of the solution for classification/non-classification in a degree of disability, accessible to all persons at the end of the assessment process, is not available in all counties. And, an explanatory statement/substantiation containing detailed information to substantiate the classification/non-classification solution and that can be used in court is provided in only 4 counties.

309 By comparison, with regard to the Child Protection Commission (CPC) assessing children with disabilities, the average score is 8.1, on a scale from 1-very negative to 10-very positive.

310 Quotes from Q3B questionnaires completed by CEPAH members.

311 CEPAH Olt.

312 CEPAH from Bucharest, Sector 2, followed by CEPAH Tulcea with 2,846 files. Data reported in Q3A questionnaires.

files.[313] A rough estimate indicates a national number of applicants benefiting from SECPAH/CEPAH services of about 250,000 people, in one year.

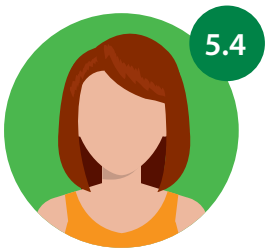
- Of the total number of cases settled in one year, around a third (in 2019), and 37 percent (in 2020), were new cases, i.e. people on their first assessment (during lifetime), the rest being re-assessments for certificate renewal. [314]

According to the regulations in force, the assessment commissions do not only make decisions related to the classification/non-classification of the disability degree and type. In addition to granting the certificate, CEPAH is obliged to draw up the PIRIS in cooperation with the person with disabilities or his/her legal representative, grants the professional orientation certificate (on request), determines the right to a personal assistant for the person with severe deficiencies and decides on the taking of a protective measure (admission in residential care centers, referral to day care centers, placement with a personal assistant/professional personal assistant, provision of social services at home).

5.3.1. Classification/Non-Classification into a Disability Degree and Type

CEPAH's decision-making process is redundant with SECPAH's comprehensive assessment approach. CEPAH`s solutions are the same as SECPAH`s recommendations for over 90 percent of the cases,[315] mainly as a result of the high workload and working practices described in the previous sections of this chapter. This situation is not specific to some counties, but it is widespread.

In Romania, more than 90 percent of the applicants receive decision of classification/maintaining of disability degree. Correspondingly, the share of files with decision of non-classification in degree and type of disability is less than 10 percent. At the level of the sample of CEPAHs in 22 counties and 2 districts in Bucharest, even if the number of files assessed varies greatly, the share of certificates with classification/maintaining of classification in degree of disability is less than 90 percent (but more than 85 percent) in only three counties (NT, HD and BC). At the other end, there are counties with shares above 98 percent, namely GJ, MH, BT and CJ.



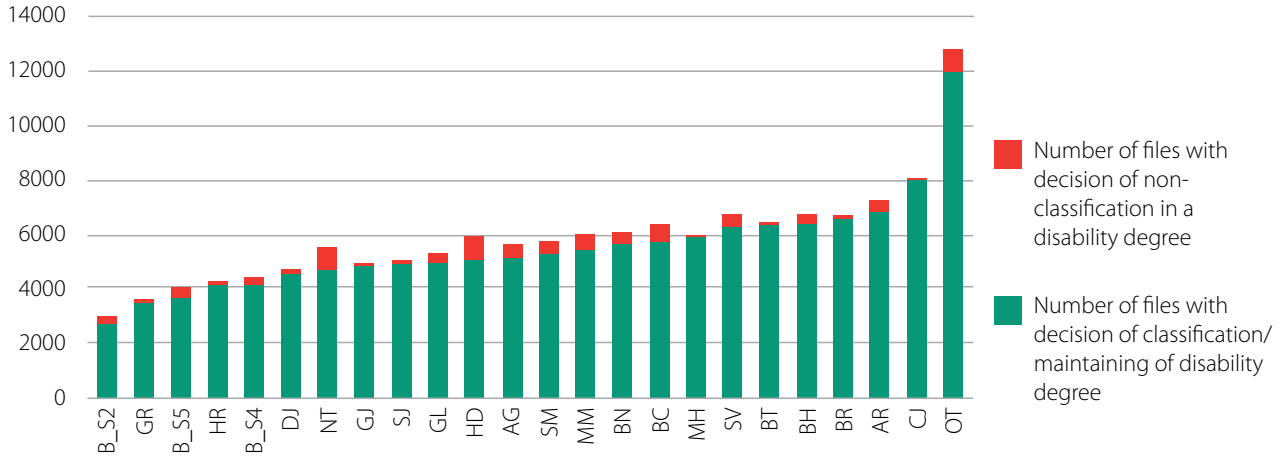
"I have a 3 hours/day contract, we have a limit of 40 files/day, per month we have 600 files and we have to be very efficient, we meet together. When it`s not possible, everyone analyzes the file, we have members who have specialized and I, as president, have to see them all. We have a very good relationship with SECPAH and we agree before the trial. I do the drafting outside the working hours, I can`t do it in the 3 hours-period specified above." (Focus group CEPAH 1)

313 The data provided by CEPAH presidents in the Q3A questionnaires, using information from the registers managed by the CEPAH secretariats. The other counties either did not provide this data or provided data discordant with that reported by SECPAH chiefs in the institutional survey Q2A.

314 Estimates based on the data provided by the commissions presidents in 7 counties and one sector in Bucharest, in Q3A questionnaires; other commissions did not provide data. The percentage of the people that are assessed for the first time varies between counties, from a minimum of 27 percent to a maximum of 42 percent, in both 2019 and 2020.

315 Average value estimated by CEPAH presidents. Standard deviation of only 18 percent. Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 18 counties and 1 district of Bucharest, January-February 2021.

Figure 34: Results of the disability determination process in Romania, by county, in 2019



Source: Consolidated data from institutional surveys Q3A (CEPAH) and Q3C (CEPAH Secretariat) for 22 counties and 2 districts of Bucharest, for 2019.

Although every country is different, and approval rates for disability benefits vary from country to country, such a high disability degree classification rate, of over 90 percent of claims, is a cause for concern.

- One possible explanation is based on (self) selection of applicants. People with health problems (which meet the medical-psychosocial criteria) do not apply for a certificate, although they could. This is because the potential applicants are not familiar and informed or are not able, supported and encouraged to engage in this process. That is, awareness raising, initial information and communication activities with the potential applicants are insufficient and/ or deficient.[316] Still, the process of preparing and registering the file is difficult, lacking in adaptations or too costly for the potential beneficiaries to commit themselves in the process. For example, municipalities/SPAS refuse to carry out the social inquiry or when registering the file at DGASPC/SECPAH people are refused (in the absence of a specific procedure) on the grounds that the conditions that they suffer from do not fit the criteria, before the comprehensive assessment takes place.[317] The process is not simple, but requires substantial capabilities and effort from the potential applicants, because it involves many steps with too many institutional actors with different rules, uncoordinated and not automatically communicating or transferring information between them. Instead, at the end of the whole process, very little monetary benefits can be obtained,[318] if there is no hope of obtaining the severe degree with the right to a personal assistant, and almost no services. Therefore, the population of potential beneficiaries is discouraged and reduced to people in truly desperate, hopeless situations, or braver people willing to face all challenges. Given this (self) selection of applicants before the comprehensive assessment of SECPAH, it is normal that more than 90 percent of them receive disability degree classification/maintaining of disability degree.
- Another explanation relates to the way in which the disability assessment and determination are carried out at SECPAH and CEPAH level. Although the medico-psychosocial criteria contain some dysfunctional and incomplete criteria, nevertheless more than 90 percent of the applicants receive a classification solution. And this result has to be seen in the light of the fact that exclusion and inclusion errors are rare, according to the specialists involved. However, both the comprehensive assessment and the determination of disability are predominantly carried out based on the medical model, as is clear from the previous sections of this chapter. Consequently, an applicant with an impairment/deficiency that fits the criteria may obtain the classification even if functioning is not significantly impaired, precisely because activity

316 The subject is dealt with in Chapter 2.

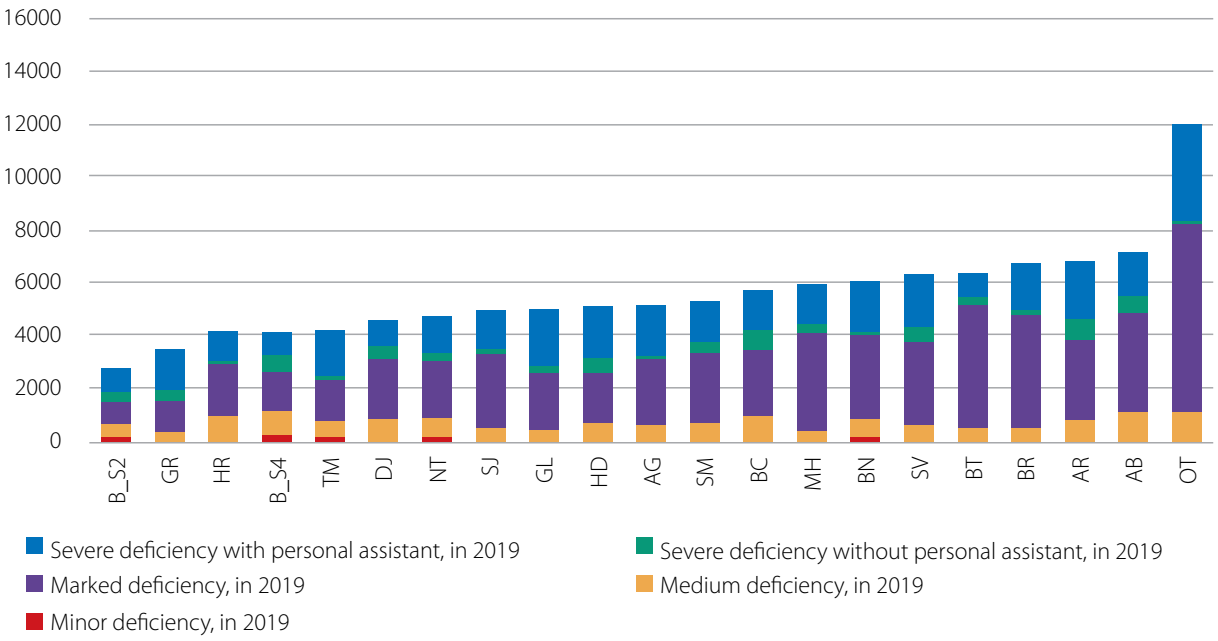
317 These issues are discussed in Chapter 3.

318 For example, the adult with a medium deficiency degree benefits only from a complementary personal budget in the amount of 60 lei per month, according to ANDPDCA, the level of social beneficiaries as of January 1, 2021.

limitations and participation restrictions are still under-considered in the final SECPAH/CEPAH solution. The result is a high rate of granting a degree of disability, which is, however, accompanied by a considerable number of appeals, so high that it has been necessary to change the institutional arrangement for contesting the certificate, as presented in Chapter 7. The two facts seem to be conflicting: if the applicants are successful (obtaining disability degree classification), why are so many dissatisfied? Because the dissatisfaction is not only about not being classified, but especially about obtaining a degree of disability perceived as unsatisfactory in relation to the needs and limitations of the person. Thus, the disability determination phase, as it is currently conducted in Romania, produces dissatisfaction, frustration and perceptions of unfairness, even though it results in an over 90 percent approval rate for granting disability benefits.

According to the regulations,[319] the assessment commissions must ensure that the certificates are accompanied by a confidential appendix, and within the certificate they must provide an explanatory statement/substantiation for the non-classification solution in a degree of disability. CEPAH presidents (in Q3A) and commission secretariats (in Q3C) report data showing that almost all certificates issued have the confidential appendix completed. Instead, the substantiation for non-classification is a practice carried out only in some counties,[320] so that, nationally, about a third of the certificates do not have this section of the certificate completed. This is all the more relevant as the commissions do not draw up a substantiation even outside the certificate, and the absence of such an explanatory statement is one of the two main elements that the courts take into account when ruling in favor of the claimants in the proceedings challenging the certificate.[321]

Figure 35: Distribution of certificates according to the deficiency degree, by county, in 2019



Source: Institutional study Q3C: The outcome indicators of the disability degree determination process for the CEPAH Secretariat, in 19 counties and 2 districts of Bucharest, January-February 2021.

319 GD no. 430/2008, Annex 1.

320 Namely, 15 counties and 1 district in Bucharest, out of a total of 22 counties and 2 districts included in the research.

321 More details can be found in Section 7.4.4.

At the aggregate sample level, the degree of disability granted by CEPAHs follows the existing national pattern: minor - 1 percent, medium - 11.3 percent, marked - 51 percent, severe - 36.7 percent, in 2019.[322] The percentage of the certificates for a severe degree of deficiency with the right to a personal assistant range from 14 percent to 44 percent of all certificates issued by CEPAH countywide, in 2019. Only 3 counties (AB, DJ and BT) and one district in Bucharest have percentages of certificates for a severe degree of deficiency with the right to a personal assistant below 25 percent. At the other end, in 3 other counties (TM, GL and GR), those accounted for more than 40 percent of the total certificates issued during the year (Figure 35).

Out of the certificates for a severe degree of deficiency issued in 2019:

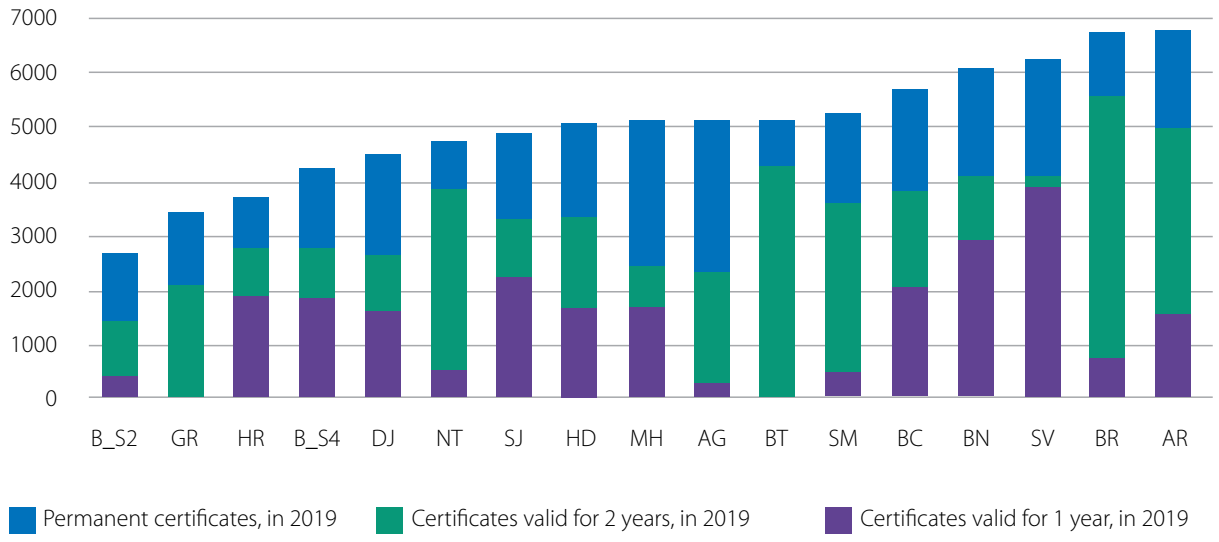
- 6.7 percent were certificates for a severe degree of deficiency, without personal assistant
- 30 percent were certificates for a severe degree of deficiency, with personal assistant.

The adults with a severe deficiency with personal assistant may opt for a personal assistant or for a monthly attendant`s allowance, and this option is expressed by written request registered with the DGASPC. Even so, only the CEPAH secretariats in 5 counties and 1 district in Bucharest provided data in this regard, because although they collect it, this data is not recorded in a database from which it can be easily extracted. Although the number of answers is low, they indicate major discrepancies between counties in how they treat access to the personal assistant service, which is key to independent living and quality of life for families caring for an adult with disabilities.[323] Thus, among the 6 DGASPCs, the share of options for monthly allowances ranges from 30 percent to over 90 percent of the persons with a severe deficiency with personal assistant in the county. There is no uniform approach at national level in this respect either.

CEPAH practices for determining the validity period of the disability certificates differ widely, as shown in Figure 36. At the aggregate sample level, of the total certificates issued in 2019:

- 30 percent were valid for 1 year
- 36 percent were valid for 2 years
- 34 percent were permanent certificates

Figure 36: Distribution of certificates by validity period, by county, in 2019



Source: Institutional study Q3C: The outcome indicators of the disability degree determination process for the CEPAH Secretariat, in 15 counties and 2 districts of Bucharest, January-February 2021.

322 The data reported by CEPAH secretariats in Q3C questionnaires, for 19 counties and 2 districts of Bucharest, for 2019. For comparison, according to the MMPS Statistical Bulletin, on 31 December 2019, the distribution by degree at national level was as follows: minor - 0.9 percent, medium - 9.1 percent, marked - 51.9 percent, severe - 38.1 percent.

323 In many cases, the local authorities encourage options for monthly allowances because they do not involve employing a personal assistant (usually a family member caring for the person with disabilities). Even if the monthly guardian's allowance is no less than the personal assistant's salary, the disadvantage is that the family member caring for the adult with disabilities loses the rights associated with being an employee, such as health insurance, social contributions for pensions, etc.

However, at county level, there are CEPAHs that grant certificates with a 1-year validity to most applicants, such as those in BT or SV, while other commissions grant them only in isolated cases (GR).[324] At the same time, there are counties where commissions have a preference for 2-year certificates (NT, BR or SM), just as there are also CEPAHs that do not issue 2-year certificates (BT).[325] Finally, permanent validity certificates no longer vary extremely between counties, but still vary significantly between 16 percent (in BT or NT) and 55 percent (in AG or MH) of total certificates in 2019. This pattern of extreme inter-county disparities is also verified in the data for 2020, which indicates stability over time.

- As only 7 out of 22 CEPAHs[326] have a specific approved procedure (paragraph in the general procedure) on how to classify in a degree of disability, the basis and the algorithm according to which the assessment commissions determine the validity period of the certificate are neither transparent nor explained to the beneficiaries of the certificate.

5.3.2. Individual Social Rehabilitation and Integration Program (PIRIS)

PIRIS is discussed at length in subchapter 6.2 of this volume. Here, it is relevant to mention that, in practice, CEPAH is involved in the elaboration of PIRIS, alone or in collaboration with SECPAH, in only 12 of the 36 counties and 4 districts of Bucharest that participated in the study. Most often, SECPAH prepares the first draft of the PIRIS, which is usually approved by CEPAH without changes.[327] In only 10 counties the PIRIS is usually prepared by CEPAH and its secretariat.

- The redundancy between CEPAH and SECPAH is not limited to the degree and type of disability, but also relates to PIRIS.

As far as PIRIS beneficiaries are concerned, in 17 counties (out of 40), all applicants receive a PIRIS attached to the disability certificate, regardless of the decision to classify or not to classify them in a particular disability degree. In the other counties (23), only the beneficiaries of a disability certificate receive PIRIS as an annex.

- Given the above mentioned practice and the fact that the rate of the solutions for non-classification in a disability degree is less than 10 percent, at national level, the share of the files with PIRIS amounts to more than 95 percent of the total files assessed in one year.
- However, for people with a permanent disability certificate (who no longer present themselves for assessment), CEPAH members confirm that over 80 percent of them have a PIRIS that has not been reviewed for more than 3 years.[328]

However, 42 percent of CEPAH[329] members believe that the current standardized format of PIRIS[330] should be revised. More importantly, however, 75 percent of the commission members indicate that PIRIS can only become a truly useful tool if it is linked also to other benefits or services than those currently in place, in order to respond to the real needs identified in the comprehensive assessment.[331] There is a need to "include recovery actions that could be monitored and depending on which the person could be assessed when they return for certificate renewal".[332] It should also "contain, where appropriate, recommendations for social integration, professional or educational orientation and psychological support." At the same time, however, all these services must be made accessible, because otherwise simply recommending non-existent or inaccessible services in PIRIS cannot add value. Only around a third of the CEPAH members consider that the revised form of PIRIS should reflect the voice of the person being assessed.

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324 The percentage of the certificates with a validity period of 1 year varies between 1.6 percent and 83.9 percent of the total certificates in 2019.

325 The share of the certificates with a validity period of 2 years takes values between 0 percent and 71.7 percent of the total certificates in 2019.

326 According to the data reported by CEPAH presidents in the Q3A questionnaire.

327 This is the situation in 30 of the 40 SECPAH/CEPAHs studied. In the opinion survey Q3B, 82 percent of CEPAH members (with valid answers) reported that the SECPAH projects of PIRIS were accepted in their original form. In the other cases, the main reason for modifying the SECPAH`s drafts of PIRIS relates to incomplete plans and/or plans that do not reflect the applicant's situation.

328 A share of 87 percent of the respondents confirmed this statement. Opinion survey Q3B: Practices and experiences of CEPAH members (N=45), from 15 counties and 1 district of Bucharest, January-February 2021.

329 Opinion survey Q3B: Practices and experiences of CEPAH members (N=43), from 24 counties and 2 districts of Bucharest, January-February 2021.

330 GD no. 430/2008, Annex 2.

331 For example, the wheelchair for which the person has to make a new application and a new file to be submitted to CNAS. Or the national health programs.

332 The quotes in this paragraph come from the Q3B questionnaires.

5.3.3. Professional Orientation Certificate

The total number of the professional orientation certificates issued in 2019 and 2020 reported by CEPAH presidents in the institutional survey Q3A, was particularly low. Out of 24 commissions participating in the survey, only the CEPAHs in two counties (SB and BR) and one sector in Bucharest (sector 5) reported numbers less than 5 certificates issued per year, while commissions in 16 counties reported that they did not issue professional orientation certificates, and 5 CEPAHs did not respond.[333] Thus, an extremely small number of people with disabilities have benefited in recent years from vocational assessment leading to a professional orientation certificate.

On the one hand, this is the result of the regulation according to which CEPAH issues a professional orientation certificate only at the request of the person with disabilities, based on an application which he/she submits to the town hall of the domicile/residence locality or to the DGASPC registry office.[334] On the other hand, CEPAHs presidents state that the number of professional orientation certificates is so low either because SECPAHs do not carry out the vocational assessment, or because the person`s interest in vocational guidance (or other labor market services) is not a subject of systematic analysis for specialists (but is considered proven only by an express request submitted to the town hall).

The low participation of people with disabilities in the labor market is also reflected in a low number of certificates issued for the application of the provisions of Art. 58 or 59 of Law no. 263/2010 on the public pension system. People with disabilities who have contributed to a pension throughout their lives are entitled to a reduction in the standard retirement age and full contribution periods. In 2019 and 2020, about half of the sample (of 24) CEPAHs issued disability certificates allowing applicants to benefit from the mentioned rights. The number of these certificates is increasing and the CEPAHs granting them mention difficulties in issuing them,[335] mainly related to the lack of documents proving the date of the onset of the disease. However, only 3 CEPAHs have developed a specific procedure for issuing these certificates.

5.3.4. Granting Protective Measures

Most counties report low numbers of cases, less than 1 percent of total cases assessed per year, in which CEPAH provides protective measures, such as admission to residential care centers, referral to public/private day care centers, placement with a professional personal assistant or home care services. Recommendations for the necessary protective measures for the person are made by SECPAH/CEPAH within PIRIS. However, in order to be admitted to a public residential or day care center, the person with disabilities or his/her legal representative must submit an application to this effect, to the town hall where he/she is domiciled or resides.[336]

As a rule, social assistance in residential care centers is decided by the assessment commissions in the case of persons with disabilities who cannot be provided with adequate care at home, either for social reasons such as homelessness, lack of family, poor financial situation, or because they need specialized services that are not available in the community. Most of the CEPAHs presidents consider that the documents available on file allow a solid argument that treatment and the socio-medical care can be carried out at the person`s home or admission in a residential center is necessary.[337] In addition, most commissions (16 out of 21) ask for a report/certificate/proving document from the municipality showing the service situation at local level and the steps taken to keep the person in the family/community.[338]

333 In the case of one county (SJ), CEPAH did not respond, but SECPAH reported professional orientation certificates for about 15 percent of total files in both 2019 and 2020.

334 Only one county (BC) stated that they issue the professional orientation certificate also without an express request made by the person concerned, based on the vocational and occupational skills assessment carried out by SECPAH (as part of the comprehensive assessment) and the interest expressed by the person concerned during the interview/interaction with SECPAH.

335 In 2019, 12 CEPAHs reported that they issued such certificates, between 1 and 30 per county/per year. In 2020, 15 counties provided data, reporting between 5 and 63 certificates per county/per year. The other CEPAHs studied either did not issue such certificates or do not have data on their number. Institutional study Q3A: Factual data and indicators on the activity of the Commission for Assessing Adults with Disabilities (CEPAH) in 22 counties and 2 districts of Bucharest, January-February 2021.

336 GD no. 430/2008, Art. 17, para. (1) However, in most counties (13 out of 19 that answered the question) it is possible for a person coming for assessment for a new certificate to apply for admission to public residential or day care centers at the same time.

337 In the institutional survey Q3A, 18 of the 23 CEPAH presidents who responded to the question expressed this opinion.

338 In the institutional survey Q3A, 21 CEPAH presidents answered the question, 16 of whom stated that they require concrete evidence that there have been attempts to keep the person in the family/community that have failed and admission in a residential center is the last solution proposed.

Social assistance in day care centers is aimed at providing direct recovery, socialization or various therapies. Most of the time, SECPAH/CEPAH only makes a recommendation for day care centers and not an actual referral to such services. However, because these services are insufficient, and the existing ones are overcrowded, the number of recommendations to day care centers is very low in relation to the needs of the people with disabilities, less than 50 per year in most counties.

- With regard to the admission of persons with certificates valid for 1-2 years, only 6 commissions have developed a specific procedure. Therefore, the decision on this matter is usually taken "on a case-by-case basis", "where appropriate", "depending on the needs".[339]

Half of the counties surveyed report that there is a waiting list of those who have submitted an application/file for admission to public residential or day care centers. As of December 31, 2020, there were between 3 and 141 people on the waiting lists. A third of CEPAH presidents say that there are cases where the applications for admission to public residential or day care centers have not been approved due to a lack of available places at county level. The number of applications rejected due to lack of places ranged from 5 to 113 per county in 2020 (with no increase in the context of the COVID-19 pandemic).

5.4. The need for reform of the disability assessment and determination system in Romania

In conclusion, a real paradigm shift in disability assessment is needed. In the opinion of CEPAH members (in Q3B), the need for reform is at a level of 7.4, on a scale of 1-none to 10-total.[340] The objective of the reform should be a scientifically robust disability assessment that, at the same time, accurately identifies the needs of people with disabilities. One possible solution would be to introduce ICF-based criteria for adults with disabilities in Romania, not just for children and young people. This is the view shared by almost 75 percent of the members of the assessment commissions, as expressed in the opinion survey Q3B. The other 25 percent either say they don`t know what ICF is, [341] or explain that any reform is almost impossible under the current conditions - high caseloads and insufficient staff at both SECPAH and CEPAH.

The main changes needed, mentioned more frequently, include:

1. Adoption of new criteria for disability degree classification, allowing a holistic approach to the individual, based on an integrated model that also takes into account the consequences of impairments in terms of functionality, activity limitations and participation restrictions;
2. Development of procedures, tools and methodologies to ensure a uniform approach at national level. But they should, on the one hand, take into account the current state of affairs and, on the other hand, incorporate the views of all stakeholders and not only those of specialists (patients` associations, associations of people with disabilities, service providers, etc.);
3. Ensuring sufficient staff members who, however, to be selected based on clear and transparent conditions, both at the level of the assessment services and the commissions;
4. Staff training in ICF, but taking into account the belief shared by many specialists that only medical criteria can be measured rigorously;
5. Increasing benefits and developing services for people with disabilities, so that it becomes possible to develop individual intervention plans in line with people`s needs. These plans should, however, include actions on recovery that can be monitored and depending on which the person is assessed when they return for certificate renewal;
6. Information, education, communication activities for the general population and the decision-makers to change the widespread belief that illness is handicap/deficiency, that handicap/deficiency is disability and that the disability certificate is a compensation for certain medical conditions.

339 Quotes from Q3A questionnaires completed by CEPAH presidents.

340 In the opinion survey Q3B, 80 percent of CEPAH members answered this question. Standard deviation of 2.1.

341 Section 9.3.2. shows that training on ICF is extremely limited at all levels, SPAS, SECPAH and CEPAH. Among the members of the commissions, out of 120 members, only 8 (out of 8 counties) have ever participated in ICF training.

Conclusions of Chapter 5

Unlike most countries, Romania has separate processes for assessing disability and determining disability. The assessment is carried out by SECPAH, while the final decision on the classification (determination) of the disability degree is made by CEPAH.

1

Romania implements a multidisciplinary procedure for disability classification. At the legislative level, the classification procedure (determination of disability) was developed on the premise that disability is a multidimensional phenomenon and a result of both social and medical factors. However, in practice, the classification of degree and type of disability is predominantly based on the medical model. Psychosocial criteria are taken into greater account in granting entitlement to services (vocational orientation, personal assistant, protective measures), but not in determining the degree and type of disability. Most specialists in the assessment commissions believe it is necessary to reform the disability assessment system in Romania; a viable solution would include the adoption of new criteria that allow for a holistic approach that is based on an integrated model that also takes into account the consequences that impairments generate in terms of functionality, activity limitations, and participation restrictions; i.e., on the ICF model. But in order to implement such a reform, members of the assessment commissions stress that sufficient staff must be ensured and selected based on clear and transparent conditions and trained in the use of the ICF, both at SECPAH and CEPAH level.

2

Typically, the assessment commissions review a significant number of files that vary considerably from county to county and year to year.[342] Given the large volume of files, the decision on classification by degree and type of disability is taken too quickly to be thorough. The classification is based on document analysis, and CEPAH members rarely see applicants. The average length of the commissions' decision-making process for each case is so short—about 5 minutes—that it precludes proper deliberation and evidence-based decision-making.

3

Consequently, the CEPAH decision is essentially the same as the SECPAH recommendations based on the comprehensive assessment. Redundancy refers not only to the classification/non-classification of disability degree, but also to the PIRIS, which recommends the activities and services that the adult with disabilities needs in the social integration process. The role and responsibilities of CEPAH in relation to SECPAH regarding the disability classification process should be clarified and standardized at county level. A general review of the role and responsibilities of CEPAH and SECPAH is needed, taking into account the need for assessment and classification to be carried out by a single institutional structure and, as far as possible, using standardized tools and procedures, at the level of all Romanian counties. The review should aim to add value to CEPAH and avoid overlap or redundancy with SECPAH. Improving working procedures and tools will enhance the performance of the system.

342 For example, in 2019, before the pandemic, the maximum number of cases examined by a commission was 12,807, which means an average of 1,067 cases per month, while the minimum number was 2,700 cases, with a monthly average of 225 cases. During the pandemic, the number of cases fell drastically. Across the sample of 23 CEPAHs, the average number of files per county decreased from 2019 to 2020 from over 6,100 to 4,800 files per year.

4

In Romania, unlike other countries, the degree of disability is obtained by over 90 percent of applicants. In other words, in general, to obtain the certificate, it is enough to have a relevant medical condition (which is included in the medico-psychosocial criteria) and to submit an application. However, the high rate of disability degree granting is accompanied by a considerable number of appeals, so many that it has been necessary to change the institutional arrangement for appealing the certificate.[343] The two facts seem to be conflicting: if the applicants are successful (obtaining disability degree classification), why are so many dissatisfied? Because dissatisfaction does not only refer to obtaining non-classification, but especially to obtaining a degree of disability perceived as unsatisfactory in relation to the person's needs and limitations. Therefore, the process of determining disability, as currently carried out in Romania (mainly based on the medical model), produces dissatisfaction, frustration, and perceptions of inequity, although it results in a more than 90 percent approval rate of granting disability benefits.

5

In accordance with the regulations in force, the assessment commissions, in addition to granting the certificate, have the obligation to develop PIRIS in collaboration with the person with disabilities or his/her legal representative, to grant the Professional Orientation Certificate (upon request), to establish granting the right to a personal assistant to the persons with a severe deficiency and deciding on whether to take a protective measure (including admission in a residential or day care center). In this regard, CEPAH members point out that PIRIS should be reviewed and linked to other benefits or services than those currently in place, in order to meet the actual needs identified in the comprehensive assessment. Half of the counties surveyed report that there is a waiting list of those who have submitted an application/file for admission to public residential or day care centers. Also, a third of CEPAH presidents say that there are cases where applications for admission to public residential or day care centers have not been approved due to a lack of available places at county level. Therefore, developing services for people with disabilities and increasing access to existing services is a priority.

6

In practice, CEPAH's decision-making process is not participatory; interaction with the applicants is very limited or nonexistent, and does not incorporate a feedback mechanism, which violates the principle "nothing for us, without us." More generally, in Romania, the whole disability assessment system lacks a grievance redress mechanism that complements (but does not replace) the formal legal channels for handling grievances, such as the judicial system or the organizational audit mechanism.[344]

7

The decision-making process within CEPAH is not transparent. The absence of guidance procedures or rules is accompanied by a lack of substantiation of the decisions regarding classification/non-classification or degree of disability. The inclusion of a legal adviser in the membership of the SECPAH/CEPAH could bring value in the transparency of the decision-making process for disability degree classification. However, the presence of a legal adviser within SECPAH/CEPAH would only partially resolve the transparency of the decision-making process. To minimize the interference (political or otherwise) in the assessment and decision-making process, the scientific and professional autonomy of the structures responsible for assessment should be ensured. One model that could be considered

343 This topic is covered in detail in Chapter 7.

344 Also see Chapter 7.

is that of the invalidity system. And, ideally, a single system could be created based on the invalidity model, covering both invalidity and disability. Doing so could help reduce the system's significant fragmentation.

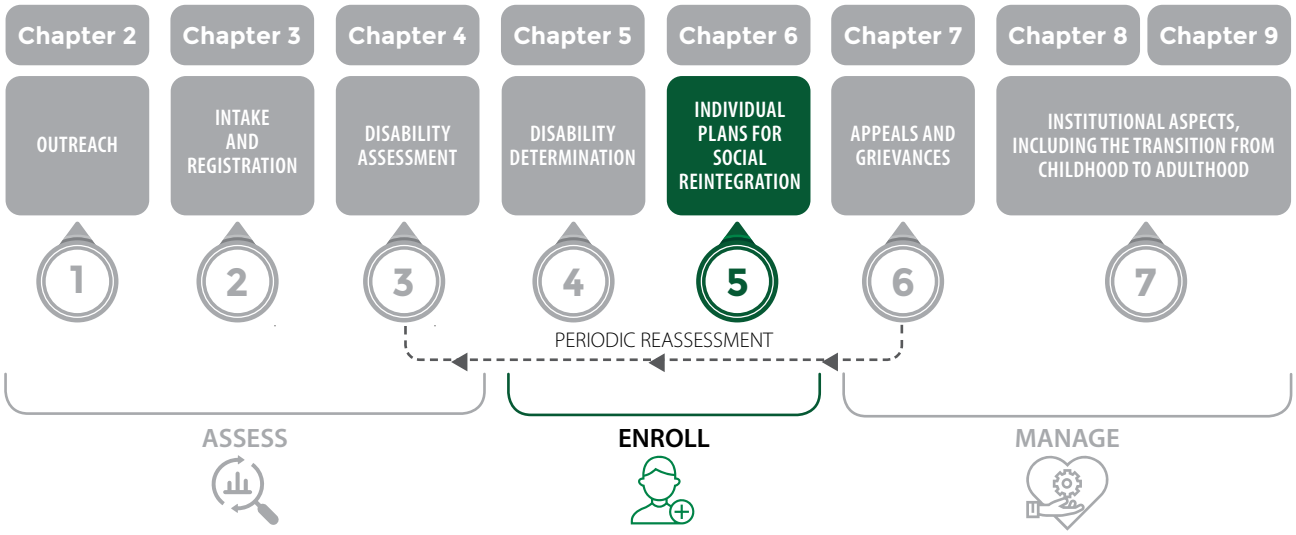
Despite all the pressure of overwork, under the assumed responsibility of making decisions that affect the lives of people with disabilities, in the perception of commission members, the decision-making process is smooth and efficient, situations of disagreement between commission members are reportedly rare, and errors of exclusion or inclusion are reported to represent only isolated cases.

8

The working practices of the assessment commissions differ considerably between counties in all steps of the process, from the working meetings, to who determines which files enter a meeting (and how), to the management of and access to the files during the process, to the determination of the certificate's validity period. What all the county commissions have in common is that the procedure for classifying a person in a disability degree and type does not benefit from any adaptations for vulnerable groups.

A new working procedure for CEPAH and SECPAH based on the ICF principles is urgently needed. Rethinking and implementing such a procedure will provide an opportunity to introduce a more relevant, scientifically robust working tool and a new approach to the disability determination process. The new procedure should be developed via coordination between specialists, social workers, international ICF experts, policy makers, and disability activists. Doing so will provide a unique opportunity to redesign and introduce a modern functional approach to effective disability determination.

6. Identifying the need for services



This chapter focuses on how disability assessment is linked to the social protection system for people with disabilities. Identifying persons with disabilities' needs for services is core phase 5 within the delivery chain. In Romania, the Individual Rehabilitation and Social Integration Program (PIRIS) and the Individual Service Plan (PIS) are the instruments used for this aim. The following sections examine how the individualized plans are filled in, and how the proposed measures are implemented and monitored. From a person-centered approach, the analysis combines institutional data with persons with disabilities' feedback and their experiences in accessing social benefits and social services.

345 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.

6.1. Identifying the need for services: An overview

After finalizing the disability assessment based on the medico-psychosocial criteria,[346] SECPAH drafts the comprehensive assessment report, which includes results and recommendations of the main assessment in three areas: classification or non-classification into a degree of disability, vocational orientation, and protection measures (see Flowchart 5). The PIRIS includes the services/actions that SECPAH recommends for the applicant. Afterward, the applicant's file, along with the comprehensive assessment report and PIRIS, is transmitted to the CEPAH secretariat. CEPAH takes the final decision on (i) classification or non-classification into a degree of disability; (ii) vocational orientation certificate, on request; and (iii) services/actions recommended in PIRIS, including protection measures such as granting a personal assistant or admission into an institution or day care center.[347] The CEPAH secretariat notifies the person of the results and mails the approved documents. In the next step, a case manager elaborates the PIS, based on PIRIS. Subsequently, SECPAH endorses PIS,[348] and the case manager coordinates and monitors the implementation of PIS and reviews the beneficiary's progress.[349]

Flowchart 5: Identifying the persons with disabilities' needs for services and links with the other core phases: An overview

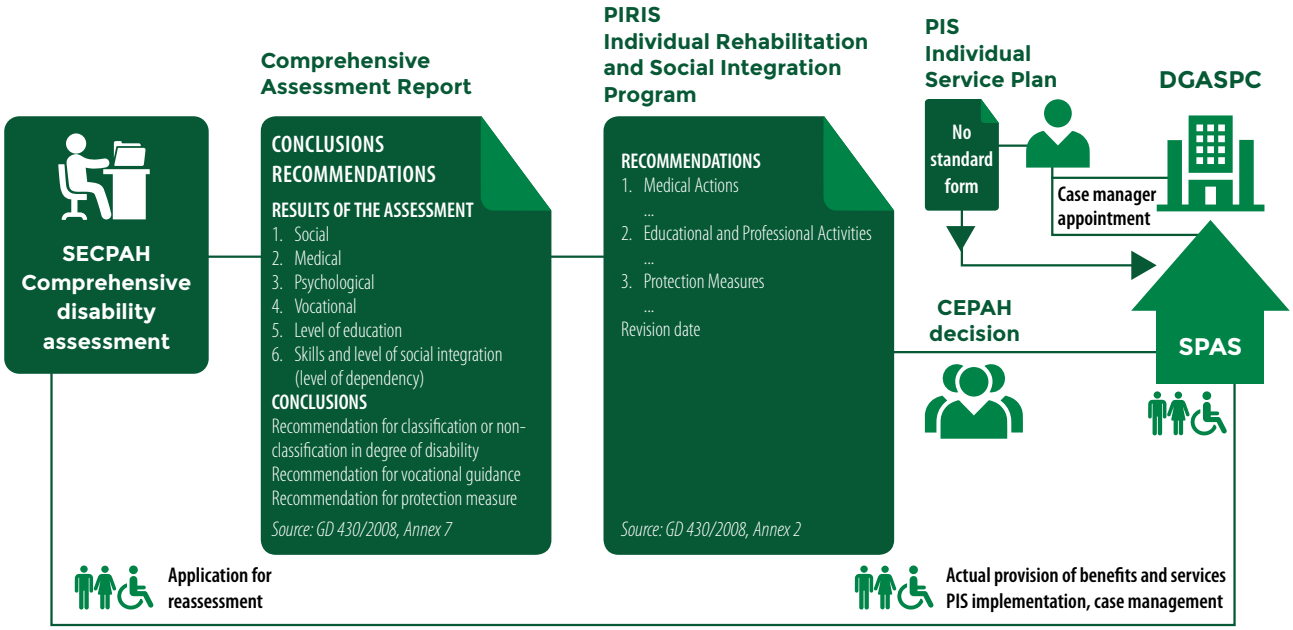


Figure 37 shows how the number of persons evolves across the delivery chain, from disability assessment to identifying needs for services, in 10 selected counties in November 2020. Thus, from almost 4,500 applicants for whom SECPAH writes a comprehensive assessment report, the number decreases to 4,392 beneficiaries of a disability certificate decided by CEPAH, to less than 3,600 beneficiaries of PIRIS,[350] 1,200 beneficiaries of PIS, and only a few beneficiaries of vocational orientation certificates or protection measures (according to regulations, those are released only upon request).

346 See more details in Chapter 4. GD no. 268/2007, Art. 48.

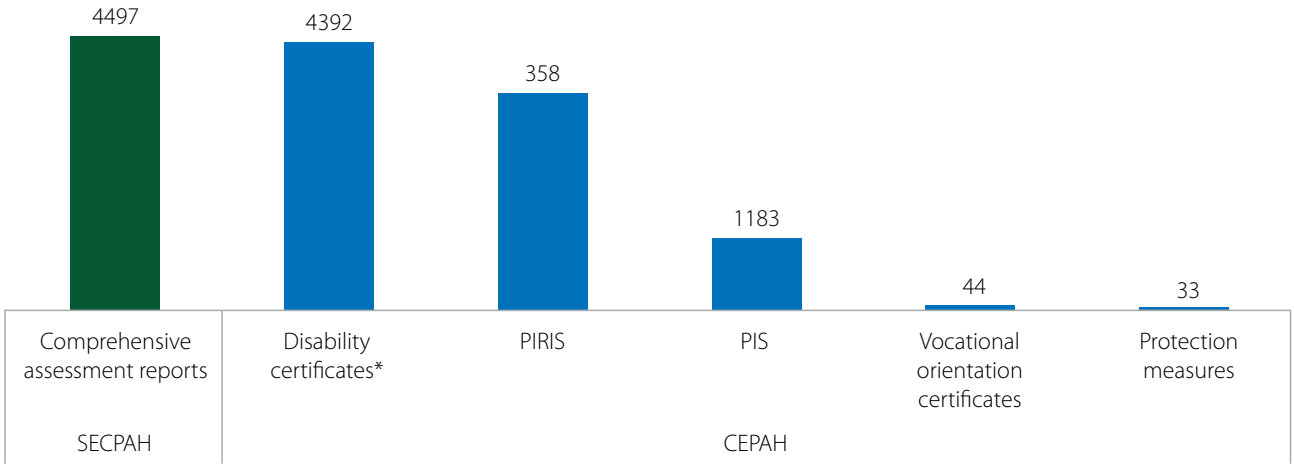
347 GD no. 430/2008, Art. 2.

348 Order no. 2298/2012, Art. 5(d).

349 Law no. 448/2006, Art. 5(23).

350 According to the legislation, PIRIS is issued together with the certificate. However, there are situations in which the PIRIS can be revised without the issuance of a new certificate, as well as situations in which a new certificate can be issued without the PIRIS (in cases where issuance of the certificate is required for the application of Art. 58 or 59 of Law no. 263/2010 when the person, who already has a permanent certificate, no longer goes through the comprehensive assessment stages).

Figure 37: Statistics from core phase 3, disability assessment, to core phase 5, identifying the needs for services, November 2020 (number of applicants/beneficiaries)



Source: Data for November 2020 regarding 10 counties that reported the necessary data in (i) Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH); and (ii) Institutional survey Q3C: Result indicators of the disability determination process for the CEPAH Secretariat, January-February 2021.

Note: *Disability certificates are issued both in cases of classification and non-classification into a degree of disability. For non-classification, the certificate should list the reasons.

In Romania, the needs assessment is performed by SECPAH, according to Art. 23 of GD no. 268/2007, but it is not done with adequate evaluation tools or according to a specific methodology.[351] The only instruments that include conclusions on needs for services are the PIRIS and the PIS. The following sections detail the levels and aspects of implementation and present the various operating models developed at the county level for identifying needs for services.

6.2. The Individual Rehabilitation and Social Integration Program (PIRIS)

The PIRIS is the "document developed by the CEPAH, which specifies the activities and services that the adult with disabilities needs in the process of social integration."[352] Under the current regulations, SECPAH makes the recommendations included in PIRIS, based on the conclusions and recommendations of the comprehensive assessment report,[353] while CEPAH should draw up PIRIS in collaboration with the person with disabilities or their legal representative.[354]

The dominant practice is that the SECPAH team drafts the PIRIS, with specialists filling in the chapter related to their respective specialization (in 25 out of 40 studied counties). In other counties, one single SECPAH specialist, to whom the file has been assigned, fills in all chapters (in 3 counties), while in others, CEPAH or its secretariat drafts the PIRIS, and the SECPAH is not involved (5 counties). Finally, there are also seven counties in which the PIRIS is done by SECPAH or CEPAH, with no specific pattern. However, according to the SECPAH chiefs and CEPAH presidents, in 30 of the 40 studied counties, SECPAH prepares the first draft of PIRIS, which is usually approved by CEPAH with no changes.[355] In the other 10 counties, PIRIS is most often prepared by CEPAH and its secretariat.

351 Art. 23 of GD no. 268/2007: „The individual needs of the person with disabilities shall be assessed within the complex assessment service of the general directorates of social assistance and child protection of the counties and local districts of Bucharest, respectively, and shall be specified in the individual service plan".

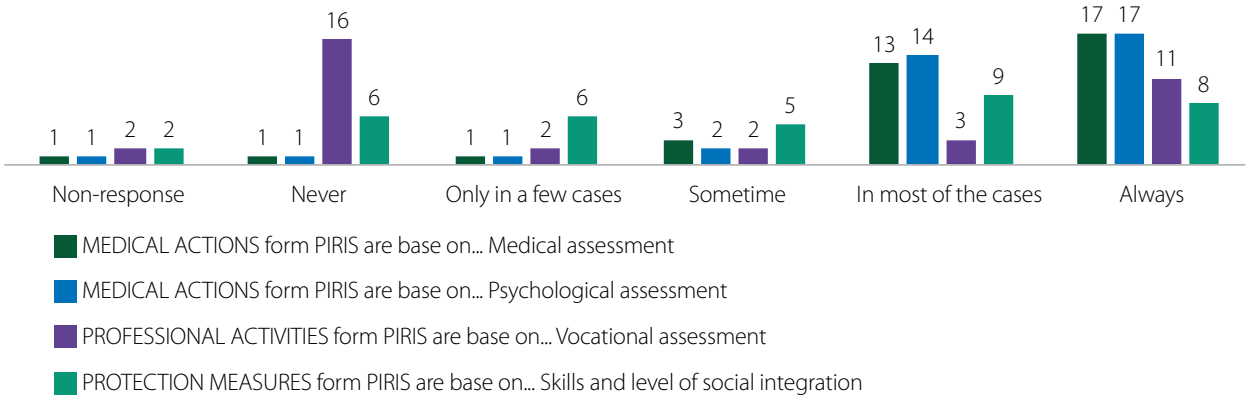
352 Law no. 448/2006, Art. 5(25).

353 GD no. 268/2007, Art. 50(c).

354 Law no. 448/2006, Art. 89(1)(2).

355 In the opinion survey Q3B, 82 percent of CEPAH members (with valid responses) reported that the SECPAH drafts of PIRIS had been accepted in their initial form. In the other cases, the main reason to change the SECPAH drafts of PIRIS involved incomplete plans that do not reflect the applicant's situation.

Figure 38: Link between PIRIS and the comprehensive assessment report: Factual data (number)



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January-February 2021. Note: Sum of bars per category is 36.

In elaborating and deciding on PIRIS, neither SECPAH nor CEPAH have a team member (with a certain specialization) who contributes more than the others. Also, there is neither an assessment area nor a category of criteria that weighs more than the others.[356] GD no. 430/2008 regulates the comprehensive assessment report and PIRIS, and provides standardized templates of these instruments (see Flowchart 5). By design, they are correlated, SECPAH's comprehensive assessment report representing input for PIRIS. Regardless of the author (SECPAH or CEPAH), PIRIS is based on the national standardized template in nearly all counties.[357]

However, Figure 38 shows that the link between the conclusions of the comprehensive assessment report and the recommendations included in PIRIS is weaker than the legal provisions designed for. Because SECPAH does not provide a full-fledged assessment, the services and actions included in PIRIS adequately reflect the results of the medical and psychological assessments and less often the vocational, educational, and skills/social integration assessment. In the opinion survey Q3B, CEPAH members provide similar information, as shown in Figure 39. Thus, CEPAH members are rather critical and consider the correlation between PIRIS and the needs expressed by applicants to mark only a 6, on average, on a scale of 1 to 10. Nonetheless, in the SECPAH practitioners' perception, the services and activities recommended in PIRIS satisfactorily meet the needs both identified by the assessment and expressed by the applicant.[358]

Regarding PIRIS beneficiaries, the counties split into two groups. In 17 (of 40) counties, all applicants receive PIRIS annexed to the disability certificate at the end of the process, irrespective of the decision to classify/not classify into a degree of disability. In the other (23) counties, only the beneficiaries of a certificate with classification into a degree of disability receive as annex the PIRIS (those not classified into a degree of disability receive the certificate but not the PIRIS). However, the PIRIS is revised once the certificate is reassessed. Once a person obtains a permanent certificate, the PIRIS is no longer updated. Therefore, for a considerable number of persons with disabilities, PIRIS is largely irrelevant. In the opinion survey, CEPAH members confirm that over 80 percent of the individuals with a permanent disability certificate have a PIRIS that has not been reviewed in over three years.[359]

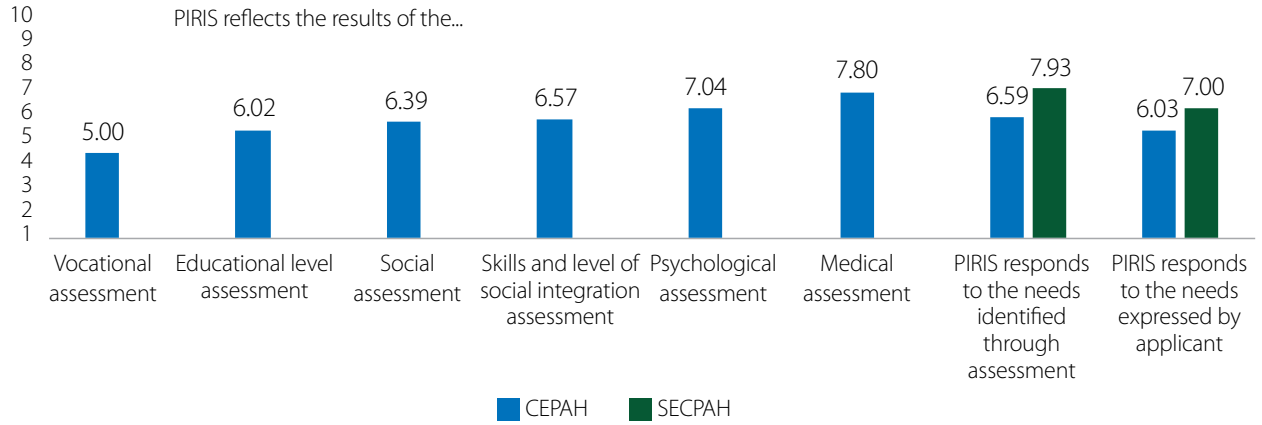
356 Consolidated data from the institutional surveys Q2A and Q3A for 35 counties and 5 districts of Bucharest.

357 GD no. 430/2008, Annex 2. Five counties did not answer.

358 In the opinion survey, they assessed both aspects with average scores of 7–8 (Figure 39), on a scale of 1 to 10, and standard deviation values less than 2. Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=181), January-February 2021.

359 Eighty-seven percent of respondents confirmed this statement. Opinion survey Q3B: Practices and experiences of the CEPAH members (N=45), from 15 counties and 1 district of Bucharest, January–February 2021.

Figure 39: Link between PIRIS and the comprehensive assessment report: Opinions (average values on a scale of 1–10)



Sources: (i) Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=181), from 36 counties and 4 districts of Bucharest, January-February 2021; (ii) Opinion survey Q3B: Practices and experiences of the members of evaluation commissions for the classification in degree and type of disability for adult persons (CEPAH, N=46), from 24 counties and 2 districts of Bucharest, January-February 2021.

The total number of PIRIS follows the same trend as the number of application files assessed by SECPAH.[360] Both have considerably decreased during the COVID-19 pandemic, with significant variation across counties.[361] Overall, in the pre-COVID period (2019), at the national level, SECPAH/CEPAH used to prepare about 550 PIRIS per month, on average. The minimum number of PIRIS prepared in a county (in GR) was more than six times lower than the maximum number (in OT); from about 150 to over 970. Due to measures related to the COVID-19 pandemic,[362] the average number of PIRIS per county dropped to 415 (or by 24 percent) in November 2020. The decline was recorded in all counties but the reduction varied widely—in some counties it almost halved, while in other counties it declined by only 7 percent. At the same time, discrepancies between counties have persisted.

Notably, there are differences between data on PIRIS reported by SECPAH and CEPAH. A comparative analysis shows that differences in data do not follow a certain pattern. For 15 counties that provided all data, the aggregated gap between the two sets of data is approximately 1,000 PIRIS per month. The gap reaches over 8,000 PIRIS at the year level (2020).[363] The main cause of this inconsistency is the existence of parallel databases/records that are not cross-checked by SECPAH and CEPAH.[364] Other causes involve limited computations allowed by the existing software applications, and the mostly manual data management. As stated in a Q2A questionnaire: "Whereas many of the data could not be obtained based on the D-SMART software, being processed manually, based on other indicators at SECPAH level, there may be small errors in the data." After the research team double-checked with the SECPAH chiefs and CEPAH presidents and corrected and validated the data with them, there were still 13 counties (out of 15 counties with completed Q2A and Q3A questionnaires) that recorded discrepancies.

Drawing up the PIRIS is not a participatory process, as foreseen in the legislation.[365] Most of the surveyed counties report that SECPAH collects a person's opinion (feedback) about the services and

360 See also Chapter 4 and Section 9.2.1.

361 The estimates included in this paragraph are based on the data from 15 counties that reported the necessary data in (i) Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH); and (ii) Institutional survey Q3A: Facts and indicators regarding the activity of evaluation commissions for the classification in degree and type of disability for adult persons (CEPAH), January–February 2021.

362 Law no. 55/2020, Art. 4(5).

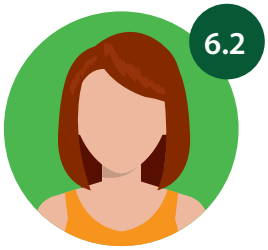
363 A small part of this difference comes from the fact that CEPAH (unlike SECPAH) issues PIRIS on request. However, such situations were reported (in the Q3A survey) only in three counties and only for 2020.

364 See also Sections 9.2.4 and 9.3.5 on data management and information system.

365 Law no. 448/2006, Art. 89(1)(2).

actions contained in the PIRIS, and CEPAH (and its secretariat) adjusts the PIRIS accordingly. However, no studied county has developed a work procedure regarding PIRIS or, for example, for situations in which an applicant does not agree with his/her representative regarding a specific service or action included in PIRIS. In only 8 (out of 40) counties, SECPAH and CEPAH report that they first draft a version of PIRIS, which is then discussed with the applicants and their representatives, amended, and adapted to the specific needs of the person. The general practice (in 29 counties) is that specialists (SECPAH or CEPAH) elaborate a single draft of PIRIS, and the persons' involvement is limited to being informed thereof and receiving it with the disability certificate. Furthermore, there are also three counties in which the applicants' feedback is neither collected nor incorporated into PIRIS. The interviewed persons with disabilities told the same story; most did not even know what PIRIS is. They identified it only after the researcher informed them. Nobody has ever asked their opinion or explained to them why it is useful.

"I wanted to restore the degree to make an application and to re-analyze Alexandra's certificate from the perspective of the degree and from the perspective of the recovery program. That must exist there, even if it is a paper without any meaning. I wanted to do this … When the social worker came I insisted on writing her need for occupational therapy. They seem to be told not to write. Eventually, when I went a second time, I saw that the exact things I had asked her to write for the evaluation were missing. I told her, madam, my daughter needs occupational therapy. She told me that they don't have occupational therapy … But when you do an assessment and ask me my needs, please write there that she needs occupational therapy. You can't write me that we don't have it, but I don't care that you don't have it, you don't have it, that's your story. My story is to make a correct recording and for this reason, I wanted to redo so that in the certificate in the personalized intervention plan or as it is also called … there is introduced the need of my child for occupational therapy." (Interview with NGO representative, Bucharest)



"In the rehabilitation plans, I was only told to avoid conflict situations, I was not recommended to certain resorts. I would have liked that. What happens? Other psychiatrists tell me that my mental illness does not recommend going to the mountains—the alpine area, but pre-alpine area - up to 600-700 meters altitude. Here in PIRIS he doesn't write something like that and he should have written it. He should also have written which resorts are indicated for mental illness: resorts and treatment. … PIS and PIRIS are stapled to the certificate. On one of them it says just that: to avoid conflict situations, I am recommended psychotherapy sessions. I do not agree with them. only if the psychologist is very good and only if the sessions seem intelligent to me. I don't know how to say and it is also recommended to follow the drug treatment. And that's what I do anyway. That's all he tells me." (Interview with person with disabilities, woman)

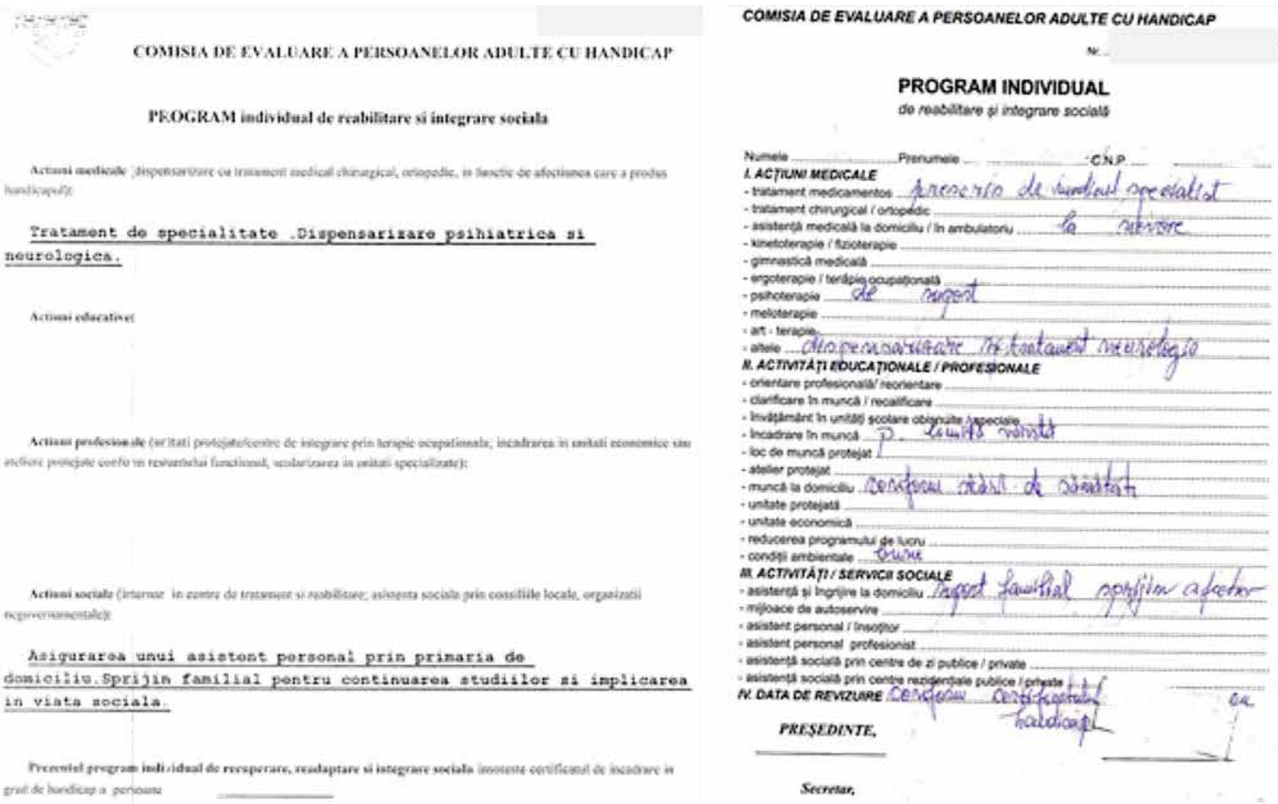
"- When you received the certificate of disability, it had other documents attached. Somehow PIRIS? Maybe PIS?

- I can't tell you. Wait a minute to see what I received in the mail. I'll tell you right away. So, by mail I received an address informing me that I have been evaluated and that I can go. what is the program with the public and that the monetary rights are carried out ex officio, according to the degree in which I was classified. Followed by the certificate itself, followed by the appendix to the certificate of classification. which are three lines and appendix two to the certificate of classification. Ah, that's it, I found it. There is also the Rehabilitation and Social Integration Program. a paper in which he writes: drug treatment, professional educational activities and social services activities. This is all." (Interview with person with disabilities, men, 45 years old)

The current PIRIS template focuses solely on needs and does not mention the person's resources, the way he/she wants to live, or plans for the future. Therefore, PIRIS, as they are now, are weakly linked to the assessment conclusions and do not represent anything in terms of an intervention plan. As part of the institutional survey Q3A, CEPAH from eight counties sent the package of documents approved for the last three individuals assessed in the most recent CEPAH meeting. The analysis of this sample shows that they are barely filled in. Two examples of more complete PIRIS are found in Figure 40. Others are empty and do not even mention the revision date, or have a single word, such as "oncology." The interviewed persons with disabilities provided some additional PIRIS specimens that are like those included in the sample. The completed ones include mainly general recommendations such as specialized medical treatment or medication "as prescribed by the doctor," family support, or work "according to the health condition," while the sections on education and professional activities are most often empty.

Therefore, about a third of the SECPAH and CEPAH specialists who participated in the opinion surveys think that "developing PIRIS, which is now a purposeless piece of paper, is a must."[366] However, changing the template would not make PIRIS more effective so long as the service package connected to disability assessment is not extended, services are not more readily available (especially in rural areas), and a mechanism to monitor PIRIS/PIS implementation is not put in place.

Figure 40: Two examples of PIRIS


COMISIA DE EVALUARE A PERSOANELOR ADULTE CU HANDICAP

PROGRAM individual de reabilitare si integrare sociala

Actiuni medicale

Tratament de specialitate .Dispensarizare psihiatrica si neurologica.

Actiuni educative:

Actiuni profesionale

Actiuni sociale

Asigurarea unui asistent personal prin primaria de domiciliu.Sprijin familial pentru continuarea studiilor si implicarea in viata sociala.

Prezentul program individual de recuperare, readaptare si integrare sociala

COMISIA DE EVALUARE A PERSOANELOR ADULTE CU HANDICAP

Nr.

PROGRAM INDIVIDUAL
de reabilitare și integrare socială

Numele ... Prenumele ... C.N.P. ...

I. ACȚIUNI MEDICALE
- tratament medicamentos
- tratament chirurgical / ortopedic
- asistență medicală la domiciliu / în ambulatoriu
- kinetoterapie / fizioterapie
- gimnastică medicală
- ergoterapie / terapie ocupațională
- psihoterapie
- meloterapie
- art - terapie
- altele

II. ACTIVITĂȚI EDUCAȚIONALE / PROFESIONALE
- orientare profesională/ reorientare
- clarificare în muncă / recalificare
- învățământ în unități școlare obișnuite / speciale
- încadrare în muncă
- loc de muncă protejat
- atelier protejat
- muncă la domiciliu
- unitate protejată
- unitate economică
- reducerea programului de lucru
- condiții ambientale

III. ACTIVITĂȚI / SERVICII SOCIALE
- asistență și îngrijire la domiciliu
- mijloace de autoservire
- asistent personal / însoțitor
- asistent personal profesionist
- asistență socială prin centre de zi publice / private
- asistență socială prin centre rezidențiale publice / private

IV. DATA DE REVIZUIRE

PREȘEDINTE,

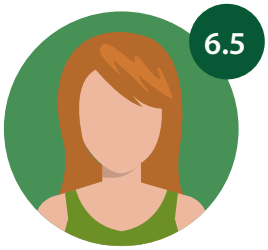
Secretar,

Source: Models extracted from the sample of PIRIS attached to Q3A questionnaires.

366 Focus group SECPAH 3; about 30 percent did not answer the question and 37 percent believe that PIRIS should not be changed.

"We consider these PIRIS to be bureaucratic work, in addition. The indications in the plan are observed only in 1 percent of cases. In small and common towns, they have [services] nowhere to go. However, they [the applicants] are only interested in the monetary value." (Focus group CEPAH)

The existing PIRIS are of poor quality and their content is not entered into the SECPAH/CEPAH database(s). Among the 25 counties that extracted information from their databases, in connection with PIRIS, only 3 CEPAH were able to provide data about persons recommended for home care and only 7 counties about services for independent living.[367] Also, from the SECPAH reports, only between 4 and 11 counties (out of 36) could provide data (for 2019–20) regarding the number of PIRIS that included personal assistant services, public/private day care or residential centers, a cognitive stimulation program, psychotherapy, or any type of education program (formal and nonformal) to complete education for persons who dropped out of school or left early.[368] Consequently, data from PIRIS are not recorded or analyzed to identify the needs for social services at the county level. Therefore, at present, PIRIS does not represent an effective instrument either at the individual or public policy levels.



"- PIRIS is next to the disability certificate that is proposed by SECPAH. It's just an administrative act, just a paper. SECPAH to make recommendations because they know people with disabilities. It would be necessary for the evaluation for the driving license. then we record what results from the medical documents. But they only remain on paper, no one monitors them. If we have recommended something, for example, recovery. the man does not come for certain reasons, because it costs him, the distance is very long, he does not settle, or the personal assistant has a job and does not have time. On the reintegration side, it is not up to the commission, NGOs need to develop certain services. They don't even have case managers for adults.

- We have a recovery center, but those who get the degree do not come. Those up to the age of 45 want to work. The people have PIRIS and we the members of the commission sign this document, but it is up to the person whether he makes a recovery or not. There are not enough recovery centers in the county.

- It's the same in other counties, we issue another document, without any purpose, we put some more toner." (Focus group CEPAH)

367 Institutional survey Q3C: Result indicators of the disability determination process for the CEPAH Secretariat (N=25), from 23 counties and 2 districts of Bucharest, January–February 2021.

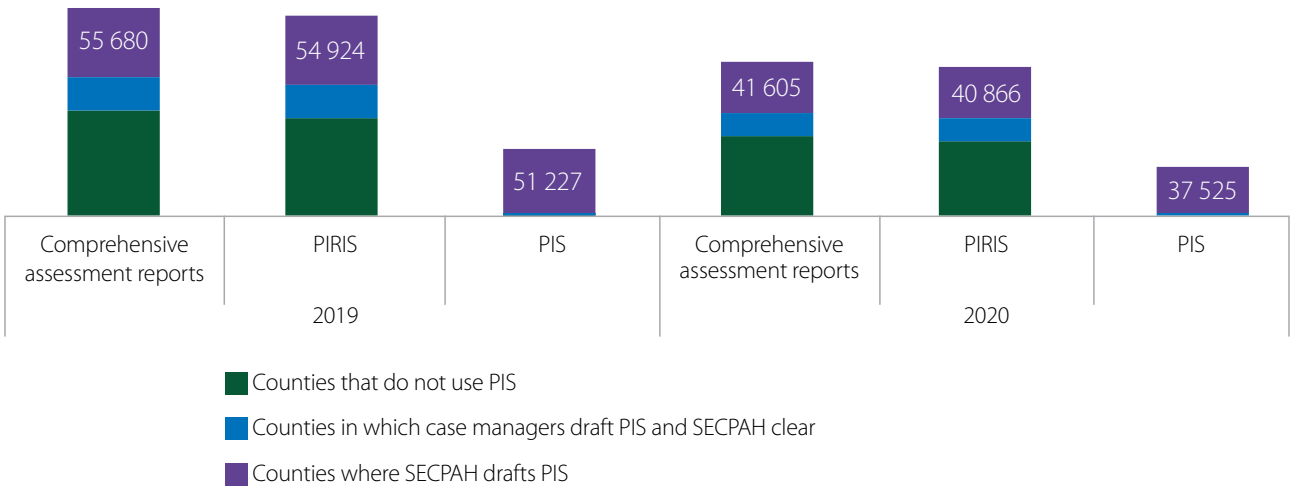
368 Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January–February 2021.

6.3. Individual Service Plan (PIS)

The PIS is "the document setting short, medium and long-term objectives, specifying ways for intervention and support for adults with disabilities, through which the activities and services specified in the PIRIS are carried out."[369] Under current regulations, for adults with disabilities, a case manager[370] draws up a PIS at-need and submits it to SECPAH for clearance, to the public service of social assistance of residence for implementation, and then to the applicant.[371] The beneficiaries of the case management method are adults with disabilities who live in the residential system and those who live with family and have an individual plan of service and other protection measures under implementation.[372] Thus, a case manager should be appointed to those who have a PIS. However, a case manager is appointed only for adults with disabilities who live with family and already have PIS under implementation. This lack of clarity in the current legal framework leaves room for different interpretations and implementation practices regarding both PIS and case management. This section focuses on how PIS is filled in and how the proposed measures/actions are implemented and monitored.

Across the country, there are three practices for drawing up a PIS for adults with disabilities. Among the 40 studied counties,[373] 21 SECPAH do not use PIS; 13 SECPAH draw up PIS at least for some categories of persons with disabilities; and 6 SECPAH only approve the PIS drawn up by case managers for beneficiaries of social services (public or private). The practice of not using PIS does not depend on the size of the population of persons with disabilities registered within the county.[374] In counties with such large populations (over 20,000 persons), the common SECPAH practice is to limit to officially clearance the PIS submitted by case managers, usually only for people who live in residential centers. In counties with fewer persons with disabilities, more often SECPAH draws up a PIS either for all beneficiaries of a certificate with classification into a degree of disability or for broad categories such as people with a marked or severe deficiencies or people with severe deficiencies and a personal assistant.

Figure 41: Total number of PIS for selected counties, by the SECPAH strategy regarding drafting PIS



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 26 counties and 3 districts of Bucharest that reported the necessary data, January-February 2021.

369 Law no. 448/2006, Art. 5(24).

370 A case manager is "the member of the multidisciplinary team that coordinates, monitors and evaluates the fulfillment of the PIS, as well as the measures taken in connection with the adult with disabilities," according to Law no. 448/2006, Art. 5(23) on the protection and promotion of the rights of persons with disabilities.

371 GD no. 268/2007, Art. 50(d); Order no. 2298/2012, Art. 5(e).

372 The appointment of a case manager is the responsibility of the public/private social service provider. Order no. 1218/2019 for the approval of the specific mandatory minimum quality standards regarding the application of the case management method in the protection of adults with disabilities, Standard 1, Minimal requirement 3.

373 Consolidated data from the institutional surveys Q2A and Q3A for 35 counties and 5 districts of Bucharest.

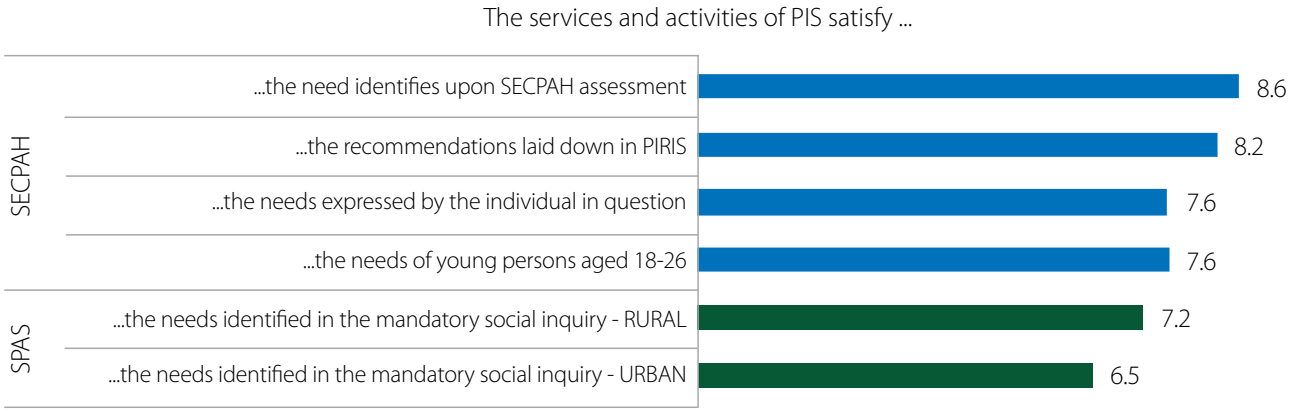
374 See Section 1.3.

PIS are not equitably used across the country. As discussed, in more than half of the country, no persons with disabilities benefit from a PIS. In contrast, in 13 counties nearly all persons with disabilities have a PIS, whereas in 6 counties only people living in institutions do. Furthermore, the revision of PIS is not regulated. According to the mandatory minimum quality standards, the case manager draws up the PIS at-need and also revises it at-need.[375] Usually, the PIS is revised once with the reassessment of the certificate and renewal of PIRIS. Once a person obtains a permanent certificate or is classified with the minor disability degree, the PIS is no longer updated. Therefore, for a considerable proportion of this population, the PIS is either missing or is obsolete.

The total number of PIS followed the same trend as the number of assessed application files by SECPAH or PIRIS (see Figure 41).[376] It has considerably decreased during the COVID-19 pandemic, with significant variation across counties. Figure 41 shows how the aggregated number of PIS evolved during 2019–20 for 26 counties and 3 districts of Bucharest, of which 14 do not use PIS, 4 have only PIS done by case managers, and 11 where SECPAH drafts PIS for the majority of people with disabilities. At the aggregated level, about a third of all assessed files have a corresponding PIS, for both 2019 and 2020. Yet around 95 percent of all PIS come from the counties where SECPAH draws up PIS, while the other 5 percent represent PIS drafted by case managers that SECPAH cleared. On average, in a county in which SECPAH draws up PIS, the average number of PIS per month decreased from 500, in November 2019, to 300, in November 2020. By contrast, in counties where case managers draft the PIS (usually for institutionalized persons with disabilities), the average number of PIS per month stayed flat, at around 50. The same is true in counties where SECPAH has not used PIS.

By design, the PIS is the instrument through which the activities and services specified in PIRIS are carried out. SECPAH practitioners think that both the links between PIS and PIRIS and between PIS and the comprehensive assessment report are satisfactory. Rather adequate, as well, is the link between PIS and the needs expressed by individuals (young or not). The SPAS representatives are more critical and think that PIS could be improved to respond more adequately to the needs identified through the mandatory social inquiry, especially for the adults with disabilities living in urban areas.

Figure 42: On a scale of 1 (not at all) to 10 (completely), to what extent do the services and activities included in PIS satisfy … (average scores)



Sources: (i) Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=139), January-February 2021; and (ii) SPAS survey with responses provided only by social workers who have ever seen a PIS/PIRIS from 33 localities (N=20 rural and 13 urban) situated in 18 counties; the districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January-February 2021.

375 The case manager must periodically reevaluate the Action Plan and, depending on the beneficiary's needs, decide to revise the PIS or other documents and make concrete proposals for completion/modification. Order no. 1218/2019, Standard 3, Minimal requirement 9.

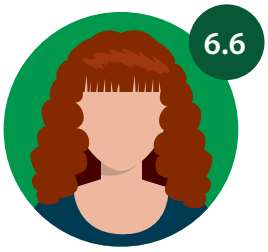
376 See also Chapter 4 and Section 9.2.1.

In 32 counties and 4 districts of Bucharest that participated in the institutional survey Q2A, only 5 SECPAH developed an approved specific working procedure for drawing up PIS. Only one SECPAH provided its specific working procedure on PIS to the research team. That refers only to the relationship between PIS and PIRIS. Specifically, in this county, the PIS approval triggers the need to draft a new PIRIS aligned with PIS. The involvement of the applicant is not mentioned.[377]

The existing PIS are just lists of general recommendations that do not even comply with the basic standards of proper information, let alone orientation or referrals to necessary services. There is no national standardized format for PIS. Only 6 SECPAH (out of the surveyed 36) developed a specific template for PIS. As part of the institutional survey Q3A, CEPAH from eight counties sent the package of documents approved for the last three individuals assessed in the most recent CEPAH meeting. The analysis of this sample shows that they are filled in randomly, with no specific elements for young people or the elderly, or any vulnerable groups. With or without a specific template, most often, the PIS is a table that replicates the structure of PIRIS. An example is provided in Annex 6.

Most often, within the existing PIS, the "short, medium and long-term objectives" imposed in legislation[378] are activities or services such as "specialized permanent care and supervision" or "socialization and free occupational therapy activities." The activities are organized in chapters, usually medical, psychological, vocational, and social services (assistance or protection), while services/activities are presented in checklists. The template specifies the period for delivering all services/activities per chapter, with answer categories such as 6 months, 12 months, or permanent. Responsible persons/institutions are not assigned for each service/activity but on chapters of activities, and range from family to specialist doctors, psychologists, councilors, and employers.

The legislation contains no express requirement on drawing up PIS based on interaction with the applicant. Like PIRIS, PIS focuses solely on needs and does not mention the person's resources, the way he/she wants to live, or environmental factors. At the same time, a few interviewed people with disabilities who received PIS mentioned that nobody explained its meaning or use.



"Yes, in that paper he recommends going to recovery. But I didn't receive a sheet with for example let me know there is that service where you can call so you can get help at home or I don't know about. I didn't receive that, and I think it would catch me good to know exactly who offers services and where and how. Or what else I would like to have. I know that after I graduated, I thought maybe to know what organizations are involved or how we are Something to Say, we are an Association of self-representatives. I would have liked to know that there are some kind of support groups or some kind of groups where you can go to do different activities, guidelines like this." (Interview with person with disabilities, woman, 33 years old)

There is no monitoring and evaluation (M&E) mechanism connected with PIS and PIRIS. In line with the legal framework, case managers are expected to coordinate, monitor, and evaluate PIS implementation for persons with disabilities. Case managers should also review the beneficiary's progress. Yet in 24 of the studied 36 counties, there is no case manager for adults with disabilities. Available data necessary for M&E are also very limited. As in the case of PIRIS, PIS is seen rather as a formality and, consequently, its content is not recorded or entered into the SECPAH/CEPAH database/software application. Out of 27 counties, only 3 could provide selected information about the services and activities included in PIS and their beneficiaries.[379] Moreover, only 4 (out of 36) surveyed SECPAH report systematically monitoring/measuring progress on implementing the services and activities recommended in PIS,

377 SECPAH general procedure, Section 7.3.2.2 on particularities of the disability assessment based on the medico-psychosocial criteria, county IS.

378 Law no. 448/2006, Art. 5(24).

379 Institutional survey Q3C: Result indicators of the disability determination process for the CEPAH secretariat (N=27), from 25 counties and 2 districts of Bucharest, January–February 2021.

but only 2 have a specific methodology to support this aim.[380] At the community level,[381] half of the surveyed SPAS report that they have ever seen a PIS/PIRIS, without difference between rural and urban SPAS. Out of these, a quarter claim to systematically monitor the implementation of services and activities in PIS/PIRIS by adults with disabilities and their caretakers. Furthermore, only three SPAS use a specific methodology for this purpose.

The legal provisions stipulate that persons with disabilities and their caretakers are obligated to fully carry out the services and activities included in PIS, but there are no consequences for failing to do so.[382] Only 2 SECPAH (out of 36) and 3 CEPAH (out of 24) declare that they have a procedure in the event that persons with disabilities and their caretakers fail to execute the PIS.[383] Besides, both the interviewed SECPAH chiefs and CEPAH presidents report that during the 2018–20 period, no case managers or SECPAH specialists were penalized for drawing up an unworkable PIS, and no persons lost their degree classification due to a failure to perform the PIS.

Even in the absence of a monitoring system or clear procedures, the interviewed NGOs and persons with disabilities provided anecdotal evidence that, at least in some counties, there were people who lost their classification or received a milder disability degree due to failure to implement (some or all) activities from PIS. The CEPAH members offered additional evidence in this sense.[384] In the opinion survey they explained that, although there is no monitoring system, they quickly check how PIS has been implemented during the certificate reassessment process. For applicants who do not bring hard evidence (documents) that show they followed the PIS/PIRIS recommendations (especially rehabilitation), some commissions indeed tend to decide shorter validity periods for the certificate or a milder degree of disability. CEPAH members think that such decisions have mainly an educational role, as "it is a way of pushing people to do what is best for them."[385] There is widespread belief among the SECPAH and CEPAH practitioners that many persons with disabilities do not rehabilitate precisely because they do not want to lose their disability benefits.

By contrast, the NGOs and persons with disabilities emphasized in interviews that PIS/PIRIS are neither specific nor related to their needs, possibilities, and preferences, and they do not benefit from proper information, orientation, referrals, or support adequate to their financial or time resources. Many explained that services are either not available, too far away, or are too expensive to afford. Actually, the SECPAH chiefs provided similar information. They reported in institutional survey Q2A that out of almost 40,000 PIS in 2020, there were only 37 with clearly specified services, including information about location, contact, types of provided services for persons with disabilities, appointment, and other concrete information.[386] Therefore, there is a weak correlation of the recommendations from PIS (and PIRIS) both with a person's specific needs and with the map of existing services in the county (which, at least theoretically, should be available and constantly updated).

380 Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January–February 2021.

381 SPAS survey with responses from 71 localities (N=43 rural and 28 urban) situated in 26 counties; the districts of Bucharest are not included since the DGASPC also plays the role of SPAS, January–February 2021.

382 According to Law no. 448/2006, the person with disabilities is required to follow the activities and services provided in PIS (Art. 59[1][e]); the person who cares for, provides supervision to, and has as dependent an adult with a disability is required to observe and/or follow the activities and services provided in PIS (Art. 60); the personal assistant, and the professional personal assistant, respectively, must perform all activities and services in PIS (Art. 38b,c and Art. 49b,c). Moreover, the personal assistance of the adult with severe disabilities must sign a commitment, as an addendum to the Individual Labor Contract, undertaking liability to implement PIS fully (Art. 38a). Similarly, for the Professional Personal Assistant (Art. 49).

383 Institutional surveys Q2A_SECPAH and Q3A_CEPAH, January–February 2021.

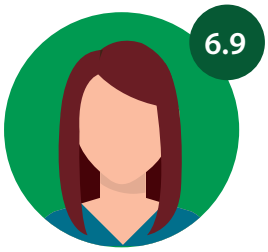
384 About half of the CEPAH members from counties that use PIS provided the type of response mentioned in the text. Opinion survey Q3B: Practices and experiences of the CEPAH members (N=40), from 16 counties and 1 district of Bucharest that use PIS, January–February 2021.

385 Quote from the comments provided by a doctor, CEPAH member, in a Q3B questionnaire.

386 Aggregated data for 32 counties and 4 districts of Bucharest that participated in the institutional survey Q2A.

"The comprehensive assessment for the classification in degree and type of disability must be central in the SECPAH activity, to offer quality instead of quantity, to make the person come out more encouraged than entering us. But if PIRIS, PIS, professional personal assistant (APP) also fall into our tasks, this will remain a desideratum. […] PIRIS and PIS or APP accreditation can be tasks distributed to the services that manage the social services and know them, monitor them, develop these services. SECPAH focuses on criteria, ICF, document interpretation, programming, evaluation at headquarters or at home, HUMAN relationship with the adult with disabilities, ensuring a professional level of evaluation. If the SECPAH task remains, we propose that at the re-evaluation, it should matter whether or not the person complied with the PIRIS recommendations; that's why the person doesn't do motor recovery, he doesn't do prosthesis because he knows that if he recovers from the body's functionality, he loses the degree of disability! What could be sadder? We want him to regain his autonomy, which means he will receive less money." (Quote from observations provided by a SECPAH chief in a Q2A questionnaire)

"PIRIS, we [CEPAH] are just signing it! We compensate the impotence of the society to offer services by giving them money! And people with disabilities are interested in money, not recovery. As long as the society has got rid of responsibilities, respectively the development of services, and only provides money, then this is the situation! Abroad, people are provided services, not money! And since some of the money goes on alcohol, then the caretakers are happy! Just a formality, these are PIRIS and PIS, do not help at all." (Focus group CEPAH)



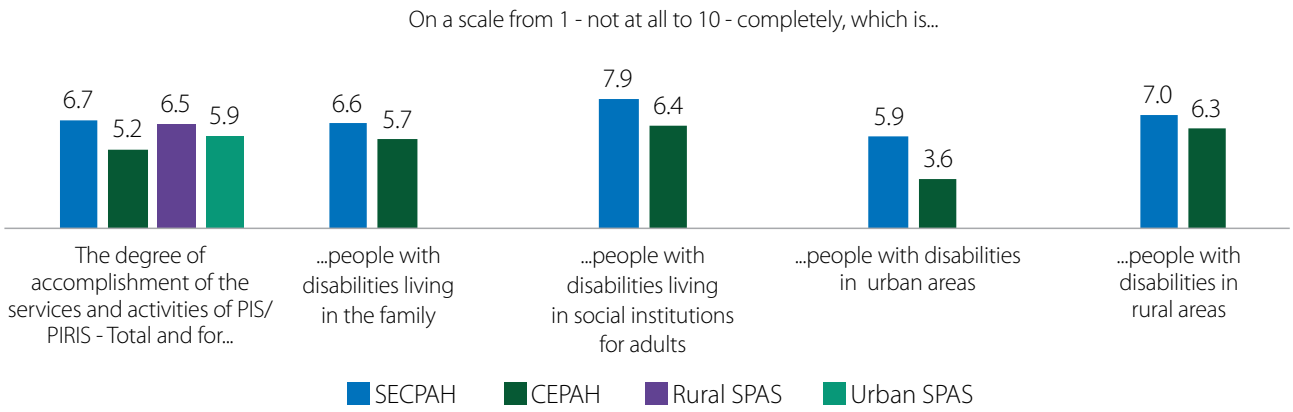
"I know they're written down there, yes. it's a recovery plan. But I didn't benefit from it. I didn't go to take advantage of them. Because I should go find out more, I know, but I didn't go. The fact that I have to go, to ask, I have to take someone with me all the time. made me give up. I wish there was a person. whether it's a psychologist. a person who can give you more complex information and not have to run from side to side. but say what documents you need, what it entails, what benefits you have afterward. It was quite difficult for me to accept this [disability]. so it would have been okay for me to have a psychologist. I think that. there is a person who can tell you certain things in more detail, so you don't have to ask left and right so that you can find out information about this whole process." (Interview with person with disabilities, woman, 33 years old)

"- Regarding the Individual Service Plan, can you use something from it, is it useful to you?

- They didn't mention anything to me and even at one point I was thinking if there are recovery centers. neuro. well. physiotherapy recovery centers, neuro-locomotor recovery centers for adults. I mean, they didn't even recommend me if there was anything like that. I guess there are private ones, but I was thinking to the state ones which I can afford. That plan is just a piece of paper with no useful information in it." (Interview with person with disabilities, woman, 24 years old)

The general degree of implementation by the person with disabilities of the services and activities recommended in PIS/PIRIS is rather low, as estimated by representatives of the key institutions involved in the disability assessment system (see Figure 43). It is lower for adult person with disabilities who live with family compared to those in institutions. It is also lower for persons with disabilities in urban areas compared to those in rural communities. Adult persons with disabilities who live with family in a city appear to be the most vulnerable. Therefore, PIS and PIRIS do not live up to their aims of improving the lives of people with disabilities by providing easier access to the support they need.

Figure 43: Key institutional actors' opinions regarding degree of accomplishment of services and activities in PIS/PIRIS (average values)



Sources: (i) Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=130), January-February 2021; (ii) Opinion survey Q3B: Practices and experiences of the CEPAH members (N=31), from 16 counties and one district of Bucharest that uses PIS, January-February 2021; (iii) SPAS survey with responses provided only by social workers who have ever seen a PIS/PIRIS from 33 localities (N=20 rural and 13 urban) situated in 18 counties; the districts of Bucharest are not included since the DGASPC also plays the role of SPAS, January-February 2021.

Changing PIS and PIRIS, as well as improving case management for adults with disabilities, is considered necessary to reform the disability system. That said, how specifically to change it remains a topic of debate. The opinion survey Q3B polled CEPAH members on four options for changing PIS, but none were considered in the same time a good idea and realistic—CEPAH members gave all four options average scores of lower than 8 (on a scale of 1 to 10). In their view, the best option would be to require, at the national level, SECPAH to draw up PIS and PIRIS for all individuals classified into a degree of disability, based on a standardized PIS template and a revised PIRIS format. The other options—expanding the case managers network or developing an M&E system linked to specific responsibilities both for persons with disabilities and case managers or SECPAH specialists that write up PIS—are perceived as being unrealistic and even impossible to implement under current circumstances.[387]

However, SECPAH and CEPAH members emphasize that merely drawing up PIS for all persons with disabilities would not make PIS (or PIRIS) more effective. The individualized plans of intervention are not effective because there is a lack of case management for adults with disabilities. The PIS and PIRIS are not effective because they are not monitored and evaluated and because beneficiaries' progress is not linked to the disability reassessment. First and foremost, the individualized intervention plans are not properly drawn up by specialists or adequately implemented by beneficiaries because services for persons with disabilities are massively underdeveloped, which poses a major structural issue. For this reason, the SECPAH and CEPAH specialists perceive PIS and PIRIS as an administrative burden with no real impact on the lives of people with disabilities.

387 Opinion survey Q3B: Practices and experiences of the CEPAH members (N=41), from 18 counties and 1 district of Bucharest, January–February 2021.

The development of ICF-based rehabilitation services represents a top priority for reforming the disability system and making effective individualized plans (PIS, PIRIS). Figure 44 shows the availability of physical and rehabilitation medicine (PRM) physicians by county. The 1,417 PRM physicians account for 2 percent of all doctors in Romania, and are very unevenly distributed throughout the territory.[388] More generally, medical rehabilitation services are insufficient and unequally developed. In relation to the ICF, the medical rehabilitation services stabilize, improve, or restore impaired body functions and structures, compensate for the absence or loss of body functions and structures, improve activities and participation, and prevent impairments, medical complications, and risks.[389]

Besides medical rehabilitation, vocational rehabilitation is equally important.[390] The UNCRPD is clear on the importance of services, as vocational rehabilitation is a process that enables persons with disabilities (with functional, psychological, developmental, cognitive, and emotional disabilities, impairments, or health disabilities) to overcome barriers to accessing, maintaining, or returning to employment or another useful occupation. Historically, like most of the developing countries, Romania has been more focused on combatting diseases, as compared with the developed countries such as the U.S., the U.K., and Australia, which have had rehabilitation services systems in place for many years. Accordingly, vocational rehabilitation services are even less developed than medical ones.

The SECPAH specialists confirmed in the opinion survey that in their counties/Bucharest districts, support services for persons with disabilities who wish to work in a protected environment or on the free labor market are missing or seriously underdeveloped.[391]

"- PIRIS and PIS are formal, I cannot force the person to bring me proof of recovery. There is no collaboration between recovery doctors and specialist doctors. This is the problem! The mayor should also get involved here, there should be mobile teams rather than paying so many personal assistants. Community services are completely lacking. SECPAH makes PIRIS/PIS, CEPAH signs it, but it is null!

- In our county, there is a recovery clinic, but it is private and has a waiting list of one year. However, on the recovery side, an important role is also played by the social worker from the mayor's office and the family. In vain the person stays in the center for 18 days for recovery but after that… what happens?" (Focus group CEPAH)

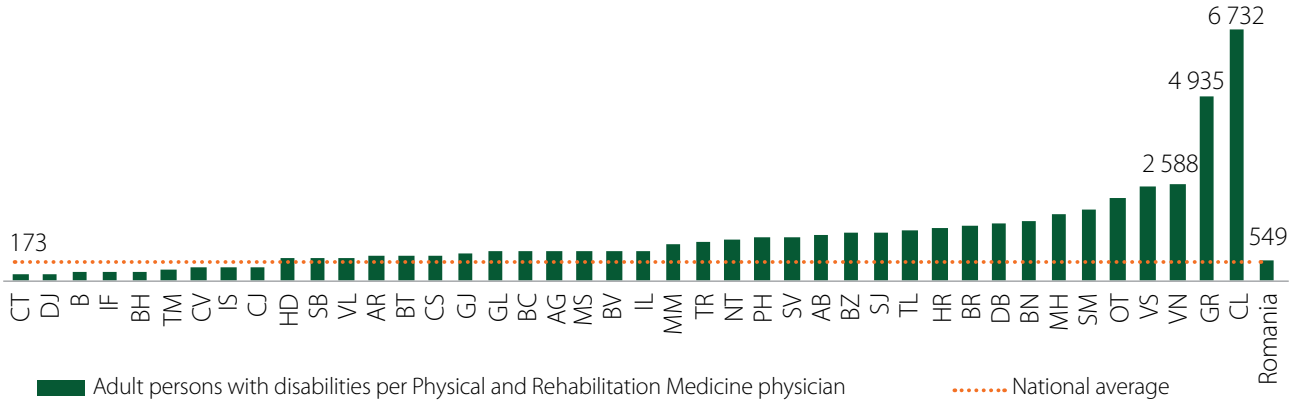
388 At the national level, there are only 13 PRM physicians for children, but within the residency training curriculum, every resident in PRM must complete a six-month internship in pediatrician rehabilitation. In addition, there are 368 PRM resident doctors, most of them grouped in university centers (National Institute of Statistic, 2020).

389 Rehabilitation services are based (where possible) on a functional assessment and diagnosis to determine the goals and plan for rehabilitation. These are followed by agreed upon interventions (including biomedical and technological approaches, as well as peer support) to optimize a person's capacity. Rehabilitation plans are monitored and adapted in accordance with an individual's needs and resources. The careful monitoring of outcomes related to specific interventions may help determine improvements to the intervention so as to optimize functioning and minimize disability (OECD, Eurostat, and WHO 2017: 87).

390 The ICF-based conceptual model of rehabilitation is a strategy that integrates approaches (i) to assess functioning in light of health conditions; (ii) to optimize a person's capacity, to build on and strengthen the resources of the person; (iii) to provide a facilitating environment; (iv) to develop a person's performance, and (v) to enhance a person's health-related quality of life, in partnership between person and provider and in appreciation of the person's perception of his or her position in life, over the course of a health condition and in all age groups and across sectors, including health, education, labor and social affairs, with the goal to enable persons with health conditions experiencing or likely to experience disability to achieve and maintain optimal functioning (Meyer et al. 2011, 768, Table II).

391 Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=139), January–February 2021.

Figure 44: Ratio between adults with disabilities and PRM physicians, by county



Sources: National Institute of Statistics (2020, Table 13); MMPS/ANDPDCA, Statistical Bulletin for December 31, 2019.

Improving persons with disabilities' access to existing services is as important as developing new rehabilitation services. If PIRIS can be limited to recommending the type of services and activities more appropriate to the needs identified through the disability assessment, PIS should contain specific information about the available services (name, address, contact, available places, etc.). As PIS is given to the person, it also represents a means of information and could help to identify the best available service. To this end, the SECPAH specialists and the case managers who draft PIS should have access to updated information on the available services. In this sense, less than half of the surveyed SECPAH (15 out of 36) report that DGASPC has a list, database, or map with the public and private institutions/organizations that provide social services for persons with disabilities, to ensure that the services and activities included in PIS are effectively accessible to that person.[392] The same counties benefit from collaboration agreements between DGASPC/SECPAH and other service providers that could provide services to persons with disabilities. Yet in only 11 counties (out of 15), information on the type and availability of these services are updated in real-time, while only 5 DGASPC have a person designated to liaise with other service providers in the field of disability.

Furthermore, within the focus groups, SECPAH practitioners showed that data about the available services are either part of the tacit knowledge (rather than institutional memory)—"We know most of them [services], we have them in our head;"—or are limited to residential services—"We have a list of services where they can be institutionalized and we offer them a list where they can call."[393] Therefore, more efforts should be made at the county level to develop partnerships, communication, and collaboration between DGASPC/SECPAH and the other service providers (public and private) to create a functional network rather than existing clusters of isolated services.

392 All data in this paragraph come from the institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January–February 2021.

393 Quotes from Focus group SECPAH 4.

Conclusions of Chapter 6

Identifying the service needs for people with disabilities is the core phase 5 within the delivery chain. The PIRIS and PIS are the instruments used for this aim in Romania.

1. The PIRIS specifies the activities and services the adult with disabilities needs for social integration. Practices for filling in PIRIS vary by county. The total number of PIRIS followed the same trend as the number of assessed application files by SECPAH, considerably decreasing during the COVID-19 pandemic, with significant variation across counties. However, PIRIS is only relevant for a small part of the population of persons with disabilities. Over 80 percent of individuals with a permanent disability certificate have a PIRIS that has not been reviewed in over three years.

2. Because a significant part of SECPAH does not provide a full-fledged disability assessment, the services and actions included in PIRIS adequately reflect the results of the medical and psychological assessments, but less often the results of the vocational, educational, and assessment of skills or level of social integration. The existing PIRIS are of poor quality, and their content is not entered into the SECPAH/CEPAH database(s). Consequently, data from PIRIS are not recorded or analyzed to identify the social services needs of persons with disabilities at the county level. Therefore, at present, PIRIS does not represent an effective instrument either at individual or public policy levels.

3. The PIS specifies interventions and supports for adults with disabilities, through which the activities and services recommended in PIRIS are carried out. The current regulations need to be revised to clarify who is responsible for drawing up a PIS, and when, as well as clarifying the relationship between PIS and case management. The use of PIS is not equitably distributed across the country. About half the counties do not use PIS, while about 95 percent of all PIS that exist in the country are provided by only 13 counties. Therefore, for a considerable proportion of persons with disabilities, PIS is either missing or obsolete. The total number of PIS followed the same trend as the number of assessed application files by SECPAH or PIRIS, considerably decreasing during the COVID-19 pandemic, with significant variation across counties.

4. Only 5 SECPAH (out of the surveyed 36) developed an approved specific working procedure for drawing up PIS, and only 6 SECPAH have a specific template for PIS. Consequently, the existing PIS are just lists of general recommendations that do not comply even with the basic standards of proper information, let alone orienting or referring persons with disabilities to the necessary services. The correlation of the recommendations from PIS and PIRIS both with the specific needs of the person and with the map of the existing services in the county is still deficient.

5

Key elements of the ICF-based conceptual model include a partnership between person and provider to appreciate the person's perception of his or her position in life, across all health conditions, age groups, and sectors (health, education, labor, and social affairs). Thus, from the ICF perspective, both types of individualized plans used in Romania (PIRIS and PIS) are still overly focused on medical needs, insufficiently participatory, and based on templates that need to be revisited to include the person's resources, the way he/she wants to live, and environmental factors, in addition to the needs identified through assessment.

6

There is no M&E mechanism connected to PIS and PIRIS. The careful monitoring of outcomes related to specific interventions is also missing. A person with disabilities' general degree of implementation of the services and activities recommended in the PIS/PIRIS is rather low, as estimated by consensus by key institutional representatives involved in the disability assessment system. Even in the absence of a monitoring system or clear procedures, the interviewed NGOs and persons with disabilities provided anecdotal evidence that at least in some counties, there are people who lost their classification or received a milder degree due to failure to implement (some or all) activities from PIS. The widespread belief among SECPAH and CEPAH practitioners that many persons with disabilities do not rehabilitate precisely because they do not want to lose their disability benefits supports such an approach.

7

Changing PIS and PIRIS, as well as improving case management for adults with disabilities, is considered necessary to reform the disability system. In CEPAH members' view, the best option would be to require, at the national level, SECPAH to draw up PIS and PIRIS for all individuals classified into a degree of disability, based on a standardized PIS template and a revised PIRIS format. However, merely drawing up PIS for all persons with disabilities would not make PIS (and PIRIS) more effective.

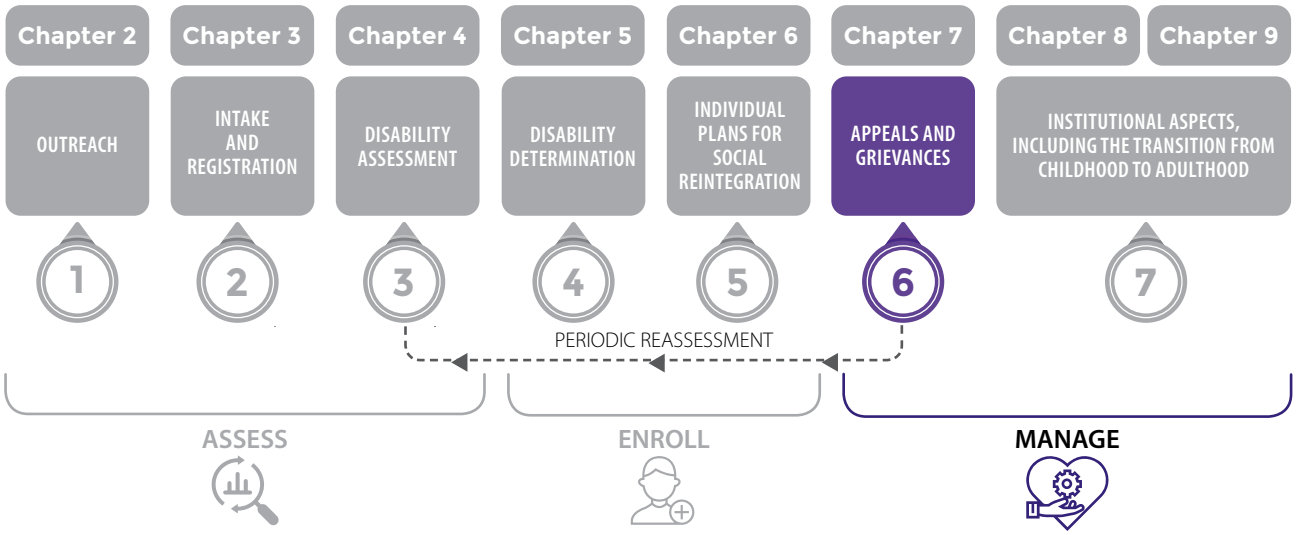
In any country, the relevant authority can accompany the disability assessment with a needs assessment, including recommended services/benefits. Yet the disability assessment authority can only recommend the necessary services/benefits; it cannot ensure access. Ideally, assessed needs would be paired with recommendations and electronically shared with relevant benefits/service providers, as an input into the eligibility testing process to increase access for persons with disabilities. The legal framework in Romania is designed precisely with this in mind. However, in practice, both PIRIS and PIS seem to be based more on what exists than on what is required. PIRIS/PIS seem more like instruments limited to identifying the available services (unevenly in the territories), but the identification and management of the unavailable supply of services are not envisaged at the local level. This management task is not established or carried out, which limits the ability of the PIRIS/PIS to support the needs, development, and effective integration of people with disabilities. Therefore, PIRIS/PIS will remain of little use until the available menu of benefits and services covering the variety of needs related to person with disabilities is extended and diversified, services become available (especially in rural areas), and a monitoring mechanism for implementation is put in place. The service package connected to disability assessment can be extended by developing the referral system, especially for the relevant national programs implemented by the Ministry of Health. ANDPDCA should also explore the possibility of introducing new support measures, such as grant programs to adapt houses or cars to meet a specific person's' needs.[394]

394 Grigoraș et al. (coord.), World Bank (2020: 122-23).

8

The development of ICF-based rehabilitation services, both medical and vocational, represents a top priority for reforming the disability system and making effective individualized plans. Improving the access of persons with disabilities to existing services is equally important. More efforts should be made at the county level to develop partnerships, communication, and collaboration between DGASPC/SECPAH and the other service providers (public and private) to create a functional network, rather than the existing clusters of isolated services. The development of an integrative platform with information about lifelong benefits and services available to persons with disabilities, coordinated by the ANDPDCA, could add considerable value in this respect.

7. Appeals against disability certificates



This chapter reviews the process for appealing disability degree certificates and explores the process's main characteristics, strengths, and weaknesses. The analysis is based on factual data reported by the CEPAH secretariat in 24 counties and 2 Bucharest districts, and on the opinions expressed in interviews with judges, lawyers, NGOs, and persons holding a disability certificate.[396]

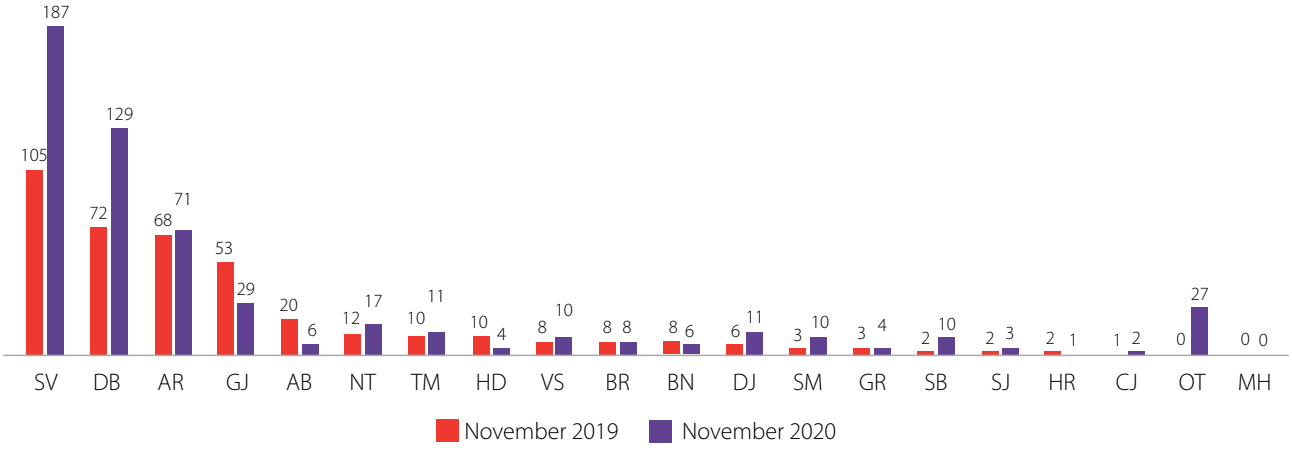
According to the initial form of Law no. 448/2006, people with disabilities who were not satisfied with the classification/non-classification into a deficiency degree, could use an appeal mechanism managed by the Higher Commission for Assessment of Adults with Disabilities, part of the former ANPD.[397] Although Order no. 1261/2016 on approving the organization and operation regulations for the Higher Commission has not been revised, as of 2017, the provisions concerning appeals against disability degree certificates were modified by EGO no. 51/2017, providing that the certificates issued by the evaluation commissions "can be appealed by their holders within 30 calendar days from communication, at the administrative litigation court sections that have jurisdiction on the matter, according to Law no. 554/2004 on administrative litigation, as subsequently amended and supplemented; the requests filed with these administrative litigation sections are exempt from the filing fee."

395 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.
396 See Data and Method section for more information.
397 Law no. 448/2006, Art. 90.

This legislative change came about because of the difficulties generated by the fact that the Higher Commission had too few members to cover the large number of appeals. As a result, the appeal against the disability certificate was "merely an intermediary action which, according to the procedure, extended over a period of 60 days, after which most of the disabled people turn to the courts."[398] Therefore, the declared purpose of introducing the new regulation was to simplify the appeal procedure "by facilitating the right of the disabled people who are unhappy with the disability degree assigned to them to file directly with the administrative litigation sections."[399]

The following sections look at whether, in what way, and to what extent the appeal process was facilitated. Romania currently has no complaint redress mechanism[400] in the disability assessment system that supplements (not replaces) the legal, formal complaint management channels, such as the judicial system or the organizational audit mechanism.

Figure 45: Distribution of appeals on the disability certificates per counties, November 2019 and November 2020 (number of appeals/month)



Source: Institutional survey Q3D: Appeals on the disability degree and disability type certificates (CEPAH Secretariat) in 20 counties, January-February 2021. The remaining 4 counties and two districts of Bucharest that participated in the survey did not answer these questions.

A consequence of this change to the law is that the number of appeals has dropped significantly at national level. Before EGO no. 51/2017 was passed on June 30, 2017,[401] 500 appeals were registered weekly with the Higher Commission for Assessment of Adults with Disabilities against the decisions of CEPAH. Meanwhile, the Litigation, Human Resources Service of ANPD had more than 700 appeals against the decisions issued by the Higher Commission on the dockets of the courts. Therefore, about 26,000 appeals were registered every year at national level, which means a workload too high for the Higher Commission, at least one of the size and with the membership specified by law. Therefore, the need to have a different appeal redress mechanism had become urgent in 2017. The solution was EGO no. 51/2017, by which this task of the Higher Commission was removed, and appeals started to be referred to the administrative litigation sections of the courts.

Compared to the state of things up to 2017, the data reported based on the documents available at the CEPAH secretariats in 20 counties only count approximately 400 appeals in November 2019, and 550 appeals in November 2020. A gross estimation shows that, at a national level, the number of

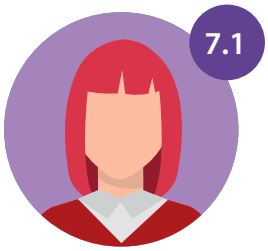
398 Substantiation note for EGO no. 51 of 30 June 2017, published on https://www.gov.ro/ro/guvernul/procesul-legislativ/note-de-fundamentare/nota-de-fundamentare-oug-nr-51-30-06-2017&page=7

399 Substantiation note for EGO no. 51 of 30 June 2017.

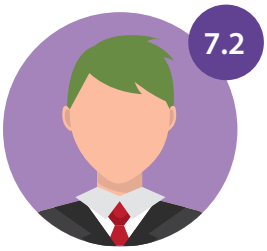
400 In line with UNDP (2017: 1), the complaint redress mechanism is defined as a system of organizational procedures and resources established by national/county/local government agencies to receive and manage dissatisfaction, complaints or concerns related to the impact of their policies, programs and operations on external stakeholders.

401 Substantiation note of EGO no. 51 of 30 June 2017, published on https://www.gov.ro/ro/guvernul/procesul-legislativ/note-de-fundamentare/nota-de-fundamentare-oug-nr-51-30-06-2017&page=7

appeals that the DGASPCs are aware of in a month is currently smaller than the number of appeals that would be filed with the Higher Commission in about two weeks in 2016–17. By contrast, some CEPAH presidents and members stated in the focus groups that the number of appeals in their counties is currently higher than in 2017, as shown by the quotes 7.1 and 7.2 provided below. The two types of information are not necessarily in contradiction, as it is possible that the number of appeals at national level decreased, while in some counties it increased. Thus, the validity and completeness of the data regarding appeals provided by some counties cannot be verified, especially given that the current legislation no longer requires appeals to be registered or monitored at county or national level (see Section 7.3).



"For instance, we have about 50 cases per month in the courts; much more than before, when the Higher Commission was in place." (Focus group CEPAH 1)



"About appeals, there is a problem, because the courts show empathy for the disabled person. This is about the credibility of the service (SECPAH), about how the assessment is conducted within the service, including if a Higher Commission or some other institution was in place, so that you can refer them towards them in case of discrepancies, before getting to court ... There were a lot fewer appeals when the Higher Commission was in place." (Focus group CEPAH 3)

Figure 45 shows there are substantial discrepancies between counties. Moreover, in 2020, it seems that some counties had significant increases in the number of appeals, while in others, the number remained the same or decreased. The number of appeals reported by four counties—Suceava, Dâmbovița, Arad, and Gorj—makes for about 75 percent of the total appeals. There is no research or data to show whether these four counties actually have much higher rates of appeal compared to other counties, or if they are just more active in registering appeals and are, in reality, typical at national level. Therefore, the statistics presented in this chapter must be taken with caution; however, they provide the only data-driven snapshot of the reality in the territory.

One key requirement for all people with disabilities to access judicial and/or administrative procedures—in this case, the procedure of appealing disability certificate—is the existence of efficient, accessible complaint mechanisms that are provided in a timely manner. Actual accessibility entails the participation of persons at all stages of the procedure, and includes providing information in an intelligible, accessible manner; recognizing and adapting various forms of communication; physical accessibility at all stages of the process; and financial support in the case of legal assistance. In addition, to ensure transparency, the state must make sure that all relevant information is accessible and available, and that all relevant requests, cases, and court rulings are registered and reported properly.[402] All these aspects are reviewed in the following sections.

402 Point 51, 52 letter a, b, c, d, point 54 & 73, letter h) , page 12-13, General Comment no. 6 – Article 5 Equality and Non-discrimination, 2018, UNCRPD/C/GC/6.

7.1. Information regarding appeals

The first requirement to enable easy access to the appeal process is that people with disabilities must receive information on time and in an appropriate language. Such information should be provided ex officio, not upon request, because the interested persons may be afraid to request such information or seek to avoid creating a "conflict" with institutional representatives (DGASPC, SECPAH, CEPAH). Or, they may not have the capacity to formulate their request, especially those persons with impaired understanding or poor education, those who grew up in an institutional environment, or those who are isolated. According to current regulations,[403] information regarding the manner in which a disability degree is assigned can be obtained from the CEPAH secretariat by any interested natural person or legal entity. There is, however, no explicit provision regarding information about appeals. The explicit information that "this certificate can be appealed within 30 days from communication" is part of the standard form of the disability degree certificate, according to Government Decision no. 430/2008, Annex 1.

Detailed information about how to appeal the certificate is not publicly available in all counties. In the sample of 24 counties and 2 Bucharest districts,[404] 6 CEPAH secretariats reported that such information is not available. However, for the majority of the counties/districts surveyed (20 out of 26), the CEPAH secretariat reports that such detailed information was provided to everyone interested.[405] In most cases (18 out of 20), information is available in simplified language. However, there are only two counties where the information is provided by people who have been trained specifically on appeal procedures. In other words, article 9 of the UNCRPD is not implemented equally in the country.

The predictability of the appeal procedure is low, and the information provided at the DGASPC does not always improve predictability. In only 6 out of the 20 counties where detailed information about the appeal procedure is available do the DGASPC/CEPAH secretariats have a specific, approved procedure (or sections/chapters of the general procedure). Out of these six counties, only three provided the information to the research team. Review of the three procedures reveals major discrepancies between the counties. One of the procedures is very general; it quotes the text of the law and mentions that petitioners should be referred to the competent authorities, with no other details. A second procedure includes two measures, depending on the result of the assessment for assignment of a disability degree, without any specific information about how the dissatisfied applicant is assisted in filing an appeal. The procedure, however, specified additional instructions, meaning that there is a collaboration with the Legal Service to prepare the "medical-psychological-social substantiation of the disability degree assigned for those appeals that are filed with courts."[406] The third procedure comes from CEPAH Sălaj and can be seen as good practice. The Sălaj operational procedure includes information about:[407]

- informing the person about how the disability degree were decided;
- explaining the substantiation that accompanies the certificate for assigning/not assigning a disability degree;
- advising the person(s) about steps to follow for the appeal;
- offering support with a petition (standard form) and, if needed, assistance in filling it in; the petition can be filed with the register desk of the Sălaj Court for the appeal to be registered;
- help with copying all the documents on which the solution was based; for instance, the medical file;
- use of adequate language that features simple words and expressions that are easy to understand; and
- making clear that the petitions filed with the court are exempt from a registration fee.

403 GD no. 430/2008, Art. 6.

404 Institutional survey Q3D.

405 All 20 counties declare that providing information about filing an appeal against the disability degree is mainly the responsibility of the CEPAH Secretariat. However, there are 3 counties where the CEPAH members or the president or the commission share this responsibility, 3 counties where information is also provided by specialists of the SECPAH, and one county where the Services department of the DGASPC also participates in this activity.

406 Operational Procedure excerpt, Cluj County Council, CEPAH, page 1, point 6.

407 Sălaj Operational Procedure, DGASPC Sălaj, P.0.10.01, Edition II, Revision 2.

BOX 9

Example of good practice: Operational procedure regarding appeals at CEPAH Sălaj

Către,

Domnul Preşedinte al Tribunalului Salaj,

Subsemnatul(a) . . . . . , domiciliat(ă) în localitatea (comuna) . . . . . ., str. . . . . nr. .... ., bl. . . . . ap. . . . ., judeţul. . . .., posesor al actului de identitate seria . . . nr. . . . . ., eliberat de . . . . . la data de . . . . . ., contest Certificatul de incadrare în gradul ..... de handicap/neincadrare în grad de handicap nr..... eliberat de Comisia de Evaluare a Persoanelor Adulte cu Handicap din judeţul Salaj la data de __/__/____, din următorul/rele motiv/e:

-.....

-.....

-.....

Ataşez copiile Certificatului de încadrare în grad de handicap şi a documentelor medicale depuse la registratura D.G.A.S.P.C. Salaj în vederea evaluarii şi incadrarii în grad de handicap.

Având în vedere cele prezentate, vă rog respectuos să dispuneţi admiterea cererii de chemare in judecată, anularea certificatului de handicap si obligarea comisiei la emiterea unui nou certificat de incadrare in grad de handicap.

În speranţa unei rezolvări favorabile, vă mulţumesc anticipat.

Data

. . . . . .

Semnătura

. . . . . .

Paşi de urmat pentru **Contestaţie** împotriva
Certificatului de încadrare/neÎncadrare În grad de handicap

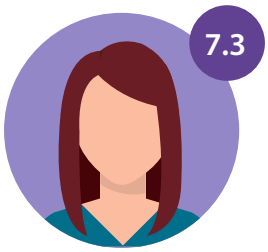
1.Completarea formularului contestatie (model Anexa)
2.Copii ale documentelor medicale care au fost depuse la registratura DGASPC Salaj, anchetei sociale şi cartii de identitate
3.Dosar cu sina

Dosarul se depune la registratura Tribunalului Sălaj în **termen de 30 de zile calendaristice de la comunicarea Certificatului,** conform OUG nr. 51/2017.

Nu se percepe taxa judiciară de timbru!!!!

However, a standard document describing the appeal process in simple steps, such as the one provided in Box 9, is only available in 7 out of the 26 counties/sectors surveyed. This document is available at the CEPAH secretariat, and only 4 out of the 7 counties have it. It is distributed through other services as well, such as the SECPAH, SECPAH register desk, DGASPC register desk, or other departments of the DGASPC. Moreover, this standard document is handed out to all applicants ex officio by only 5 CEPAH secretariats, while the other two counties only offer it to those who expressly request such information. In any case, in all 7 counties, the standard document is only provided after the CEPAH evaluation, possibly sent together with the certificate, but not at the moment of filing the request for the disability assessment.

Interviews revealed that people with disabilities did not receive information and/or guidance before filing the appeal with the tribunal, except for information regarding the 30-day deadline written on the disability degree certificate.



"On that very day, with all the documents on me, I went to the tribunal. The lady at the desk told me it was very easy to file a petition. I asked whether there was any standard petition, but she told me, 'What petition, lady? Go on the internet, you'll find a petition there.' I also asked whether I would be needing a lawyer: 'What lawyer, lady, it's just a simple petition to make, and you enclose the documents.'" (Interview with the mother of a woman with disability)

"- When and how did you learn about how to actually make the appeal? Did you have an overall image of all the steps to take from the beginning, or did you learn step by step?

- I learned the way, because nobody gives you the exact information. You are a little bit hanging on a tree, and the tree itself is hanging too if you don't try to do something by yourself or through your acquaintances or ... I don't know ... It's quite complicated, and the steps are quite cumbersome." (Interview with a man with disabilities, 18 years old)

The CEPAH members generally agree with persons with disabilities. Less than 40 percent of the CEPAH members interviewed report that they find information about how to appeal the disability degree certificate on the DGASPC site, published visibly, and in an easy-to-understand format (complete or partial), with details regarding the petitioner, the institution where it should be filed, the format, obtaining free legal assistance, how to withdraw an appeal, the duration of the trial, etc.[408] Moreover, the accessibility of the existing information is very low. On a scale of 1 (not at all) to 10 (fully accessible), CEPAH members gave the DGASPC sites an average score of 4.7 in terms of how easy they are to use by visually impaired persons, and with only an average score of 3.2 in terms of how easy they are to use by people with intellectual and understanding impairments. These accessibility scores show that in many counties, information on the DGASPC sites is not accessible for these types of disability.

Therefore, CEPAH members claim, the majority of people learn about the right and ability to appeal the disability certificate from the public social

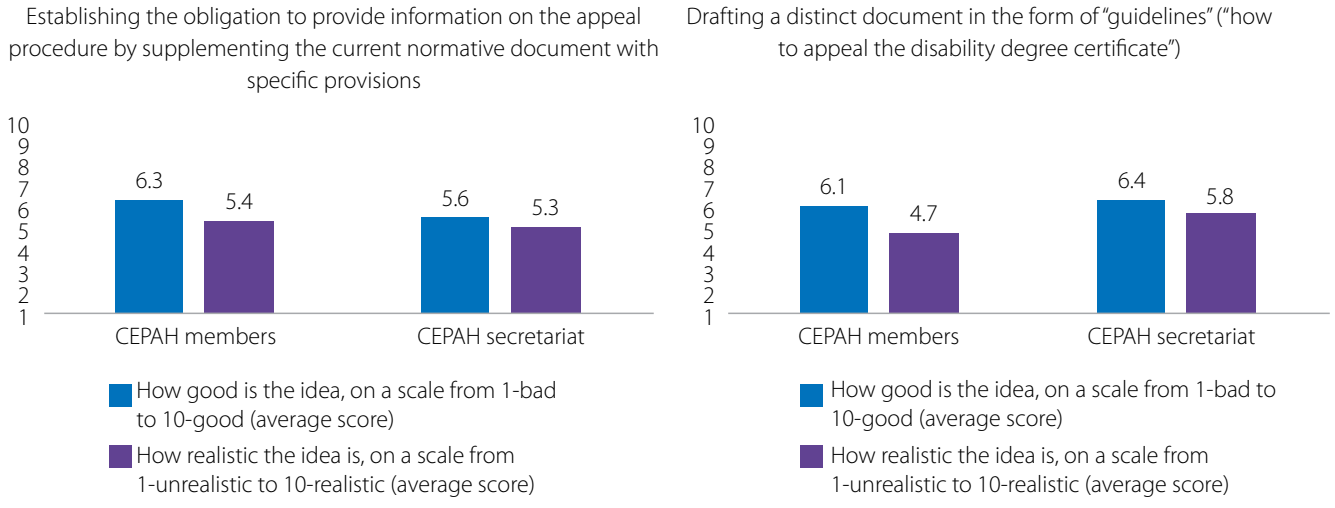
408 A share of 25 percent state that the information is complete, while 14 percent say that the information is partial. The remaining 31 percent of respondents say that the DGASPC site in their county/district does not include such information, and 30 percent do not answer the question. Opinion survey Q3B: Practices and experiences of CEPAH members (N = 65), in 24 counties and 2 districts of Bucharest, January-February 2021.

assistance services (SPAS), or from the certificate itself. And the two main sources of information regarding the steps and documents required for the appeal process are the SPAS and the CEPAH secretariat. In the perception of CEPAH members, relatives, friends, neighbors, social networks, and NGOs are marginal sources of information regarding the appeal. By contrast, interviews conducted with people with disability for the purpose of this report showed that, in most cases, relatives, friends, neighbors, social networks, and NGOs have been the main sources of information and support for the appeal process.

Providing accessible and fair information is a key requirement for any complaint and appeal redress mechanism, without which people with disabilities cannot adequately access justice. All persons with disabilities who are unhappy with the resolution of their disability degree certificate must have reasonable access to the necessary sources of information, advice, and expertise to appeal based on fair, informed, and respectful terms. Furthermore, the institutions in charge of disability assessment (DGASPC, SECPAH, CEPAH, ANDPDCA) must provide adequate assistance to dissatisfied persons who face certain obstacles in terms of access, from not being aware of the mechanism, to communication barriers, poor education, costs associated with the procedure, residence environment, or fear of retaliation.

To this end, the surveys with practitioners tested two measures to improve accessibility and fairness of appeal information: (i) the first measure concerns establishing the obligation to provide information on the appeal procedure by supplementing the current normative document with specific provisions—who must carry out the task, how, with what information, etc.; and (ii) the second measure concerns drafting a distinct document in the form of "guidelines" ("how to appeal the disability degree certificate"), including an easy-to-understand description of the actual steps to take when appealing, which document the CEPAH secretariat would need to send to beneficiaries, together with the disability certificate and other documents. Furthermore, this document should be made available on all relevant institution web pages, at the very least the ANDPDCA, the County Councils, hospitals, DGASPC, and SPAS. Figure 46 shows the opinions of CEPAH and CEPAH secretariat members concerning the two measures.

Figure 46: Practitioners' opinions regarding two possible measures to improve information regarding the appeal, on a scale of 1 to 10 (average scores)



Source: Opinion survey Q3B: Practices and experiences of CEPAH members (N = 65) in 24 counties and 2 Bucharest sectors. Institutional survey Q3D: Appeals on the disability degree and disability type certificates (CEPAH Secretariat) in 24 counties and two Bucharest sectors, January-February 2021.

According to practitioners, the two measures proposed are somewhat of "a good idea," with average scores between 5.6 and 6.4, on a scale of 1(bad idea) to 10 (good idea), but less realistic, with average scores between 4.7 and 5.8, on a scale of 1 (unrealistic idea) to 10 (realistic idea). In their experience, this kind of measure has a low chance of being implemented. A change to the law under current circumstances, without increasing the available institutional resources, would only increase stress and noncompliance. Drafting guidelines to be universally distributed could work if the guidelines were developed nationally and provided to counties/sectors. If just a new requirement was delegated to county level, the chances of implementation are limited to several counties at most, where such materials are already developed (such as the good practice in the county of Sălaj, presented above).

7.2. Key reasons to appeal

Romania's disability degree certificate appeal mechanism does not include a continuous learning dimension. A good complaint and appeal redress mechanism[409] uses relevant measures to identify lessons for improving the mechanisms and preventing future dissatisfaction and damage. To this end, the frequency, patterns, and causes of dissatisfaction are analyzed regularly, as well as the strategies and processes used to solve the complaints. In the case of the Romanian disability assessment system, not only do people with disabilities only have the legal path available to resolve their complaints, but the institutions in charge do not even identify the key lessons or take steps to improve the mechanisms and prevent dissatisfaction. Since 2017, when the new legal framework was included, until the present, no county covered in the research conducted a rigorous review of the reasons for appeal.

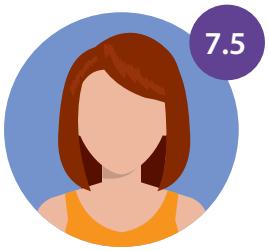
According to CEPAH representatives, the three most frequently cited reasons why people appeal the certificate are: (i) dissatisfaction regarding the disability degree; (ii) dissatisfaction regarding the valid term of the certificate; and (iii) a lowering of the degree from one assessment to another, or in the case of minors transitioning to adulthood. Dissatisfactions related to the disability degree or the lowering of the degree are mainly connected to the impact on the person's revenues,[410] namely losing benefits, receiving smaller benefits, and losing the right to have a personal assistant. These situations seem to be frequent in the case of children transitioning to adulthood, due to the different criteria for establishing a disability degree in the case of a child and that of an adult.

Interviews with people with disabilities confirm the three reasons mentioned by CEPAH representatives, but also add other reasons for appeal, such as the perception that the file was not analyzed sufficiently, that not all the conditions contained in the medical file were taken into account, that the condition for which the criteria specify a lower disability degree were randomly selected; problems with classification in the case of conditions with temporary manifestations or conditions that cannot be identified within the Romanian medical system;[411] cases where the right to a personal assistant is not granted because the person has no caretakers and the DGASPC does not have a public personal assistant service for cases in which hire-able persons cannot be identified in the residence community; that the PIRIS cannot be appealed against (just the certificate), and the person's PIRIS makes no recommendation for any type of services that the person would need, either because the services are not available or because there are no vacancies; and the lack of ethics and corruption at the level of the CEPAH or the DGASPC.

409 UNDP (2017: 1).

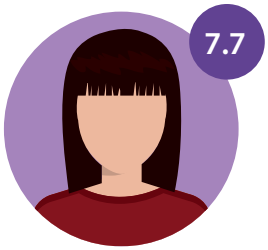
410 According to ANDPDCA, from January 1, 2021, the level of social benefits provided in Art. 58, para. 4 of Law no. 448/2006 on the protection and promotion of the rights of persons with disabilities is as follows: the adult with severe deficiencies benefits from a monthly allowance of 350 lei, to which is added the complementary monthly personal budget in the amount of 150 lei, regardless of the person's income. The total monthly value is 500 lei. If the adult with severe deficiencies is entitled to a personal assistant, then he can opt for an accompanying allowance in the amount of 1,386 lei per month or a personal assistant employed by the mayor's office in the locality of residence. In contrast, for the adult with marked deficiencies, the corresponding values are reduced to a monthly allowance of 265 lei, a complementary personal budget in the amount of 110 lei, respectively a total value of 375 lei per month. The adults with a medium degree of deficiency benefit only from a complementary personal budget in the amount of 60 lei per month, while those with a minor degree receive no benefits.

411 For example, due to the lack of certain technologies, equipment or specialists.



"For instance, we knew in 2017, the girl was 17 and we knew she had problems with the temporary epilepsy diagnosis. There is a specific diagnosis for temporal lobe trauma. Here in Romania, all MRIs couldn't show anything, same for the EEGs. Everything seemed ok, and nonetheless, she would have those seizures. To validate it and prove that the diagnosis was real, we did an MRI and spectroscopy, to prepare for the age of 18 when she would become an adult. And when we saw that they still assigned a lower degree to her, I told you that we asked for a re-assessment and we went to Italy. We went to Italy for the re-assessment ... because epilepsy, according to the existing criteria—at least that's what I was told, it would be maximally a serious disability. The problem is, how can you prove, for instance, an epilepsy seizure that lasts for three days in a row, going stronger and then decreasing in intensity. How do you do that?" (Interview with the mother of a woman with disability)

"The first appeal was in 2019, and the second one in 2020. ... Because, from what I read in the law, it says that, for people suffering from epilepsy, when they go to the commission for the second time, they are assigned a permanent disability degree. Since there has been no improvement in so many years, in 19 years, the disease is still there, it did not go away. Why didn't you assign a permanent degree? Because they say the same thing: if you have ... epilepsy before the age of 16, I believe, or 26. ... So, they picked epilepsy, not his actual disease, tuberous sclerosis, which they should have done, because it's a rare, severe disease and they should have taken that into account, but they said it wasn't in their codes. Ok. But they have 'rare disease' in their codes. They didn't go for that, they went for epilepsy. ... Why not a permanent degree?! The court didn't do it either, they gave it for two years. And you can imagine, in 2021 I have to go to the commission again. I am fighting the system. Fight to get ... what? They will assign it for one or two years again, they will assign a "serious disability" degree and we'll go to court again, the court will change it to "severe" again, and that's how I spend my time between the commission and the court ... First of all, it's a reason of stress, for myself and for the child as well. But for me ... Maybe I won't be here tomorrow, I had a stroke in 2016, so maybe I won't be here any longer. Who will go with this boy, because he will not go by himself. What will become of him? Although it's a small amount, those 500 Lei, but at least it's there." (Interview with the father of a man with disability)

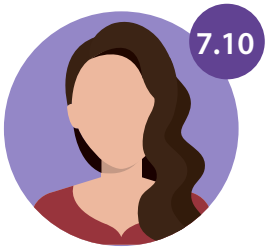


"There is a public day care center for adults in Timișoara and it's overcrowded. And there is also a private center that works with people with severe impairments and Down syndrome...and they can't manage. There's no possibility that they can manage. For the public center, there are 3-years long waiting lists. That's what we are talking about. It's absurd to have to wait for someone to become so sick that they can't go to therapy anymore, so that you can take their place—or wait for them to die. Here...everything is connected. If there was a day care center where I could take her...or protected units...but not one or two in the county, because you can't do anything with those. There should be protected units where they can be employed. To be honest? We would not have appealed against the degree, if that were available. But like this...she has nothing. No revenue, no possibility for employment...nothing. Nothing. And...it's not only about her. It's about the whole family, because the rest of the family is also involved in this, and then everything reflects on the family. How long will the family be able to stand? And when the family cannot take it anymore, then it's terrible." (Interview with the mother of a woman with disability)

"The lawyer shrugs and says there is nothing she can do, she needs to do these processes because she is asked to, and there is nothing she can actually do. Imagine that we are in court now for so long already (since 2019), and now in autumn, in Timișoara, I am sure you found out about that—the chief from the adults [SECPAH] was taken in for bribe. Five thousand Euro for a certificate, for a degree with a personal assistant. I mean...other people who need it don't get a "severe" degree, while...even the lawyer told us that we can go and file an appeal. ... The integrity of the commission...even that." (Interview with the father of a man with disability)

"I had all my tests and the whole file and I went to the center for people with disabilities in Timișoara. And I got an allowance that made me laugh. It was just mockery: 39 Lei per month, and I should go with new health tests every year. Then I said, it was not worth it. For that little money, all that hassle and all those tests, it's not even worth going back. So I gave up. I appealed, but I got no answer. ... Can you imagine, with the money I get, I should go to the Tribunal too ... It's really useless. I will make a fool of myself, for such a small amount ... If this is what the system is. ... I just know how I was dissatisfied. You go to do some blood tests and it's more than 30 Lei. ...Everything costs money. ...If you go to have your tests done in the public system, through the Insurance House, it's not possible; only at the beginning of the month—and when you go at the beginning of the month, they tell you there is no more place, other people were scheduled, so you still have to pay. I don't know if it's worth it. ...You don't even get back the money you pay for the tests, in one year." (Interview with a man with disability, 60 years old)

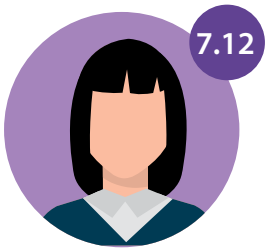
Other people with disabilities who were interviewed, as well as the NGOs, reveal that some people drop the appeal because of the cumbersome procedure and the costs involved, particularly those with a medium disability degree, people from rural areas, or people with poor education.



"The person supported by the organization suffers from leukemia and serious vision problems. They had a certificate until last year, with a 'severe disability with personal assistant' degree. At the last assessment, they got 'severe disability, no personal assistant.' The organization reviewed all the aspects and noticed that not all the medical and psycho-social criteria had been considered, as the law provides. They appealed and pointed to what was not taken into account. The visual acuity was not right for a 'severe disability with assistant,' but the other criteria, yes—visual field and other criteria. The court ruled in favor of the NGO. The proceeding continues only if the opponent files for appeal. Our organization files an appeal whenever we deem that the criteria for assigning a disability degree were not complied with. If a member feels they have been treated unjustly, the organization explains to them whether the criteria have been observed. In some cases, the members ask for assistance in court, even if it is explained to them that the criteria have been observed. They get support in those cases too." (Interview with an NGO representative, Brașov)

"A lot of people don't file an appeal because of the cumbersome procedure and the related costs." (Interview with an NGO representative, Bucharest)

CEPAH members think that there are virtually no cases of people with disabilities who do not file an appeal against the certificate because they fear upsetting the commission members, and that would affect their next assessment.[412] However, such cases were mentioned in interviews with persons with disabilities, NGO representatives, and lawyers. It is not possible to estimate how many such cases there actually are, or if they are concentrated in certain counties or categories of persons with disability; but they exist, and should not be neglected.



"Psychologist – I tell you of a situation from another county, from Sibiu county, it is the situation of my father who had an amputation and in the next year they cancelled his assistant and had we filed an appeal he could have lost that degree, as well." (Interview with an NGO representative, Mureș)

"The lady was dissatisfied when she received the disability certificate and she communicated that she was dissatisfied and they were to assign another degree to her... so they told her to stop complaining and not file an appeal, because if she will, they will remove even the degree she got - well, the degree that her husband got. ... They didn't tell her too much about how to file the appeal, since they discouraged her. But I don't know any other details about that conversation, I know that they lady was confused." (Interview with a lawyer)

7.3. Registering appeals

The mechanism for appealing the disability degree certificate does not follow the transparency principle that should underpin any good complaint and appeal redress mechanism.[413] According to the transparency principle, the petitioning person should be regularly informed about the status of the appeal, and information should be published about the performance of the complaint/appeal mechanism to increase confidence in its efficacy and to satisfy any public interest that may be involved. This can be achieved by publishing statistics, case studies, or more detailed information about how certain cases are dealt with, which is important for proving the legitimacy of the mechanism and helping improve confidence about its efficiency. The current mechanism does not meet any of these requirements.

Under the terms of the new legal framework regarding the procedure for appealing the disability certificate, established by EGO no. 51/2017, the secretariat of the Higher Commission for Assessment of Adults with Disabilities no longer receives and registers the appeals. As a result, in most counties, CEPAH secretariats no longer

412 On a scale of 1 (not at all) to 10 (fully), the average score per the whole sample is 1.8. Opinion survey Q3B: Practices and experiences of CEPAH members (N = 47 valid answers), in 24 counties and 2 districts of Bucharest, January-February 2021.

413 UNDP (2017: 2).

register the petitions, but rather refer petitioners to the competent authorities. Within the sample of 24 counties and 2 Bucharest sectors,[414] only 3 counties reported that appeals regarding the disability degree and type are still filed with the CEPAH secretariat. Furthermore, the CEPAH secretariat also has the legal responsibility to manage an appeal book.[415] However, not only they do not register the petitions, but in most countries, they no longer keep the appeal book. Data from the institutional survey show that in 13 counties and 2 Bucharest sectors, the CEPAH secretariat no longer has an appeal book. In one county, the book is present but was out of use after EGO no. 51/2017 was passed. In just 10 counties did the CEPAH secretariat keep and continue to fill in the appeal book. However, even in these 10 counties, the data may be incomplete, since there are several registration mechanisms in place, with no coordination or communication with each other (especially tribunals and County Councils). The consequences are a lack of transparency and solid data to enable monitoring and analysis of dissatisfaction regarding disability assessments and assignment of a disability degree, or to allow evidence-based corrective measures to be designed.

"When I filed the complaint? Nobody even looked at me. It was like it wasn't there. ... Well I met two people. The person at the entrance... The order person, the security person, whatever he was... He asked me what brought me there. I told him I needed to file a complaint, and he gave me directions, he showed me where to go. I went to the window, I gave the complaint... They told me... You should wait... You will receive our point of view within 3 months. And I waited, until I gave up." (Interview with a man with disability, 60 years old)

7.4. Appealing disability certificates

Besides the insufficient, inadequate information provided to people with disabilities about the appeal procedure (Section 7.1), data analysis conducted for this report show the following problematic aspects: the long duration of the litigation; lack of or insufficient legal assistance in court; procedural aspects that are not adapted; and lack of information or specialty support at the court level to "translate" the medical-psycho-social criteria. These issues are examined in the sections below.

7.4.1. Duration of the Litigation

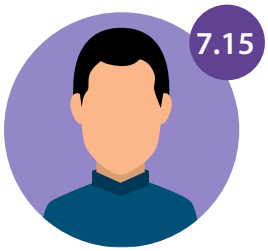
In contrast to the legal requirement,[416] these cases do not seem to be judged with urgency. With the lack of data mentioned above, the majority of CEPAH secretariats in the surveyed counties are not able to estimate the duration of the certificate appeal procedure.[417] Only 9 counties (out of the sample of 26) provided estimations based on the documents that exist at the CEPAH secretariat. Thus, disputes related to disability certificates could last between 15 and 1,000 days, with an average duration of approximately one year. There are considerable differences between counties. In Bistrița-Năsăud county, for instance, disputes are reported to last between 15 and 30 days. In Neamț county, the period increases to 90–150 days, while in Cluj, the duration of disputes varies between 200 and 1,000 days. Interviews with persons with disabilities and NGOs confirm the long duration of the appeal procedure; some people even get a new assessment to renew their certificate before they get a final decision on the existing one.

414 Institutional survey Q3D.

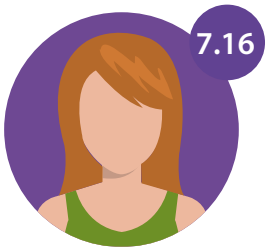
415 GD no. 430/2008, Art. 15 (2) letter g.

416 Art. 25 para. 7, Law no. 448 of 2006.

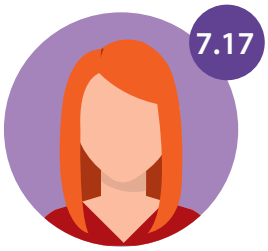
417 The duration is measured from the moment when the appeal is filed with the CEPAH Secretariat/tribunal until the moment when the court ruling with the solution for the appeal is received and remains final. So, if applicable, it includes the first trial and the appeal.



"The procedure was very long, more than one year. The whole case would not end. I filed the appeal in March 2019; in 2020 I received the judgment from Buftea, then the Court of Appeal filed an appeal. The trial date at the Court of Appeal was November 2020. Ruling was adjourned three times, three weeks in a row, in his case. Due to the pandemic, a lot of trials were adjourned, as they were not criminal trials." (Interview with a man with disability, 41 years old)



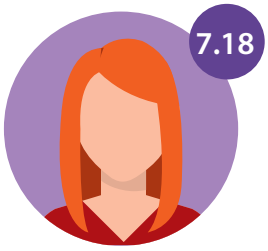
"We are on trial since July 2019, now we have this thing about forensic medicine, we must do everything in 5 days, everything, it's very difficult. If they did everything there, where forensic medicine is, it would have been easier, but they just gave us some papers and told us, solve this; it's very slow, with this COVID madness in the hospitals; we had the neurosurgery today." (Interview with a woman with disability, 20 years old)



"The appeal that our NGO filed in October went to trial on 20 January; the judgment will come through in 30 days. If there will be an appeal, we'll get to March. Until they schedule the appeal, we'll be in May. The conclusion—long periods for getting a judgment." (Interview with an NGO representative, Brașov)

7.4.2. Legal Assistance in Court

Most people with disabilities have no access to legal assistance when formulating their statement of claims or in sustaining their claims in court, NGOs report. Data available from CEPAH/DGASPC secretariats show that most persons appeal the certificate in court, through their own lawyer (paid by them or their guardian/family), in some counties, and by themselves, with no specialized assistance in other counties.[418] There is no solid data available to check these statements.



"- Would you say that access to the assistance of a lawyer is a problem for persons with disabilities?

- Yes. They cannot afford it, and they are not aware of it. They have no access to it, because they don't know how to get there, but if they went and asked for it, I think they would receive it. That's what I want to make clear. That the authorities would provide free legal assistance for them... if they got to the Bar or before the judge and asked for it, I believe they would be given that. But they don't know how to get there, and there are no support bodies available. ...Persons with disabilities are not aware of their rights; there is no one to explain these to them, and they are not effectively represented. In the two cases I worked on, those who filed the appeal, in their financial standing, they could not afford hiring a lawyer, paying a lawyer. And in the Parkinson case...I believe the lady was not even aware that legal public aid was available, because she was very intrigued about the existence of ACTEDO—an organization that provides lawyers pro bono. ...Probably she had not thought that someone could help her for free." (Interview with a lawyer)

418 Out of the sample of 24 counties and two Bucharest districts in the institutional survey Q3D, 18 CEPAH secretariats do not have any data about the type of legal assistance that most beneficiaries receive when appealing against their disability certificate. The other eight counties provide different answers. Thus, four counties report that most of the beneficiaries file the appeal with the competent court, through their own lawyer (paid by the person/guardian/family). Three counties state that beneficiaries file the appeals themselves, with no specialised assistance. There is only one county that claims that most people receive free legal assistance.

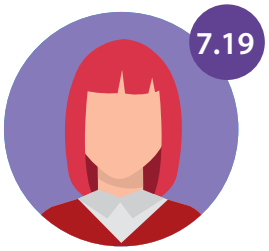
It is certain, however, that free legal assistance is rarely mentioned by all stakeholders.[419]

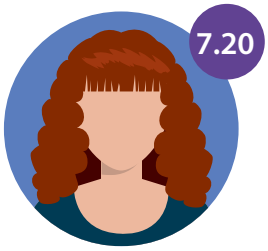
From the point of view of the representatives of the judicial system (judges and lawyers), the underuse of judicial public aid is primarily the effect of a lack of awareness about its availability and how to access it. In their opinion, the DGASPC should make sure that all persons who have/do not have a disability degree and type are aware of this, along with the fact that the certificate may be appealed within 30 days.

NGOs also provide legal advice for persons who appeal disability certificate.[420] The majority of these lack budget for a specialized department; they provide these services through a member of their organization who, in turn, is a parent or a family member of a person with disability enrolled with the organization: "We had legal advice too; unfortunately, he left this world too early, he was a father. We started working with another legal adviser and we will come back, step by step; the new legal adviser was not familiar with the field, but he is getting used to it now."[421]

Interviewed persons who received assistance from a lawyer in the appeal process have a wide range of opinions regarding the importance of such assistance, from "we wouldn't have done it without a lawyer" to "it was of no use to us."

"Let me tell you—we wouldn't have done anything without a lawyer, ... we went to a lady lawyer right away; on the other hand, we were also lucky. It's a lady who has a little grandchild with disabilities. She told me that she didn't know anything about this type of cases, because there are very few of them in the country and, since she has a case in her family, she very much wants to get involved, because it's for her benefit too, personally and professionally. She didn't even charge me; I paid that percentage on the day when she would go to court, I paid for her transportation every time ... It would have been difficult without a lawyer, it was all full of aspects that we were totally unfamiliar with; they are used to file an appeal for every small thing, and open every little door; I would have needed assistance all the time." (Interview with the mother of a woman with disability)





"For the trial in court, it was not necessary, we won without a lawyer. For the appeal, yes, we called a lawyer who knew what the medical aspects meant, too. We asked for a lady lawyer and we paid her. For Timişoara, the fee for this kind of a court case is around 2500 Lei; the lady only charged us 800 Lei, even the judge was surprised. We went to her especially, because she used to be a medical nurse; I looked for some information in advance, I didn't just go to no matter whom, it's about medical diagnostics." (Interview with a woman with disability, 20 years old)

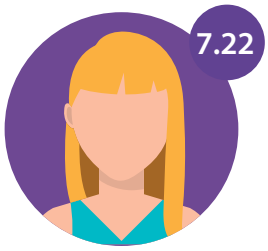
419 According to EGO no. 51/2008, public judicial aid is granted irrespective of the applicant's material standing, if the right to judicial assistance or the right to legal assistance free of charge is set forth by a special law, as a protection measure, in consideration of special situations such as minority, disability, a specific status and other similar aspects. In this case, public judicial aid is granted without the criteria set forth at art. 8 being met, but only in defence or for recognition of rights or interests resulting from or in connection with the special situation that justified the recognition by law of the right to judicial assistance or legal assistance free of charge. Furthermore, according to the Civil Procedure Code (art. 58), in certain situations, the court, upon the request of the interested party, may appoint a special curator from among the lawyers designated by the bar especially for this purpose for each court of law, who will have all the rights and obligations established by the law for a legal representative.

420 Out of the 20 NGOs interviewed, six declared that they offer legal advice services.

421 Interview with an NGO.

"- Do you think the results would have been different? The trial terms would have been shorter...if you had a lawyer?

- I don't know... I... I don't even know if that is the problem, after all. In my opinion, disabled people should not have to go to court... They should... As it used to be: you could file an appeal with the National Authority for Disabled Persons, in Bucharest. But now, you just feel like a leaf on the water. You belong nowhere. Nobody cares what happens with you... These degrees are assigned... This is the most revolting thing for me: how can someone assess you, for the first time, when you go from minor to adult—how can they assign a disability degree without even seeing you?! Based on...what?! Just on some reports we received from the specialist doctor." (Interview with a man with disability, 18 years old)



"- If you were to start again, what would you do in a different way?

- I wouldn't get a lawyer at all; that way, they would be forced to talk to her [her daughter with disabilities]. First of all, I am sure that, if we had a lawyer from the beginning, we would not have won, because the lawyer would speak for me or for her. Somehow, in these appeals, the judges should be obliged to talk to the person with disabilities, just like in the case of children, when they have to decide which parent they will be with, just like in the case of a divorce. ... But for the appeal, we did get a lawyer, because I don't understand their concepts, and they didn't even talk to her at all; I asked to speak to them myself, but they didn't accept that either, so I got a lawyer." (Interview with a woman with disability, 20 years old)

7.4.3. No Homogeneous Evidence Procedures at Court Level

The appeal proceedings are characterized by significant variation in terms of the procedures that have been adapted by different courts. The same person may file two appeals with the administrative litigation section of the same county tribunal, and have two very different experiences. Overall, according to CEPAH representatives, judicial procedures are to a small extent adapted to enable the person to file with the court to appeal against the certificate, as per the UNCRPD (Art. 13).[422] The absence of homogeneous evidence procedures at court level involves issues such as the admissibility of the challenge regarding late submission of the appeal, admissibility of testimonial evidence, the hearing being declared non-public, court dates being too close to each other, or the reasoning of the judge.

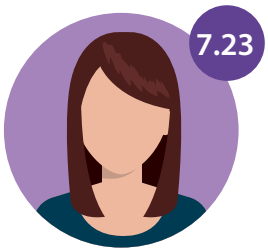
Objection on grounds of the appeal being filed too late. According to CEPAH secretariats, in most cases, people do manage to file their appeal with the competent court within the legal deadline, meaning no later than 30 days from communication.[423] There are, however, situations such as hospitalization or institutionalization,[424] whereby the person cannot comply with the legal deadline. In such cases, the defendant (the County Council, CEPAH) usually requests the court to admit an objection on the grounds of the appeal being filed too late, because the petitioner has filed the statement of claims later than the deadline specified by law. Some courts admit the request of CEPAH, while others dismiss it on the grounds of the appeal being filed too late, as per the legal provisions on administrative

422 Half of the CEPAH members participating in the opinion survey did not answer this question. The other half evaluated the extent to which judicial procedures are adapted to the needs of persons with disabilities with an average score of 5.2 on a scale of 1 (not at all) to 10 (fully). Opinion survey Q3B: Practices and experiences of CEPAH members (N = 65), in 24 counties and 2 districts of Bucharest, January-February 2021.

423 Institutional survey Q3D.

424 Beneficiaries of a disability certificate who are institutionalized may be deprived of access to justice when the certificate is communicated to the head of the centre or the case manager.

litigation.[425] Both persons with disability and NGO representatives mentioned these practices in interviews, but while the NGOs are able to find various solutions, individuals who have this experience, at least in some cases, are deprived of access to justice.



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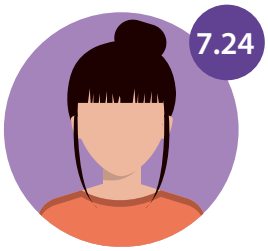
"We did have situations of people who did not manage to appeal. In order for the persons who receive their certificate by mail to no longer have access to the appeal, there was this trend not to count the term as of the day when the envelope arrives in the mail. We had this kind of a surprise two years ago, so last year we were more careful and paid attention to all the mothers (and had them) go take the certificate, not wait for it to come by mail, and there was this mother who told me—you know, they reprimanded me for not waiting to get it by mail." (Interview with an NGO representative, national association)

Court hearings are often public. Although during the trial, people with disabilities must present information pertaining to their private life, as well as issues that pertain to their physical or mental health, the hearing is public. Therefore, in some cases, applicants and their families find themselves in a difficult situation. The person may request that the hearing be non-public,[426] but a change in the regulations (Law no. 448/2006, Art. 25, Legal assistance) could be considered as well, by introducing a specific provision for this purpose: "The hearing may become non-public even without a request, or the judge could raise the issue without a request from that person, because maybe that person is not aware of this right, especially if they represent themselves."[427] In some countries, at least in cases selected based on the assessment of a social assistant, hearings are conducted behind closed doors, in a special space, so that the person is less likely to be intimidated or placed in an awkward situation.



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"Then another problem is that they may have a problem and not be able to attend in court. In the Parkinson case, I was discussing with my wife [medical practitioner] that we can't have him attend in court, that he wouldn't be able to deal with it because there are too many people, and being in a courtroom would make him agitated. Definitely, if he were to come, he should have been alone with the judge, with no other people present. And maybe even in a smaller room... In an office arranged especially for this, like in the case of children. ... I mean, something to ensure a more relaxed environment, something pleasant, with nothing to intimidate them. So...yes, maybe modifying the proceedings would be a good thing. Totally modifying them. I mean, not in a normal hearing session. The person should be alone when they get to the courtroom." (Interview with a lawyer)

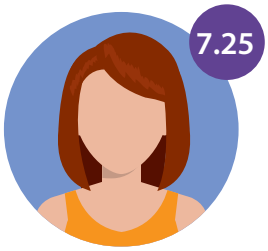
Other adaptations of proceedings.[428] Many other proceeding modifications that were missing or would have been necessary were mentioned in interviews with people who appealed the certificate, or in interviews with legal system representatives about how the appeal process took place. For example, standard appeal petitions are not available in many counties, at the DGASPC or the courts. Furthermore, in most counties, those who go for an appeal do not receive any advice before filing it, going to court, or during the trial.

425 As per the legal provisions on administrative litigation Law no. 554/2004, Art. 11 (2), for solid reasons, in the case of unilateral administrative papers, the request can be filed after the deadline set forth at para. (1), but no later than one year after the paper was issued.

426 Civil Procedure Code, Art. 213: Carrying out trials with no public attending. (1) In cases when investigation on the case or debates on the merits of a case in public session would harm the morality, the public order, the interests of minors, the private life or the parties or the interests of justice, as applicable, the court, upon request or ex officio, may order proceedings to be conducted fully or partly without any public present.

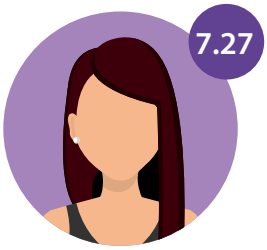
427 Interview with a lawyer.

428 OHCHR, International Principles and Guidelines on Access to Justice for Persons with Disabilities.



"Right, so there is counseling with the person with disabilities, right? But there should be counseling with the family, too. Families no longer have a personal life, and I don't only mean a personal life as a couple ... But if there are siblings in the family, those children are almost like nonexistent. Because all the energy goes to...and everything, everything... goes to the person who is disabled." (Interview with a woman with disability, 20 years old)

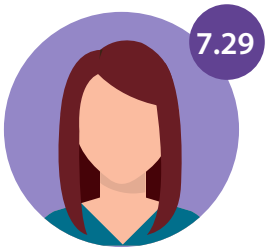
"- Was there a specialist who prepared you for the court proceedings or provided support with the proceedings (psychologist, social assistant, doctor, etc.)?
- No, no.
- Would you have needed one?
- It was not easy for us, because you are under stress all the time, you are nervous...now the child is not exposed to these things. ...He does not realize these things, but for us the parents, it's a stress, of course.
- Along the proceedings, would you say that you received enough information about all the aspects that were important for the proceedings?
- No, they just asked us what other documents we brought. Well, wait a second, first I need to know what documentation I should bring... where could I... I just learned by chance that you can also bring reports from a neurologist, because there are some scales that he could fall within or not... and all his needs are specified there very clearly. But nobody recommended that to us. I just found out from other parents of children with problems." (Interview with a man with disability, 18 years old)



"If I was certain that some rights are involved, I did not give up those rights. I wasn't like this in the beginning, you know. As much as we could, we managed by ourselves. We sold everything in the house... as Romanians say, everything that was not tied on a rope. We sold everything. But when there was nothing else left to do, that's when we actually turned to the rights that are there. That's when we got in contact with the rights of the people with disabilities and the rights of personal assistants. That was the first time for me (2017). I was lucky, because I used to work in human resources, so I was able to understand some things—regarding salaries, regarding... I knew how to look for that in the laws. I am one of the mothers who fought for the 50 percent increase for children with special educational needs. I was wearing this T-shirt... Even in the Parliament, I went and spoke about this. I was wearing this white T-shirt with "strike" written on the front and "respect the rights of children with disabilities and special educational needs". That's what I wore between December 2017 and July 2018, because everybody was telling me, you don't have this right, if you don't like it, go to court. So I said, well wait, that's not really true... You go to court for just everything? ...This had huge consequences: the rights of personal assistants in Timiș, the 15 percent bonus, the meals quota, the ranks, money for leaves... It's all my fault. That's why I tell you, with the trial and the appeal, it was the same—I did know some things, but I didn't know what it meant." (Interview with the mother of a woman with disability)

"In the case of deaf people, when they are given documents, there should be a sign language interpreter present. If they don't understand, they could miss the deadline for the appeal." (Interview with a man with disability, 41 years old)

Other proceedings adaptations mentioned in the interviews concerned the fact that there is no support service during the proceedings; such support could be provided by NGOs or volunteers. "A support person to call them before the trial, ask them how they feel, do they have any questions about how the trial will go... do they want to come to court, see the courtroom, do they need any special measures such as a chair maybe, to be seated rather than standing, to be alone with the judge, with no public and other similar things."[429] Another problem stems from the fact that the person cannot be represented in court by a guardian with a special mandate, strictly for that trial;[430] instead, the person must be placed under interdiction and a guardianship must be established, which requires a reassessment with the Forensic Medicine Institute (IML) and special efforts by the family.



"- Did anyone from the commission or the assessment service informed you that you have this right to appeal if you are not satisfied, or did someone else advise you?

- No. The disability degree assigning commission didn't tell us, and neither did the social assistance service, nobody told us. I can say that, luckily, I was informed about these things, because two years before [the daughter turned 18] I started to look for information about these things personally; but even so, I didn't know about everything. ... I knew that we had to file an appeal in court if we don't get the same degree... I did know that, but I did not know what that meant. ... I wrote in the appeal petition that I am representing her, because she has difficulty speaking. You can imagine, I didn't know I needed a power of attorney, I didn't need I needed guardianship... I didn't know any of those things... And we got there, we both stood up and took some steps forwards and of course, the judge asked me, but who are you? Well I am the mother. So what are you doing here, what do you want? ... She told me very nicely that she was going to talk with me, but that nothing I say could be noted, because I have no power of attorney or anything. She is deemed to be an adult... So then the judge lady advised us about the guardianship... The neurologist and the psychiatry lady also told us about the guardianship, but she didn't tell us it was an emergency. She only told us that we should do it... We didn't even consider it. And after the judge lady told us, we did it. ... We are still in court. We appealed in court against the disability degree, the trial is on since July 2019. We are now struggling around the Forensic Medicine Institute thing... It's a marathon... We have to do everything in five days, everything. It's very difficult." (Interview with a woman with disability, 20 years old)

Other missing adaptations concern the fact that no independent experts are summoned to the court, such as psychologists or social assistants, especially in the case of people with intellectual and psycho-social disabilities. In fact, it is not clearly regulated what evidence is admitted in these cases and whether witnesses are allowed or not; these issues are strictly for the individual court to decide.

429 Interview with a lawyer.

430 The UK, for instance, has the institution of a litigation friend who can represent a "protected party" (child or adult) in court. A litigation friend may be a parent or guardian, a family member or a friend, a lawyer, a representative of the Protection Court or a person who has a long-term or a permanent mandate. For civil cases, the "litigation friend" is appointed by request, by court decision, after the court checks that it can make decisions about the case in a correct, competent manner and its interests are not in conflict with the interests of the protected party. After the check is performed by the court, the litigation friend receives an appropriateness certificate based on which they represent the protected party in the courtroom hearings. The litigation friend can be appointed at the beginning of the proceeding or at any time during the proceedings. Their mandate can end as soon as the protected party is able to represent themselves (for instance, when the child turns 18 or the adult is recovered), or at the end of the proceeding. If necessary, the litigation friend can be replaced during the proceedings.

"In the Parkinson disease case, we asked for testimonial evidence and the judge said that he shall dismiss the testimonial evidence, because a health status is not proven by witnesses, but by medical documents only... It's just that, in such cases, as I said, you have to prove the everyday life, the level of autonomy... things that only the family or the people who are very close to the person are aware of. So, several other things need to be proven, besides the health status of the person." (Interview with a lawyer)

Solving the issue of insufficient, non-homogeneous procedural adaptations requires changing the law and developing support services that operate along the administrative litigation tribunals. The DGASPC, however, could play a more active part, from providing correct, complete, and timely information about the appeal proceeding to drawing up a detailed substantiation of the degree classification/non-classification solution provided in the certificate, to providing support in preparing the appeal petition and counseling for the dissatisfied person and their family. Developing an actual complaint and appeal redress mechanism that respects the principles of accessibility, equity, predictability, transparency, and continuous learning could be a way to support those who disagree with the assigned disability degree and reduce the number of appeals filed in court. And for those people who would still file in court, the DGASPC, through a dedicated department, could provide guidance services and refer people to free legal assistance, maybe under a collaboration protocol with the Bar Association and with NGOa, and prepare for the courts a list of procedural adaptations required for each person, based on data in their file and interactions with the person and their family. Thus, the DGASPC could provide some type of intermediation between persons with disability and the courts, and support a correct, informed, and respectful process of disability certificate appeals.

7.4.4. Court Substantiations when Rulings Favor People with Disabilities

The documentary review[431] of court substantiation samples in cases of disability certificate appeals revealed two main aspects that the courts acknowledge when they rule in favor of petitioners/people with disabilities. These are: (i) no substantiation of the CEPAH decision provided in the disability certificate (see Box 10); and (ii) aspects that have to do with the procedure or the interpretation of Order no. 762/1.992/2007 on the medico-psychosocial criteria for assigning a disability degree. The need for a detailed substantiation of the CEPAH decision to assign a disability degree (or not) through the certificate, more than "just copy-paste from the order,"[432] was also mentioned in all interviews with judges and lawyers as a key prerequisite for a fair trial.

431 In the institutional survey Q3D, CEPAH secretariats were asked to redact and provide the following to the research team: (a) two most recent court judgments that remained final in cases of appeal on disability degree certificates, irrespective of their results, and (b) the most recent court judgment by which a disability degree was changed (without ordering reassessment by the SECPAH or CEPAH). 11 counties provided one or two final court judgments. This sample was supplemented using other court judgments available online.

432 Interview with lawyer.

BOX 10 Excerpt from a final court judgment

Motivarea actului administrativ constituie o condiție esențială de validitate a acestuia, lipsa motivării ducând la nulitatea actului.

În speță, o motivare concludentă și detaliată se impunea întrucât, așa cum s-a învederat anterior, același cod boală a fundamentat într-un interval relativ scurt de 7 luni un alt grad de handicap. Motivarea se impunea și pe considerentul puterii de apreciere al pârâților. Câtă vreme au o putere de apreciere a criteriilor medicopsihosociale, încadrarea într-un grad de handicap trebuie fundamentată pe o analiză concretă a acestor criterii.

(1) No substantiation of the decision to assign/not assign a disability degree

A substantiation of the CEPAH decision to assign/not assign a disability degree, accessible to all persons at the end of the assessment process, is not available in all counties (see also Chapter 5). In the sample of 24 counties and 2 Bucharest districts,[433] six CEPAH secretariats reported that they do not provide a substantiation of the decision in cases where the applicant is classified into a deficiency degree or for those in which the applicant is not classified. The remaining 20 counties do issue a substantiation of the CEPAH decision. In the majority of cases, the substantiation is drafted by the CEPAH (in 16 out of 20 counties).[434] However, in only 4 counties is this substantiation a written document enclosed with the disability certificate, with detailed information about the decision to assign or not assign a disability degree, and which can be used in court.

Most often, the substantiation is just a box that gets checked on the disability certificate,[435] only filled in for applicants not classified into a deficiency degree (in 8 counties); in other counties, that box is filled in for all persons, irrespective of whether the disability degree (6 counties) is assigned. However, some counties only provide verbal information, which the person receives at the end of the CEPAH meeting, if the person attended it, or in some other context (1 county); as well, there are counties where a substantiation is only released upon the beneficiary's request (1 county). Moreover, the substantiation is accompanied by a specialist's explanation in only 11 counties. The specialists who provide the explanation on the substantiation are either the president or some other CEPAH member, or the SECPAH physician, or both.[436] Most counties (9 out of 11) report that the explanation of the substantiation is provided in simplified language.

Therefore, most counties lack a written document with detailed information substantiating the CEPAH decision to assign/not assign a disability degree that can be used in court. The absence of such a document makes the disability certificate appeal proceedings more difficult, both from the perspective of the petitioners and the judges who have to rule in such cases. In addition, the detailed substantiation is recorded in the CEPAH meeting minutes in just three counties.[437] But even in these three counties, a person who files an appeal against

433 Institutional survey Q3D.

434 In the remaining 4 counties, the substantiation is drafted by SECPAH and approved by CEPAH.

435 Box II in the disability certificate, according to GD no. 430/2008, Annex 1.

436 Out of the 11 CEPAH secretariats, 8 reported that the explanation is usually provided by the president or another CEPAH member; 2 mentioned the SECPAH physicians, and one declared that the explanation is provided by a CEPAH member of the SECPAH physician, as applicable.

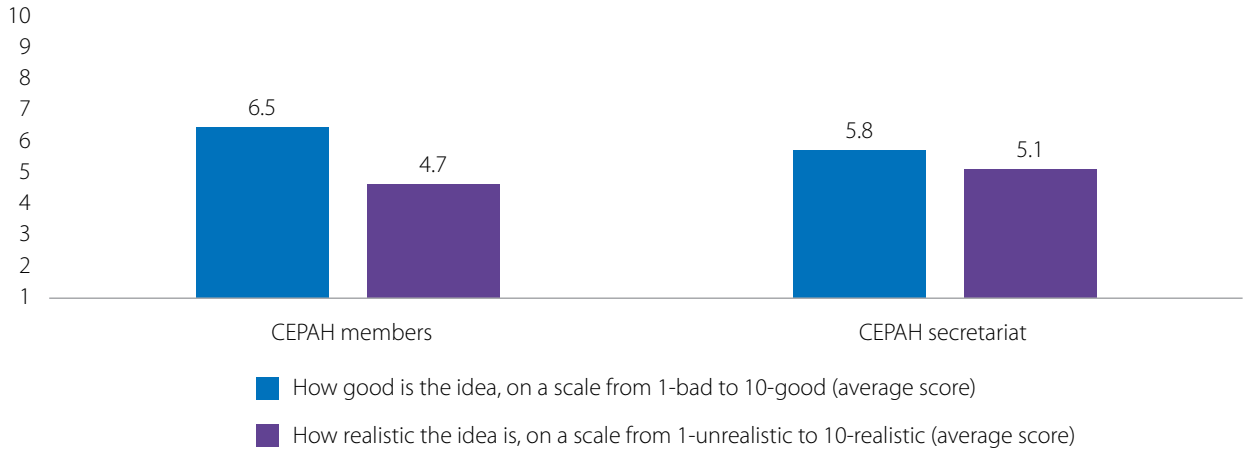
437 The CEPAH secretariat: (d) draws up the minutes of the CEPAH meetings and (f) manages the register of minutes (GD no. 430/2008, Art. 15 (2)). An analysis on the minutes of CEPAH meetings is provided in section 5.1.2.

the disability certificate can request and receive an excerpt of the minutes of the CEPAH meeting, however, such a document would be of no use in court. Therefore, the homogeneity of the court rulings is not possible without substantiations of the decisions provided in the certificates, drafted by the SECPAH and CEPAH specialists who are involved in assessing and determining disability.

One way to deal with the absence of substantiations would be the following: (i) introduce a standard template for the substantiation of the disability degree assignment/non-assignment, based on which the appeal against the disability certificate could be formulated in court; (ii) this document should be issued by CEPAH (in correlation with the conclusions and recommendations of the SECPAH assessment report), together with the disability certificate; and (iii) at the end of the assessment process, should be sent to the person along with the package of approved documents. Figure 47 shows the differing opinions of CEPAH members and secretariats regarding the aforementioned scenario. The average scores, on a scale of 1 (bad/unrealistic idea) to 10 (good/realistic idea) show that practitioners deem the scenario to be a somewhat "good idea" but unrealistic.

The results of the analyses of Chapter 5 and subchapter 9.3 regarding the activity and CEPAH's institutional resources provide explanation for that. Since the assessment commission members have about five minutes per case, on average, to come to a decision, it is understandable why expanding their responsibilities is realistic only in some counties, while in most others it would be difficult or impossible to achieve. Therefore, to make the appeal process more efficient, the process of assigning a disability degree should first be made more efficient. Given the resources and institutional arrangements in place at CEPAH level, it does not seem possible to substantiate the decisions given in the disability certificates in a way that could serve as an input for the courts.

Figure 47: Practitioners' opinions about introducing a standard template for substantiating the disability degree decision, based on which the appeal against the disability certificate could be formulated in court, on a scale of 1 to 10 (average scores)

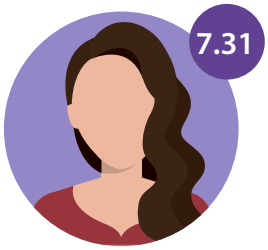


Source: Opinion survey Q3B: Practices and experiences of CEPAH members (N = 65) in 24 counties and 2 Bucharest sectors. Institutional survey Q3D: Appeals on the disability degree and disability type certificates (CEPAH Secretariat) in 24 counties and two Bucharest sectors, January-February 2021.

(2) The procedure for interpreting the medico-psychosocial criteria for assigning a disability degree

Regarding the medico-psychosocial criteria, the analysis of a sample of court substantiations revealed the following elements that the courts acknowledge when they rule in favor of petitioners/people with disability: (i) medical documents are incomplete or mistakes exist in the medical documents based on which CEPAH made the decision, as illustrated in Box 11 (ii) medico-psychosocial criteria are interpreted in a way that is not compliant with Order no. 762/1.992/2007, as shown in Box 12 (iii) in cases of transition from the children's CPC to the adults' CEPAH, when the parents of children with severe deficiencies lose their personal assistant status and other benefits because of the differences between the criteria used by the two commissions; and (iv) when CEPAH decides to assign a disability degree solely based on the medical assessment, without taking into account other evidence provided by the applicant, such as the psychosocial information.

In other words, in general, the courts rule in favor of persons with disabilities in cases when SECPAH/CEPAH are in breach of certain procedural aspects, or in connection with granting the right to receive benefits or services (especially personal assistant services) without considering the social (and not only medical) circumstances and characteristics of the case.



"JUD1: There are certain problems,[438] (the person) lives alone, the family is in a different town, no home care services are available... all that people see is the disability degree assigned. For us, the revenues of a person are of no relevance, but if they are assigned a "serious" (disability degree) and they go to court, that person will win! On the other hand, the social investigation doesn't say anything about the context! We have a lot of court cases lost SOLELY because of the social investigation! The social context is not sufficiently taken into account! Some persons were assigned a disability degree by the court solely based on social criteria, on the impossibility of the person to manage themselves by themselves. The services developed by local town halls are missing. People come for this money, the disability allowance. Nobody at the town hall follows up on how this money is spent. The social investigation does not contain information on the services that a person received, on how they are looked after. …

JUD 2: However, medical criteria are the most important ones, because they are more objective. Social criteria are more subjective and leave room for interpretation. We let the courts decide in such cases In our case, the County Council legal department represents us in court; we just draft reports for those legal advisers. But they don't know how to defend such cases. And they lose a lot of these cases ... about 10 in a month." (Focus group CEPAH 2)

BOX 11 Excerpt from a final court judgment

În continuare, Curtea constată că din cuprinsul raportului de evaluare complexă întocmit de Serviciul de Evaluare Complexă a persoanelor Adulte cu Handicap şi avut în vedere la eliberarea certificatului de încadrare în grad de handicap nr. [redacted] din [redacted] 2015 lipseste numele psihologului care a efectuat evaluarea medicală a recurentului–reclamant şi a stabilit valorile GAFS -80 şi MMSE-23. Totodată, Curtea mai observă că la rubrica „Psiholog" din cuprinsul raportului arătat nu apare semnătura persoanei care a efectuat evaluarea psihologică.

În aceste condiţii, Curtea apreciază că lipsind datele menţionate cu privire la persoana care a efectuat evaluarea psihologică în cauză, valorile de GAFS şi MMSE cuprinse în acest raport nu pot retinute ca fiind reale.

De asemenea, Curtea reţine că, evaluarea psihologică efectuată de psiholog Florea [redacted] (fila 42 în dosarul Curţii de Apel [redacted]), la testul MMSE şi la care reclamantul a obţinut un scor de 10 puncte nu are relevanţă în cauză întrucât nu rezultă data efectuării acestui test.

438 The discussion in the focus group was about the case of an elderly person, aged 68, with Alzheimer dementia, going through her first assessment for a disability degree. The conclusion of the social investigation was: "It is recommended to have a disability degree assigned for the person and obtain the benefits provided by the law", and the following information was included: The person lives by herself in a two-room flat on the 8th floor; she can walk; she has difficulties in carrying out instrumental activities; she gets lost frequently; she forgot the water running several times; it happens that she goes shopping and does not remember how to come back; she forgets to take her medicine; she no longer washes herself and is no longer interested in what she looks like; she has only one friend who lives in the same building, but has big health issues as well. Her daughter lives in a different town, and they are in touch by phone.

BOX 12 Excerpt from a final court judgment

Prima instanţă a reţinut în mod corect că actul administrativ în litigiu este nelegal dat fiind faptul că acesta nu este motivat. Astfel cum rezultă din cuprinsul certificatului de încadrare în grad de handicap nr.1110/22.02.2018, la rubrica „Motivare", nu se menţionează motivele pentru care comisia a optat pentru încadrarea reclamantului în gradul de handicap „grav", respectiv de ce nu se impune încadrarea acestuia în gradul de handicap „grav cu asistent personal".

Ori, motivarea unui act administrativ trebuie să conţină elementele de fapt şi de drept care să permită destinatarilor să cunoască si să evalueze temeiurile si efectele deciziei si să facă posibilă exercitarea controlului de legalitate, motivarea unui act administrativ fiind o condiţie de legalitate a acestuia.

În condiţiile în care certificatul de încadrare în grad de handicap nr. nr.1110/22.02.2018 nu conţine elemente de fapt care să îndeplinească exigenţele unei motivări, acesta este nelegal.

Referitor la încadrarea intimatului în gradul de handicap grav cu asistent personal, Curtea reţine că potrivit referatului medical – fila 57, încheiat de un medic primar boli infecţioase, biletului de ieşire din spital(f.58) şi scrisorii medicale(f.60), intimatul prezintă diagnosticul de *imunodeficienţă dobândită stadiul B3*.

Potrivit art. 85 alin. 3 şi alin. 10 din Legea nr. 448/2006 privind protecţia şi promovarea drepturilor persoanelor cu handicap, *încadrarea în grad şi tip de handicap a adulţilor cu handicap se face de comisia de evaluare a persoanelor adulte cu handicap, pe baza criteriilor medicopsihosociale aprobate prin ordin comun al ministrului muncii, familiei şi protecţiei sociale şi al ministrului sănătăţii.*

Potrivit criteriilor prevăzute de Ordinului nr. 762/2007, Cap. 4, subcap. III, punctul C- Funcţiile sistemului imunitar; Evaluarea gradului de handicap în sindromul imunodeficitar cronic dobândit , *în stadiile A3,B3,C1,C2,persoanele vor fi încadrate în grad de handicap grav. Necesită asistent personal. Supraveghere medicală permanentă.*

Intrucât, din probele administrate rezultă că intimatul prezintă imunodeficienţă dobândită stadiul B3, stadiu al bolii avut în vedere de pârâtă numai că pârâta a invocat că doar în stadiul C3 al bolii, când îşi va pierde total capacitatea de a efectua activităţi de autoservire, autoîngrijire şi autogospodărire, va avea dreptul la asistent personal, sunt întrunite condiţiile pentru a fi încadrat la gradul de handicap grav cu asistent personal, cum corect a reţinut prima instanţă.

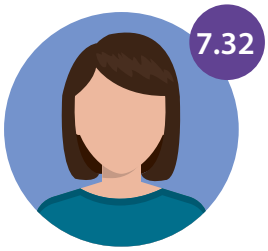
According to the judges and lawyers interviewed, all documents in a case file must be analyzed in order to substantiate the decision to assign/not assign a disability degree. The social investigation that reflects a person's circumstances and their degree of autonomy or their specific needs constitutes information that needs to be combined with medical documents to obtain a complete medico-psychosocial assessment. In addition, "those who decide on a degree should substantiate every time why that disability degree should be assigned... explain. And have better knowledge of the content of the Order,[439] in order to assign the correct degree; improve themselves or treat the case more seriously, analyze the documents in the file more carefully and listen to the families."[440] In contrast, according to CEPAH members, social investigations provide, in general, "poor quality of information;" the psychological tests are often "of low relevance" and only the medical documents and criteria "have a higher degree of objectivity."

439 Order no. 762/1.992/2007 on the medico-psychosocial criteria for assigning a disability degree.

440 Interview with a judge.

7.4.5. No Information or Specialty Support at Court Level

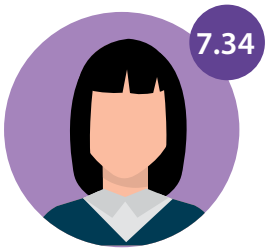
A consequence of the fact that the disability assignment is predominantly based on medical criteria/ assessment (Chapters 4 and 5) is that SECPAH and CEPAH practitioners share the belief that courts rule in favor of the petitioners/ people with disability for the very fact that they lack medical knowledge and, therefore, "don't understand the criteria," besides the fact that they are "easy to impress."



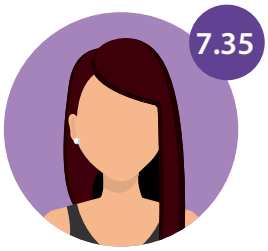
"In court, the Social Investigation is very important for the judge's judgement. Many times, the patient goes there in a chair and creates a different impression for the judge, although one day before the patient was walking. He believes the patient, not the commission. The previous system, with the Higher Commission, composed of practitioners, had a totally different value. You cannot ask a judge whose medical knowledge is not complete to judge on... There should be a body of specialists, just like, in case of malpractice, a medical certification is required, there should be a body of experts at county level that the judge should be able to rely on for expertise. I witnessed myself how much a judge could be impressed, the judge assigned a severe disability degree with personal assistant, although the diagnostic is not even among the criteria." (Focus group CEPAH 3)

"Years ago, you would consider the disease plus the sequelae of the disease (other conditions). But this way of working had to be changed in the recent years because of the numerous court proceedings. Judges don't understand the criteria. We had a case that did not fit for the disability degree that the person requested. The court ordered that we assign a permanent serious disability degree. We were told that, should we not do that, we'd fall under the criminal law. We are not scared by how a judge assigns a disability degree, but professionally speaking, we provide the answers according to the law. But there are cases when we are asked to return the money... and we pay out of our pockets. We don't have a lawyer of the institution. The Directorate [DGASPC] says that SECPAH belongs to them, to the County Council, and they don't defend us at all. We paid a lawyer ourselves; it's like we don't belong to anyone... But then we started to take the social aspects into consideration more, so that we can avoid such situations. But then we are obliged to ask for more documents, to make sure we don't make a mistake." (Focus group SECPAH 4)

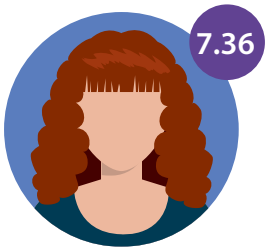
Persons with disability expressed diverse opinions on this topic in their interviews, as shown by quotations 7.34-7.37 below. The dominant opinion, however, is that they "should not be forced to spend time in courts," and should be "assessed by the specialists correctly." These opinions, too, tend to put more weight on medical criteria and the lack of medical knowledge at the level of the courts.



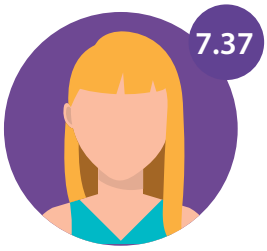
"Now when we got back to the tribunal, we got to this judge who understood all of it very quickly, and I even asked the lawyer, how come he knows, and she told me that his wife was a medical practitioner." (Interview with the mother of a woman with disability)



"I would say, everything is very biased there [in court]. I mean, I don't believe that... I don't understand why... I tell you again: why does a disabled person need to get in front of a judge... what skills qualify that man for the person with disabilities? It is totally out of place, I don't see the logic of that." (Interview with a medical practitioner, mother of an 18-years-old boy with Down syndrome)



"There should be another commission [like the Higher Commission used to be] or there should be a physician in court. There can be no physician in court, I know, but an expert... There is no way for a judge to know all those medical terms, he couldn't possibly know all the diseases... We asked for counter-expertise and the court didn't accept it. It would have been fair to accept it, because the judge only has those documents that the diseased person, the disabled person brings, he can't tell the severity of the disease... He couldn't... The judge never heard of tuberous sclerosis, just like the doctors on the commission never heard of it, those who were on the commission never heard of it. Also, when we went to the commission, honestly, I tell you, there was no doctor on the commission." (Interview with the mother of a woman with disability)



"Appeals should not be filed with the court; it's not logical, there are no competent people there who can read some medical reports." (Interview with the mother of a woman with disability)

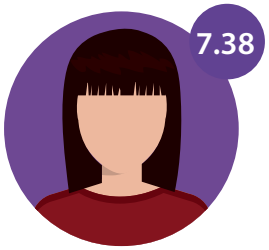
In response, the interviewed lawyers and judges declare that, at least sometimes, they are challenged to understand the specific language about disability used by doctors, psychologists, and social workers. The lack of information or specialty support at court level to help "translate" the medico-psychosocial criteria forces judges and lawyers to ask "for help from friends who work in the medical field, informal help." But most often, that happens because there is no substantiation in the file to explain why the disability degree assigned by CEPAH is necessary, and the existing explanations included in the certificates are often merely referring to Order no. 762/1.992/2007 (see Section 7.4.4).

All interviewed lawyers and judges are aware of and reject the general opinion among disability practitioners that a judge should not make different decisions than the assessment commission members. Regarding this opinion, lawyers and judges answer that any specialist in the field of law can identify documents that are not complete or contain mistakes; they can identify interpretations that do not comply with the law, and they can understand whether the case was treated seriously or not, whether all documents—not just the medical ones—were analyzed carefully, or whether the person and their representative/family were heard by the commission or not. As for more complex cases, a judicial expertise can be ordered, and the

case sent to a medical expert or to the Forensic Medicine Institute (IML). Therefore, the judge must only decide based on evidence, irrespective of whether their decision confirms or dismisses the resolution given by CEPAH in the disability degree certificate. Otherwise, it would mean that "you restrict the persons with disabilities' access to justice. This is not acceptable in any way."[441]

However, stakeholders agree on two topics. The first is the fact that there is no support available to the courts in terms of information or specialty support regarding disabilities and medico-psychosocial criteria. It is from this point of view that the opinion according to which the "previous system, with the Higher Commission, composed of practitioners, had a totally different value" prevails not only among practitioners, but also among petitioners. They all emphasize the need to have a complaint and appeal redress mechanism, the "reinstatement of the Higher Commission," "another commission," "one additional commission" or a "body of experts" at county and national level to "act as a buffer" between SECPAH/CEPAH and the judiciary and serve as a "verification factor for us, as a commission, whether or not we do our work correctly." In addition, those who were dissatisfied with the disability degree assigned to them would have the ability to go "for a second opinion without having to go to courts."

Going to court should be an option for anyone, but usually, it is not the only option available to the dissatisfied person. To this end, all modern systems that provide services to the population, especially to vulnerable groups such as those with disabilities, have developed complaint and appeal redress mechanisms that do not prevent citizens from pursuing their rights and interests by using any other route (administrative law proceedings or other official litigation mechanisms), at national or local level; nor are they meant to replace the judicial system or any other form of legal action.

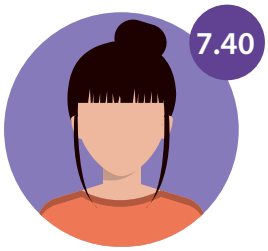


"Another issue of the essence is the dissolution of the Higher Commission. It is a matter of financial efficiency as well, and it was also a verification factor for us, as a commission, whether or not we do our work correctly. For instance, we have about 50 cases per month in the courts, much more than before, when the Higher Commission was in place. Assessments from outside are not objective, we don't have any mechanisms to verify them, we even tried to develop some procedures. Quite frequently, we call the person in for an interview. Our legislation is as if everybody is correct, and we have no control mechanism, to control whether what comes from outside is assessed correctly. The most frequent cases are dementia cases, where there is massive simulation, the persons were doing better than ourselves in the MMSE." (Focus group CEPAH 1)

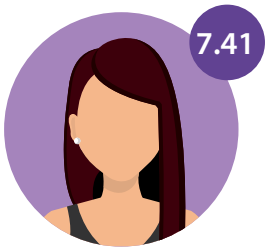
"JUD1: A person having a disease does not equal a person having a disability. The Higher Commission to be established again. In addition, there should be a recovery plan for the person, so that we can see what services they received. Recovery to be monitored. All these measures are absolutely necessary. …

JUD2: The Higher Commission—when they were the point of appeal for the certificates, the Commission was like a buffer, while now, the first instinct is to go to court. In our case, administrative litigation, things are different, compared to assessing a person's capacity to work, where the cases go to the labor court; it would take away some of the workload." (Focus group CEPAH 2)

441 Interview with a judge.



"I think it would be very easy to have someone, at the DGASPC, someone who looks at the appeal, so that you don't have to do all those things—I had to make thousands of copies of all the documents. The DGASC people could send these to the IML and sort things out between themselves. Why all this time and all this money wasted. ... Everything is so cumbersome, expensive for them and for us. I don't even know what to say, there are times when we don't even feel like human beings." (Interview with a woman with disability, 22 years old)



"The court has no competence to issue a disability degree; actually, the court decides about something that can be real or not... They didn't take the psycho-social criteria into account; they just took the medical criteria into account. From our complaint that the psycho-social criteria were not taken into account, they now take the medical criteria into account and they actually check the accident. Every doctor would go and feel and see how much of the bone is missing, but for the person involved, it's very annoying. They waste people's time, instead of having a collaboration between all ministries, social and educational as well." (Interview with a woman with disability, 20 years old)

In other words, increasing the number of experts on medico-psychosocial criteria remains a constant need, both regarding the current system or in terms of developing a complaint and appeal redress mechanism at DGASPC level. In both scenarios, the number of existing experts is insufficient to ensure that dissatisfactions are settled in a fair manner and according to a procedure that is accessible to all people with disabilities.

The second topic that finds consensus is the lack of training on these topics, among both judges and lawyers. "There is no additional training whatsoever [to work with people with disabilities]. They train themselves. I don't recall... except for the training and the activities I had under some projects, but I don't recall any other professional training programs/courses in this field."[442] The National Institute for Training and Improvement of Lawyers (INPPA) and the National Institute of Magistracy (INM) do not provide any training in the field of the rights of people with disability.

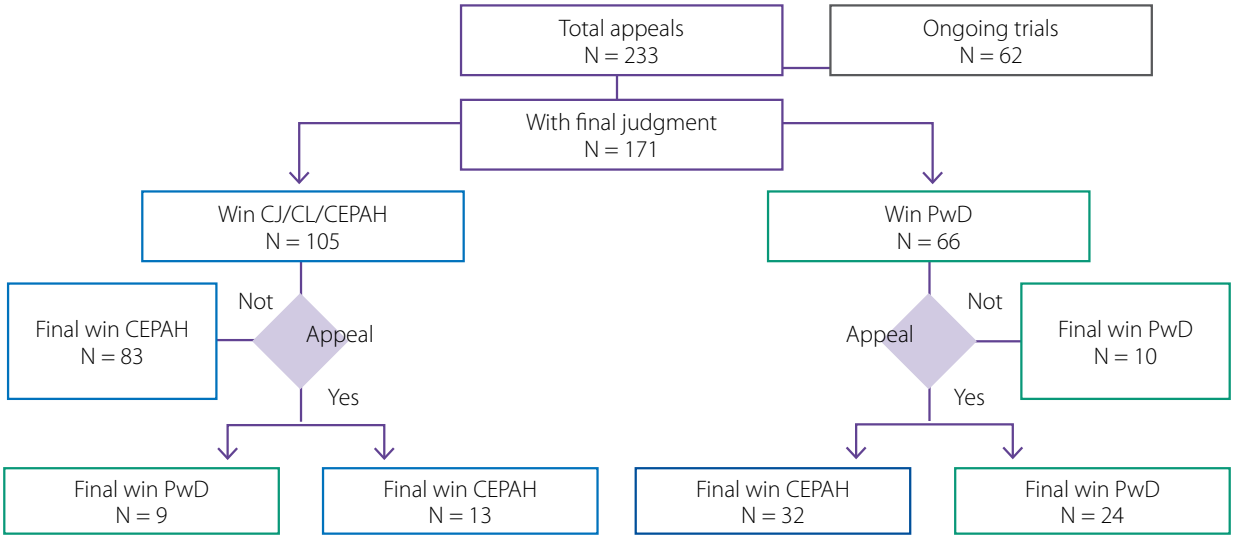
The first issue has to do with poor understanding of how people with disabilities need proceedings to be adapted when they challenge the certificate. The second issue involves the organization of the court and the fact that the administrative litigation court is not prepared to work with claimants who have disability. The third issue has to do with access of lawyers and magistrates to information resources—all information is predominantly technical and medical, in which case clarifications are needed. Moreover, many judges need to understand that the needs of people with disabilities go beyond their medical diagnosis, and that support to live independently in the community is key to their quality of life.

7.4.6. Statistics Regarding the Certificate Appeal Process

This section presents an analysis of the statistics regarding appeals to the disability degree certificate, as reported by CEPAH secretariats in the institutional survey Q3D. Out of the 24 counties and 2 Bucharest districts responding to the survey, only 10 counties provided detailed statistics for November 2019 and November 2020. The aggregated statistics are provided in Flowchart 6. The analysis focuses on the November 2019 statistics for two reasons. First, the share of appeals for which a final judgment had been issued by February 2021 was 73 percent of the total number of appeals of November 2019, but only 39 percent of those of November 2020; the remaining trials were still ongoing at the time of the survey. Secondly, the 2020 statistics are most likely affected by the COVID-19 pandemic.

442 Interview with a lawyer.

Flowchart 6: Statistics regarding appeals of November 2019, in 10 counties



Source: Institutional survey Q3D: Appeals on the disability degree and disability type certificates (CEPAH Secretariat) in 10 counties that provided statistics, January-February 2021.

Notes: Final win = favorable final decision; CJ = County Council; CL = Local Council.

The existence of an appeal register at the CEPAH secretariat does not ensure that statistics are available for monitoring. The existing appeal registers are not only out of use or not updated in most of the counties, but even when they are used, they do not record relevant data (about admitted/rejected appeals, phase of the appeal process, results, etc.) to enable the process to be monitored, ensure continuous learning, and make the mechanism transparent. Thus, out of the 10 counties that still have and use an appeal register, only 3 provided the requested statistics. The others reported that they do not have this data or provided partial information.

Therefore, the data on which this analysis is based is not collected systematically or analyzed by the DGASPC/CEPAH. The results of the analysis are rather indicative, since the validity and completeness of the data provided by the counties cannot be confirmed. Out of the 10 counties that provided statistics, 6 CEPAH secretariats reported a maximum of 10 appeals. Three counties—Cluj, Harghita, and Satu Mare—reported fewer than three appeals for the reference months. Therefore, three-quarters of the appeals analyzed in this section only come from two counties, Suceava and Arad.[443]

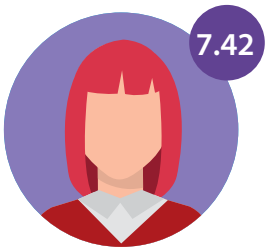
The statistics concerning the appeals confirm the information about the average duration of the appeal process, provided in Section 7.4.1. Thus, out of the appeals filed in November 2019, more than one-quarter (27 percent) were still ongoing in February 2021. The percent goes up to 61 percent when considering appeals filed in November 2020. In other words, the average duration of the process is most likely more than one year, while many of the petitioners are required to renew their certificates every year.

A small portion of persons with disabilities who appeal against the disability certificate get a favorable ruling. For the appeals registered in November 2019 that were completed, the share of persons with disabilities who got a favorable ruling in the first court was only 39 percent, and the percentage of those who had a final favorable ruling was even smaller, of only 25 percent (see Flowchart 6). Out of the appeals filed in November 2020 that were completed, the respective percentage is even smaller: 30 percent of petitioners in the first court, and 16 percent with a final ruling. In all other cases, namely in the large majority of appeals against the disability certificate, the courts ruled in favor of the County/Local Council or CEPAH. This result seems to be in line with the findings of the documentary analysis of court substantiations (Section 7.4.4), which show that, in general, the courts rule in favor

443 As we mentioned at the beginning of this chapter, there is no research or data to show whether these counties indeed have much higher rates of appeal compared to the other counties, or they are just more active in registering appeals and are, in reality, typical at national level.

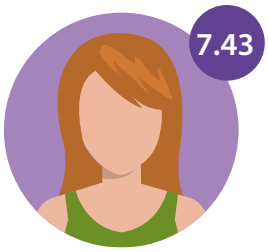
of people with disabilities only when SECPAH/CEPAH is found in breach of procedural aspects, or in connection with the awarding of the right to services and benefits established without considering the social (rather than just medical) circumstances and characteristics of the case.

The DGASPC/County Council/CEPAH do not file for an appeal in all cases in which the first court favors the person with disabilities (see Flowchart 6). In fact, the interviews with lawyers and judges show that, at least in some counties, the presence of DGASPC/County Council legal advisers in court is unpredictable. It is not clear on what grounds or criteria the DGASPC/County Councils establish which appeal cases show up in court, or for which cases they file an appeal. Greater clarity in this respect may be helpful for the courts.



"... because the disease is not contained in the classification code, [the son] was not assigned with a severe degree, but with a serious degree. [...] You see, we filed an appeal twice. With the second appeal, we started the appeal somewhere in February last year, 2020, and it ended no earlier than September. They [DGASPC/CEPAH] did not file for an appeal, because they realized that, last time, we also won in the appeal phase. So on the second year, when they saw it was the same thing, we asked for court expenses. On the first year, we didn't ask for anything; on the second year we asked for court expenses too, so they thought, they [DGASPC/CEPAH] wouldn't have all that money that they would be required to pay back. Besides the difference in the disability degree, because they had to award that too." (Interview with the mother of a woman with disability)

People with disabilities rarely file for an appeal if they lose in the first court (see Flowchart 6). Only about 20 percent of those who did not receive a favorable ruling in the first court file an appeal and go to the higher court. The reasons communicated in the interviews are varied. Some give up because they are discouraged; they do not trust that "the system will ever say that we are right;" others cite the financial costs, time, and energy required, which are already deemed high from the first phase of the trial. Several interviewees, however, discussed the "cumbersome procedures," especially those pertaining to a reassessment at the Forensic Medicine Institute (IML). People with disabilities consider the only advantage of the IML reassessment occurs if the physician at the IML is also a member of the CEPAH, which could help the person in a future assessment for certificate renewal, as the quote 7.43 below shows.



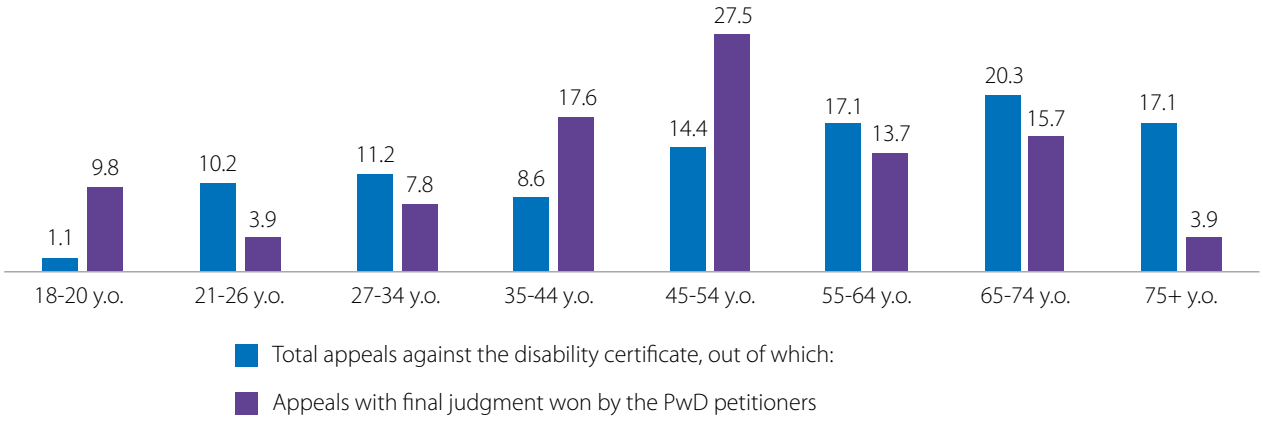
"So, we did file for appeal, definitely... It was a continuous fight. Yes, yes. That's how it was. ... They sent us to IML, and there, she got reassessed, with all aspects: neurological, psychological, psychiatric, and they gave the diagnosis and everything that was necessary, the IML, and then based on that... I was there with her, she was hospitalized for one day, they assessed her. It was terrible. At first, when we got to IML, the things are so... weird... A nurse takes the file and reviews it, and you wait for one or two or three hours until it's your turn to be assessed by a specialist doctor, who didn't want to... so that doctor, based on our medical reports from specialists, she could have given her consent, but she didn't want to. She preferred to send us to their own specialists at the IML for the reassessment. To be honest, it was ok with me, because I felt it was the fairest thing to do, and the thing is that the doctor who saw her there... at the IML, she was also a member of the assessment commission... Afterwards, because we were rescheduled in 2 weeks... This was a long one. So we were rescheduled to go there in 2 weeks...and she was there, sitting on the commission, when they gave the verdict. I was happy, in the end it was as it should have been... because that's the reality, there is nothing to hide. I had a hemorrhage while I was pregnant, and part of her cerebellum did not develop. ...She is not... If you see her, apparently, she doesn't look like she has any retard; just that, everything that is related to those functions for which that part of the cerebellum is in charge, with the fine motility functions, hands, speech, walking... Everything that has to do with fine motility functions is affected. We were in aggressive recovery up to around 14 years of age, and then we didn't stick to that pace. We were in Hungary, in Budapest for 5 years. We did everything we could..." (Interview with the mother of a woman with disability)

All the other experiences with the IML only serve to highlight how cumbersome and impersonal the process was. In addition, from the point of view of the ICF and the UNCRPD, the type of assessment performed by the IML has the great disadvantage of being purely medical. So, with the switch to the new paradigm of assessments from the point of view of the ICF, such reassessment could cause significant discrepancies with the assessment of the SECPAH/CEPAH based on ICF principles.

7.5. Profile of those who appeal the disability certificate and win

Only one county provided full data for analyzing the profile of people who appeal the disability certificate and win in court.[444] This section provides a case study of petitioners in the county of Suceava, according to the data available at the CEPAH secretariat, for the appeals existing in November 2020. The complete table is available in Annex 7.

Figure 48: Persons who filed and won appeals against the disability certificate, by age, November 2020, case study for Suceava county (% of total)



Source: Institutional survey Q3D: Appeals against the disability certificates (CEPAH Secretariat), January-February 2021 (N=187 total appeals filed, out of which 51 won by the person with disabilities petitioner). Note: y.o. = years old.

Adults who file appeals against the disability certificate are men and women of all ages, predominantly from rural areas (65 percent). The majority are people classified with a severe deficiency degree (especially "severe with personal assistant"), with the following types of disability: physical (46 percent), mental (15 percent), or somatic (14 percent). Almost all have certificates that are valid for one year (96 percent) and live with their family (68 percent). Regarding lawyer assistance, the persons who appeal against the disability certificate are almost equally spread in categories of persons with a lawyer of their choice (46 percent) and persons who represent themselves (51 percent), while petitioners who received free lawyer assistance make up less than 4 percent of the total.

The comparative analysis between the profile of people who filed an appeal and people who won through a final ruling of the court shows the categories with a disproportionally high chance of winning (see data in Annex 7). At least in Suceava, the categories that have significantly higher chances of winning in court include young people 18–20 years of age and adults 35–54 years of age (see Figure 48); they are equally men and women, from rural or urban areas, living with family; people with a somatic disability who have a permanent certificate; people under interdiction and having a family member as a guardian; people with at most 8 grades of education, and people who represent themselves in court with no assistance from a lawyer. On the other hand, people aged 55+ represented by chosen counsel in court have significantly higher chances of not winning the appeal against the disability certificate.

444 Institutional survey Q3D: Appeals against the disability degree and disability type certificates (CEPAH Secretariat) in 24 counties and two Bucharest sectors, January-February 2021.

Conclusions of Chapter 7

1. Providing accessible and fair information is a key requirement for any complaint and appeal redress mechanism, without which increased access to justice for persons with disabilities cannot be achieved. However, not all counties currently have detailed information about how to make an appeal that is accessible to all people with disabilities. Thus, Article 9 of the UNCRPD is not implemented equally across Romania.

2. The appeal process is largely unpredictable, and the information provided at the DGASPC level does not, in most cases, help improve predictability, although some CEPAHs developed good practices for providing information, advice, and support. Therefore, relatives, friends, neighbors, social networks, and NGOs are the main sources of information and support for the certificate appeal process. The two measures for improving access to and equity of the process, which were tested by survey, are deemed by system practitioners to be somewhat "good ideas" but less realistic. A change to the law without increasing the available institutional resources would only increase stress and noncompliance. Drafting guidelines that speak specifically to how to appeal the disability certificate, to be distributed to all people with disabilities, could work if the guidelines were developed nationally and provided to all DGASPCs in the country.

3. Romania's disability certificate appeal mechanism does not include a continuous learning dimension. At present, the institutions involved in disability assessment do not identify the key lessons or take steps to improve the mechanisms and prevent dissatisfaction. Since 2017, no county covered in the research conducted a rigorous review of the reasons for appeal. In terms of opinions, the three most frequent sources of dissatisfaction regarding the disability certificate concern the assessment regarding: (i) the disability degree; (ii) the valid term of the certificate; and (iii) a lowering of the degree from one assessment to another or in the case of minors transitioning to adulthood.

4. The mechanism for appealing the disability certificate in Romania does not follow the transparency principle that should underpin any good complaint and appeal redress mechanism.[445] Under the terms of the new legal framework regarding the procedure for appealing the disability certificate, established by EGO no. 51/2017, the secretariat of the Higher Commission for Assessment of Adults with Disabilities and the CEPAH secretariats no longer receive or register appeals against the certificates. In addition, they do not collect data based on which statistics, case studies, or more detailed information about how certain cases are dealt with could be published, which is important for proving the mechanism's legitimacy and improving confidence about its efficiency.

445 UNDP (2017: 2).

5

The data collected for this report show that, contrary to the requirements of the law, administrative litigation departments currently do not process appeals against a disability certificate with urgency. Free public legal assistance is available, but there is no awareness of it and it is very rarely used. The process of appealing the disability certificate is characterized by a lack of homogeneous procedures regarding the treatment of evidence at the level of courts, concerning aspects such as admissibility of the objection on grounds of late filing, admissibility of testimonial evidence or evidence by independent experts, differences in whether the court session is declared non-public, availability of support services during the trial, short periods between the court hearings, and court substantiations. Overall, the judicial procedures are only slightly adapted to the specific needs of a person with disabilities, as per UNCRPD (Art. 13). Persons with disability and NGOs express their dissatisfaction or even drop the appeal because of the cumbersome procedure and the costs it entails. Therefore, the new legislative framework (EGO no. 51/2017) did not achieve its declared purpose to facilitate access to justice for people who are not satisfied with the disability degree assigned to them, and it does not support a correct, informed, respectful appeal process.

6

The two main elements that the courts acknowledge when they rule in favor of persons with disabilities petitioners are (i) no substantiation of the CEPAH decision given in the disability certificate; and (ii) aspects related to the procedure or to the interpretation of Order no. 762/1.992/2007 regarding the medico-psychosocial criteria for assigning a disability degree. In general, the courts rule in favor of persons with disabilities in cases when SECPAH/CEPAH are in breach of certain procedural aspects, or in connection with granting the right to receive benefits or services (especially personal assistant) without considering the social (not only medical) circumstances and characteristics of the case. Introducing a standard template of substantiation of the classification decision, to be filled in by the CEPAH, could be realistically used in some counties, but is difficult or impossible to achieve in most, given that CEPAH members have 5 minutes per case, on average, to reach a decision. Therefore, to make the appeal process more efficient, the process of disability determination should first be made more efficient. Given the resources and institutional arrangements in place at CEPAH level, it does not seem possible to substantiate the disability determination in a way that could serve as an input for the courts.

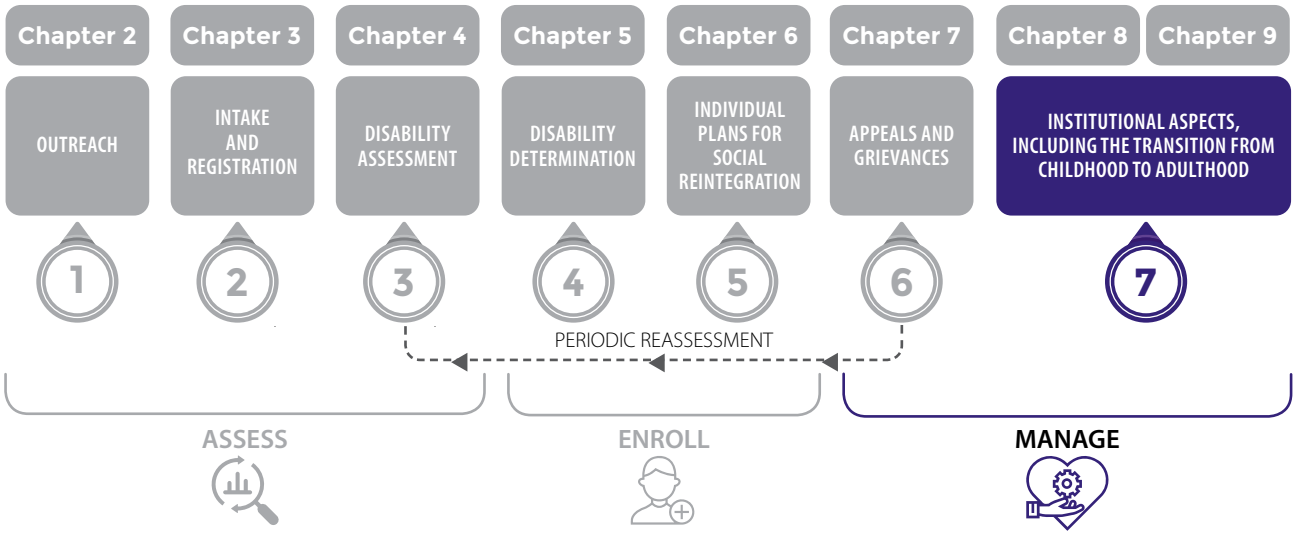
7

Currently, court judgments regarding appeals against disability certificates are highly subjective, for two main reasons, on which all stakeholders involved in the appeal process agree. First, there is no support available to the courts in terms of information or specialty support regarding disabilities and medico-psychosocial criteria. Second, there is a lack of training on these topics, among both judges and lawyers. However, the appeal process cannot be improved by changes made only in the administrative litigation courts; major changes are required at the level of the DGASPC and the ANDPDCA as well.

Thus, all stakeholders highlight the need to have a complaint and appeal redress mechanism to act as a "verification factor" for the SECPAH/CEPAH and an alternative route for people who are not satisfied with the disability degree assigned to them. The DGASPC could play a more active part in this process, from providing correct, complete, and timely information about the appeal procedure to drawing up a detailed substantiation of the degree determination, to providing support for preparing the appeal petition and counseling for the dissatisfied person and their family. Developing an actual complaint and appeal redress mechanism that respects the principles of accessibility, equity,

predictability, transparency, and continuous learning could be a way to support those who disagree with the assigned disability degree and reduce the number of appeals filed in court. And for those people who would still file in court, the DGASPC, through a dedicated department, could provide guidance services and refer people to free legal assistance, maybe under a collaboration protocol with the Bar Association and with NGOs, and prepare for the courts a list of necessary procedural adaptations for each person, based on data in their file and interactions with the person and their family. This new redress mechanism should not be a return to the pre-2017 situation, with a sole commission at the national level working with insufficient resources. Furthermore, the new mechanism should not prevent citizens from pursuing their rights and interests using any other route (administrative law proceedings or other official litigation mechanisms), at the national or local level, neither are they meant to replace the judicial system or any other form of legal action.

8. Young people with disabilities: The transition to adult life



The National Authority for the Rights of Persons with Disabilities, Children and Adoption (ANDPDCA) is the institution responsible for making policy in the field of protection of persons with disabilities (children and adults). In recent years, children with disabilities have become a main target group for the reform of the special protection system, with substantial changes being promoted in the disability assessment process and methodology for children. The legislation regarding the determination of the disability degree for children and young people is based on the International Classification of Functioning, Disability and Health: Children and Youth Version (ICF–CY),[447] adopted by the World Health Organization (WHO) in 2007, on the United Nations Convention on the Rights of the Child, ratified by Law no. 18/1990 republished, and also on the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), ratified by Law no. 221/2010.

The main objective of this chapter is to present the main differences between the disability degree evaluation processes for children and adults in order to identify the bottlenecks in the transition from the child protection system to the protection system for adults with disabilities. The chapter also explores the access to services of people with disabilities as they transition from childhood to adulthood, focusing on the challenges currently faced by young people with disabilities.

446 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.

447 The International Classification of Functioning, Disability and Health: children and youth version (ICF-CY) is a WHO-approved classification "derived" from the International Classification of Functioning, Disability and Health (ICF). https://www.who.int/docs/default-source/classification/icf/whoficresolution2012icfcy.pdf?sfvrsn=2c8e5e9b_4

BOX 13

Legislation governing the disability determination in children and youth

Disability in children is no longer assessed on the basis of the medical model, but on the basis of the social and human rights model, and the fundamental principles of the ICF. The biopsychosocial vision of the ICF (adopted by WHO in 2001) was translated into legislation in 2002, redesigning the comprehensive assessment of children and the whole case management process, and introducing psychosocial criteria, which were inspired by the Activities and Participation component. Subsequently, the psychosocial criteria have been revised twice: in 2012 by aligning with the ICF–CY, and in 2016 by introducing environmental factors. Unlike the assessment process for adults, the assessment process for children is based on the key principles of the ICF.

The main regulations concerning the determination of the degree of disability for children are:

- GD no. 502/2017 on the organization and functioning of the Child Protection Commission
- Order no. 1306/1883/2016 approving the biopsychosocial criteria for classifying children with disabilities into a deficiency degree and the procedures for their application, with subsequent amendments and additions
- Joint Order of the Minister of Labor, Family, Social Protection and the Elderly, the Minister of Health, and the Minister of National Education and Scientific Research no. 1985/1305/5805/2016 on the approval of the methodology for integrated assessment and intervention for the classification of children with disabilities into a deficiency degree, for school and the professional orientation of children with special educational needs, and for the habilitation and rehabilitation of children with disabilities and/or special educational needs.

8.1. Preparing for the transition to adult life and gathering the file

Romania's Civil Code considers a child to be an adult once he or she turns 18 years old. Although legally the change of status takes place on the day the person turns 18, in reality, the transition to adulthood involves a new life cycle marked by major changes, such as leaving school or home and becoming independent.[448] Young people with disabilities also age out of the disability degree classification based on criteria used for children and become subject to classification using the criteria for adults. Current data, including that collected for this report, indicates that the transition to adulthood for young people with disabilities involves a number of challenges. The disability determination process is substantially different for children than for adults. While there are significant personal challenges, environmental barriers are often the most significant challenges young people with disabilities face as they transition to adulthood.

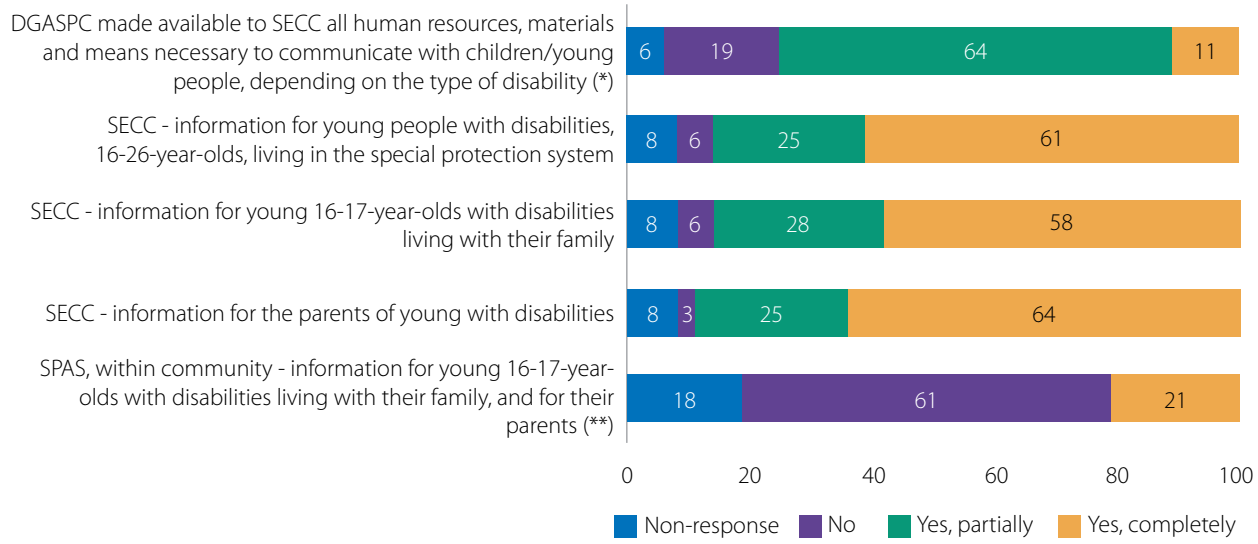
Frequently, within communities, SPASs do not adequately provide young people with easily accessible and comprehensive information about the transition to adulthood, nor are there legislative requirements in this regard. For 16–17-year-olds with disabilities living with their family and for their parents, only 21 percent of the sampled SPASs provide special information on the transition to adult life (see Figure 49),[449] and most of them are in large cities (with more than 20,000 inhabitants). By contrast, small towns and rural communities almost completely lack this type of information.[450]

448 Art. 83 of Order 1985/1305/5805/2016, para. 2, let. b mentions "transition to adult life".

449 Out of the sample of 71 SPASs, 61 percent report that they do not provide special information to young people with disabilities in the care of the family about the transition to adult life, 7 percent say that they do not have young people aged 16–17 with disabilities in the care of the family, living in their locality, and 11 percent did not answer the question.

450 Out of the 18 SPASs in the large cities in the sample, 10 SPASs (or 55 percent) report that they provide young people with disabilities in the care of their families with some special type of information about transition to adult life. By contrast, only 5 SPASs out of 53 in small towns and localities (or 10 percent) provide this type of service.

Figure 49: Informing young people with disabilities about the transition to adult life (%)



Source: SPAS survey with responses from 26 counties corresponding to 71 SPAS, January-February 2021. Institutional study Q2A: Factual data and indicators on the activity of the service for comprehensive assessment of adults with disabilities (SECPAH) and Children (SECC, N = 36) in 32 counties and 4 districts of Bucharest, January-February 2021.

Notes: The age of the 16-17-year-olds is statistically assessed until reaching the age of 18. (*) In accordance with Order no. 1985/1305/5805/2016, Art. 51 para. (2). (**) The non-response category includes 11 percent of the sampled SPAS who did not answer the question and 7 percent who stated that there are no 16-17-year-olds with disabilities in their locality.

Order no. 1985/1305/5805/2016 includes provisions for informing parents and children about the transition to adult life, as part of the comprehensive assessment carried out by the Service for the Comprehensive Assessment for Children (SECC), starting from the age of 16.[451] In terms of implementing this provision, Figure 49 shows that not all young people with disabilities in the country receive such information. Among the 36 counties that participated in the institutional survey Q2A, only about 60 percent of SECCs provide this type of information to all young people with disabilities and their parents, in a typical month, while about 25 percent of SECCs provide such a service to just some young people, regardless of whether they live with their family or live in the special protection system. Also, in two counties, SECC chiefs said they do not implement this provision. Moreover, in the context of the COVID-19 pandemic, the share of SECCs that have provided adult life preparation for all young people with disabilities aged 16–17 decreased, going from around 60 percent to around 50 percent in 2020. However, both before and during the COVID-19 pandemic, almost two-thirds of SECC chiefs reported in the Q2A questionnaires that they were also challenged to carry out these activities because the DGASPC provided insufficient human and material resources to communicate with children, depending on the type of disability (see Figure 49).

Information about the transition to adult life is very unevenly distributed across the country, general in nature, and does not really support young people with disabilities or their families. According to interviews, many people with disabilities have simply come across information about the need to apply for a disability certificate as an adult, or found out when informed by phone that benefit payments have been stopped.[452] Thus, as part of the information activities:[453]

- For almost all young people with disabilities, the SECC informs parents/representatives that when the child turns 18, they will have to apply for classification in a deficiency degree and type to another service (SECPAH/CEPAH), which

451 Also, the habilitation/rehabilitation plan is changed to the habilitation, rehabilitation and transition to adulthood program for children with disabilities. Order no. 1985/1305/5805/2016, Art. 55 (4), Art. 65 (6) and Annex 3.

452 Prior to the approval of the legislative package in December 2016, this information was not mandatory.

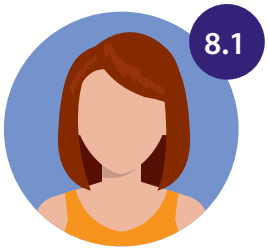
453 The data in the following paragraphs were reported by the SECC chiefs of 28 counties and 3 districts of Bucharest, for 2019 and 2020. Institutional study Q2A: Factual data and indicators on the activity of the service for comprehensive assessment of adults with disabilities (SECPAH) and children (SECC), January–February 2021.

uses different criteria to evaluate applicants and provide services. Among the 31 SECCs studied, 19 SECCs inform parents/representatives of all 16–17-year-olds assessed annually. However, there are also counties where only parents/representatives of young people with certain characteristics receive this information. As a result, in some counties, the share of young people with informed parents/representatives drops; for example, to 85 percent (in AG), 73 percent (in BV), 46 percent (in VL), or even 6 percent (in SV) of all 16–17-year-olds assessed by the SECC over a year.

- Similarly, the SECC informs not only the parents/representatives, but also the majority of 16–17-year-olds with disabilities, that when they turn 18 they will have to apply to the service for adults with disabilities (SECPAH/CEPAH) for classification, which uses different criteria for evaluation and provision of services. The share of informed young people also varies, between a minimum of around 5 percent (in SV) and a maximum of 100 percent (in 20 counties).

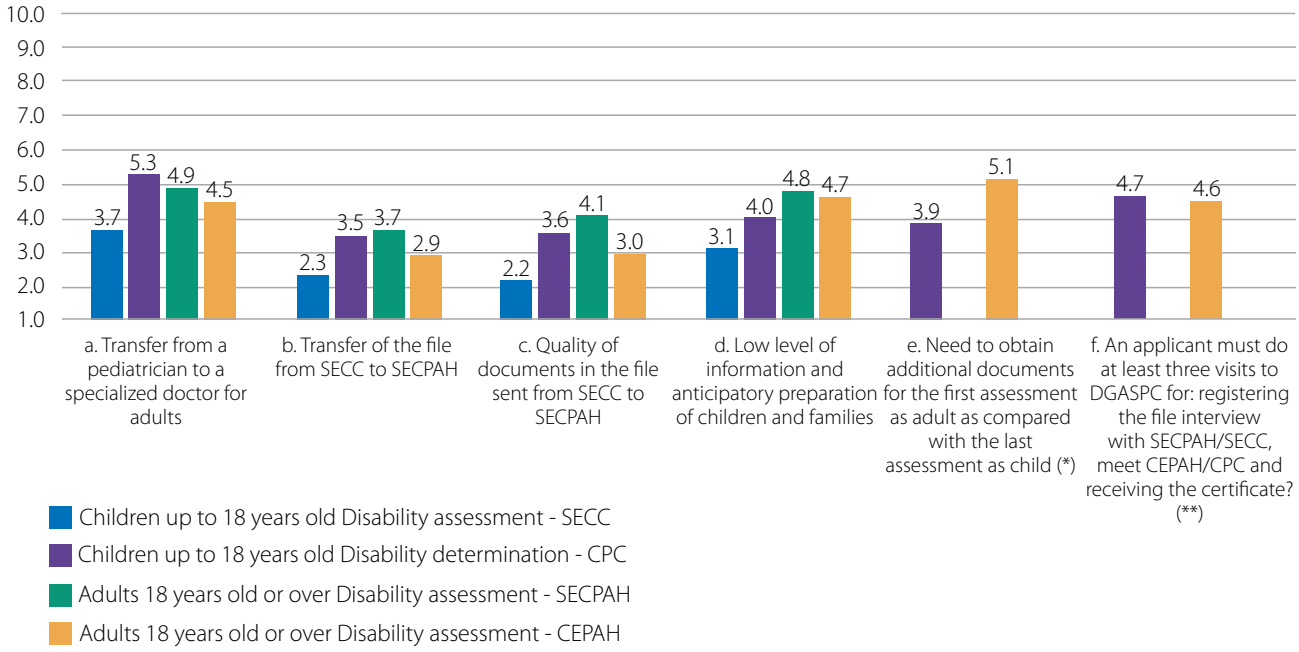
For young people with disabilities, transitioning to the adult category means a change in their disability classification file, as well as the need to obtain medical documents from a practitioner (instead of a pediatrician). However, according to specialists from SECC, the Child Protection Commission (CPC), SECPAH, and CEPAH, these issues do not negatively affect continuity of services or children's lives when they turn 18. As shown in Figure 50, other issues, such as the transfer of the file, the quality of documents in it, or the low level of information and anticipatory preparation of children and families do not have a significant negative affect on children with disabilities' transition to adult life, with averages of a maximum of 5.3 on a scale of 1 (none) to 10 (total). The process from diagnosis to obtaining the certificate are well-outlined in the legislation, including the number of visits/trips the child and his/her family must make to the SPAS/SECC to receive the degree of disability and the number of documents required, both of which are kept to a minimum, with the emphasis on inter-institutional collaboration rather than increasing/duplicating family efforts. In addition, facilities are provided for immobilized children and those from low-income families, so that children can benefit from the comprehensive assessment that ultimately secures their rights under the law.

Recent changes to regulations and procedures in the context of the COVID-19 pandemic have simplified the process of obtaining certification for children. At the beginning of 2021, in the opinion surveys, specialists in most counties indicated that for children, one trip/visit to the DGASPC is currently enough to obtain the certificate, as shown in quote 8.1 (which is also consistent with the opinions in Figure 50). However, in other counties, the situation remained unchanged from 2019, as described by quotes 8.2. Therefore, implementation of the new regulations is uneven across the country; the application process has been simplified but not for all children.



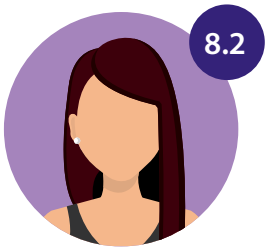
"Information on the documents required for the file can be found on the DGASPC website and at the town hall of residence which is responsible for supporting the family in completing the file, as well as the contact number for the DGASPC where they can call daily between 7.30am and 4pm for information on completing the file. On the date of submission of the file (to DGASPC/SECC), the comprehensive assessment of the child also takes place, on the same day. Appearance before the CPC only takes place in special cases, in case of change of degree, if the applicant wishes to express his/her opinion or dissatisfaction. If the file is incomplete, from March 2020, the applicant can send completed documents by e-mail to the SECC. Evaluations take place online and only the new cases (the applicants who apply for the first time to obtain the certificate) come in person for the file submission. Classification decisions are sent by mail for cases of severe, moderate and mild disability". (SECC specialist, quoted from a Q2B questionnaire)

Figure 50: Issues that negatively affect continuity of services and life for children with disabilities and their families, according to practitioners



Sources: (1) Opinion survey Q2B: Practices and experiences of specialists working within the service for comprehensive assessment of adults with disabilities (SECPAH, N=185) and children (SECC, N=165), in 39 counties and 6 districts of Bucharest, January–February 2021; (2) Opinion survey Q3B: Practices and experiences of the members of the commission for assessing adults with disabilities (CEPAH, N=46) and the Child Protection Commission (CPC, N=26) in 24 counties and 2 districts of Bucharest, January–February 2021.

Note: The chart shows the average values on a scale from 1 (none) to 10 (total) for each aspect and category of specialists. (*) The requirements for the preparation of the file are not harmonized, adults are required in addition to children: social inquiry from SPAS, psychological assessment—document valid for only 3 months, income certificate issued by the Mayor's Office or student certificate. (**) Statement extracted from the National stage analysis of the habilitation/rehabilitation of the person with autism spectrum disorders (child and adult), in order to develop the 2020–2024 National Autism Plan (SGG, Oct. 2019).



"The guardian presents himself with the medical documentation to request information on disability classification. Once this information is obtained, he goes to SPAS and applies for a social inquiry. Then he goes to the doctors in order to get all the paperwork that he needs. With these documents, he goes to the DGASPC office to submit the file"…
"Then, it is necessary to physically verify the documents and, in particular, to provide additional information if the documents are drawn up incorrectly or are incomplete. The child's presence at the SECC office is necessary and more useful to SECC specialists in the evaluation than the online evaluation in the child's home environment." …
"And then not all guardians have Internet access. The presence of the child and his/her parents/representative at the SECC for evaluation is required. Then, they have to come and pick up the certificate and submit it to the facilities department, in order to get the benefits." (SECC specialists, quotes from Q2B questionnaires)

According to interviews with 18–26-year-olds with disabilities and their representatives, preparing a new assessment file is considered time-consuming and inefficient, especially when they have first applied for disability classification as adults. In addition, they pointed out that the process is stressful for young people with disabilities and their families, and information about the process is often unclear. More details on the difficulties that young people face in obtaining medical documents and preparing and registering the file, as well as the barriers to accessing disability classification, can be found in Chapter 3.

8.2. The comprehensive assessment of young people with disabilities compared to that for adults

There is a lack of disaggregated data by age group on disability in Romania, especially for the 18–26 age group, as described in Chapter 9. This contributes to a misperception that young people with disabilities transitioning to adult life constitute a "very small group."[454] As a result, policymakers and specialists are more willing to put aside the transition from childhood to adulthood, especially as the existing legislation only covers the 16–17 age group[455] at SECC level. Furthermore, in the institutional survey Q2A,[456] only one SECC chief reported having a specific approved procedure regarding the transitional activities carried out with young people and their parents. The other SECCs in the sample, as well as the SECPAHs, have not developed any procedure in this respect.

During a year,[457] a total of about 3,800 young people aged 16–17 with disabilities are registered with the SECC in the 31 counties participating in the Q2A institutional study alone. Therefore, across all 47 SECCs in the country, the total number of young people with disabilities aged 16–17 most likely exceeds 5,500 yearly. The differences between counties are prominent, ranging from around 30 to over 300 young people per county. Among these youth, girls account for less than 45 percent, on average, with significant variations both from county to county and year to year. The majority of these youth live with their families—84 percent on average—while 16 percent are separated from their families and come from the special protection system. Here, too, there are considerable discrepancies between counties. The share of 16–17-year-olds with disabilities living with family ranges at county level from around 70 percent to over 95 percent of the total.

The disability assessment for children/youth has common features with the assessment for adults. The comprehensive assessment of children/youth is carried out in two stages. The first is a multidisciplinary assessment carried out by physicians and psychologists, social workers, and education specialists from outside the SECC. At this stage, parents/representatives can choose the professionals they consider best for their child, which is the child's fundamental right. The second evaluation is carried out by SECC specialists, who apply the biopsychosocial criteria and formulate the proposal for classification and recommendations, and by the CPC, which determines the degree of disability. Generally, the SECC team sees the applicant in person when conducting the assessment.

Although the process is generally similar for children and adults, the assessments can differ significantly in terms of how the degree and type of disability are achieved. There are two types of biopsychosocial criteria for children: medical/medical-psychological and social/psychosocial. Based on ICF principles, medical criteria are used to assess the functional impairments and corresponding qualifier, and psychosocial criteria are used to assess the child's activity limitation, participation restrictions, and the corresponding qualifier. In contrast, the comprehensive assessment of adults is predominantly based on medical criteria, with important weight given to the psychological assessment in the case of some conditions, while social assessment is used to determine the need for a personal assistant, but is rarely used to determine the degree of disability. As a result, assessment outcomes can be substantially different for adults compared to children, so that the same person, upon turning 18, can obtain very different sets of services, which indicates a lack of continuity in the provision of services and protection measures.

454 Moreover, Figure 2c in Section 1.3 also shows that in national statistics, the 18–19 age group is disproportionately small compared to all other age groups (e.g. about half of the 15–17 age group and less than 40 percent of the 20–24 age group).

455 The age of 16–17-year-olds is statistically assessed until reaching the age of 18.

456 Institutional study Q2A: Factual data and indicators on the activity of the service for comprehensive assessment of adults with disabilities (SECPAH) and children (SECC) in 32 counties and 4 districts of Bucharest, January–February 2021.

457 The data in this paragraph were reported by the SECC managers of 28 counties and 3 districts of Bucharest, for 2019 and 2020. Institutional study Q2A: Factual data and indicators on the activity of the service for comprehensive assessment of adults with disabilities (SECPAH) and Children (SECC), January–February 2021.

Flowchart 7: Assessment of the degree of disability, children and adults

	Children	Adults
Criteria used for evaluation	The biopsychosocial vision: the introduction of psychosocial criteria in 2012, by aligning with ICF–CY, and in 2016, by introducing the environmental factors.	Six mandatory areas of evaluation, but the decision is made almost entirely based on medical criteria.
The first is a multidisciplinary evaluation performed by health/social professionals, and the second stage takes place within the service for comprehensive assessment (SECC/SECPAH) at DGASPC level.	Yes	Yes
Face-to-face evaluation. Is the applicant seen by the evaluation committee (SECC and SECPAH)?	Yes*	Yes*
Medical criteria. Are the medical criteria and the results of the medical assessment generally the same for adults and children?	Yes, but in some cases different degrees of disability can be determined for the same disease, if the social factors are different.	Yes, the same degree of disability is determined for the same disease, because social factors are not taken into account in determining the degree.
Medical vs. social (functional)	Both medical and psychosocial (functional) factors are considered and used in the recommendation.	The comprehensive assessment includes both medical and social factors, but medical criteria play an essential role in the determination.
ICF. The social and psychosocial criteria are correlated with the ICF/ICF–CY codes so that specialists have a common understanding of them.	Yes. Social and psychosocial criteria are correlated with the ICF–CY codes, including environmental and attitudinal barriers obtained through social assessment.	Medical factors define the assessment. ICF principles are not used.
Standardization. A standardized assessment form is used for non-medical examination.	Yes	No
Decision algorithm. A simple algorithm that leaves no room for interpretation.	Yes	Yes
Two people with a particular condition could get different degrees of disability.	Yes, because functional factors could play a role.	No
ICF training. ICF training is available for all specialists.	Yes	No
Decision. How is the disability degree assessment recommendation made?	Joint decision of doctors and other specialists.	In theory, joint decision, but the medical element is essential.
Case management. Do ICF principles govern case management?	Yes	No
Services plan. The comprehensive assessment is carried out not only to determine the degree of disability, but also to plan the benefits.	Yes, almost always (PAR)	Yes, in some cases (PIRIS is drafted always, but PIS in some cases only)**

Source: Authors' compilation. Note: * During the COVID-19 pandemic, interactions between applicants and assessors decreased significantly, as a result of measures to prevent and combat the effects of the pandemic. ** See Chapter 6.

Medical assessments for adults and children are based on similar criteria. They use roughly the same list of health conditions but are structured and applied differently, leading to differences in assessment. The analysis of the medical criteria for adults, detailed in Chapter 4, shows they are generally robust in terms of medical classifications, but the degree of disability is inconsistently and questionably defined. The situation is similar in terms of medical criteria for assessing disability in children. These, together with the medical-psychosocial criteria, are endorsed by the specialist committees of the Ministry of Health and are correlated and have the same measurement values as the criteria for adults, in cases of common medical conditions. For both adults and children/young people, additional paraclinical investigations or medical/psychological reports may be requested during the comprehensive assessment phase, if inconsistencies are found between the documents on file or during the interview.

A detailed summary of the assessment differences in the degree of disability between children and adults is presented in Flowchart 7. The main differences are summarized as follows:

- Unlike the assessments for adults, social and psychosocial criteria for children are designed with ICF–CY principles in mind.[458] The functional part of the assessment looks at barriers related to environmental factors and attitudes, identified through the social assessment. The assessment uses scores to consider functional factors. The psychosocial criteria assess the child's performance—as defined by the ICF—highlighting the child's ability to cope and interact with his/her environment.
- Although the medical criteria relate to roughly the same list of conditions, in the case of children, clear rules of application are established, so that the absence of a condition on the list is not a reason for non-inclusion if, by its impact on the body, it falls within the deficiencies/functional impairments described in the criteria . In contrast, the application rules used to assess adults are still unclear and non-standardized, which leaves room for interpretation that can lead to discretionary decisions.
- Functional assessment of adults is not based on standardized procedures or unified tools.[459] Unlike the assessment process for adults, assessment of disability degree in children is based on well-articulated standardized tools. In assessing children, the standardized procedure and tools take into account medical and functional aspects, in line with the ICF–CY. The assessment is based on documentation from the first (multidisciplinary) stage, including the results of laboratory tests and paraclinical investigations, as well as interviews with children and their parents/legal guardians. The forms are standardized and have the period of validity provided by the law.
- Children with the same medical diagnosis as adults may be assigned a different degree of disability than adults. The disease does not constitute functional impairment, nor disability, with a few exceptions established by medical committees (such as diabetes or Down syndrome). Children are assessed holistically and individually; therefore, children with the same medical diagnosis may have different degrees of disability. At the same time, the same child may have a different degree of disability depending on progress or regression. Non-recoverable cases are not recognized in children, because children have a greater potential for recovery/rehabilitation than adults. Only in the case of palliative care is a disability certificate valid for up to 18 years granted; the typical period of validity for children/young people is 1–2 years.

SECPAH specialists reported, to a greater extent than SECC specialists, that disability types are not clearly defined and there are issues assessing and reporting them to the ANDPDCA: "As the types of disability are not clearly defined, they are interpreted and recorded according to each specialist's

458 It is important to stress that the assessment of the criteria used for children is beyond the scope of this report. The analysis presented here assumes that the assessment of children uses ICF principles based on the Ministry's expert assessment.

459 This result of the research team (see also chapter 4) is also supported by the SECPAH specialists who, in the Q2B survey, agreed with the statement "Although there is a template for completing the comprehensive assessment report, as well as guidelines to ensure a uniform way of working at national level, there are currently no assessment tools that can be used across the six areas of assessment: social, medical, psychological, vocational, educational, skills assessment and level of social integration" to an extent equal to an average score of 6.7, on a scale of 1(none) to 10 (total). Opinion survey Q2B: Practices and experiences of specialists working within the service for comprehensive assessment of adults with disabilities (SECPAH, N=186), in 39 counties and 6 districts of Bucharest, January–February 2021.

understanding, which is why correct reporting, as requested by the ANDPDCA, is not possible."[460] In fact, ANPDCA[461] made the definitions of disability types available to SECCs since the training sessions (SECC and CPC) in 2017.[462] Therefore, the methodology for determining the type of disability is more clearly defined for children than adults. But it requires some additions, SECC specialists point out, such as coding for rare diseases, neurological impairment without motor impairment, and all conditions associated with mental retardation that fall into the type of associated disability; it is not possible to tell which impairment is more severe.

To formulate the disability proposal, ICF items are associated with qualifiers according to an algorithm that was revised in 2016, based on more than 15 years of experience, by ANDPDCA and SECC specialists. It is important to note that the algorithm allows practitioners to determine the degree of disability based on the psychosocial aspects of the child's life. Thus, if the child's activity limitation and participation restrictions are rated higher than the functional impairment, the degree of disability will be higher than if it were assessed on the basis of functional impairment alone; i.e., by exclusively applying medical criteria. The only weakness of the algorithm, SECC specialists highlighted in the Q2B survey, refers to the fact that "although there is the grid with ICF items for determining the activity limitations, the scoring of these items with a qualifier between 1 and 4 is rather subjective, because there is no specific tool to determine the setting of these qualifiers."[463]

In conclusion, for children, the comprehensive assessment is aligned with the ICF and follows a modern approach to disability assessment, although it could benefit from some improvements. In contrast, for adults, the classification to a degree of disability has remained predominantly medical, although the assessment is based on medical-psychosocial criteria, a result confirmed by SECPAH and SECC specialists (see also Chapter 4). [464]

8.3. Determining disability in young people

The process of determining disability is different for children than for adults. A comparison of the results of the CEPAH and CPC determinations for some case examples are shown in Figure 51. Thus, according to the commissions presidents in the institutional study Q3A, for cases of children where the CPC assesses complete functional impairment/deficiency by applying medical criteria—i.e., a severe degree of disability—the CEPAH will not necessarily maintain the severe degree at the age of 18, even for identical medical criteria in children and adults. In most counties (but not all), CPC and CEPAH conclusions are similar in cases of severe functional impairment (according to medical criteria) and complete participation restrictions (according to psychosocial criteria). In these cases, both CPCs and CEPAHs will most likely grant a severe degree of disability in most of the counties studied (15 out of 24 CEPAHs, and 5 out of 6 CPCs).

In contrast, differences in determination between CEPAHs and CPCs can be substantial for Type I diabetes mellitus cases, where a severe degree is usually given for children, while the majority of CEPAH presidents state that they are most likely to award only a marked degree for adults (14 of the 24 CEPAHs studied). Therefore, there are significant differences between the disability degree classification carried out by CPC for children and by CEPAH for adults. These differences are mainly due to the fact that members of the evaluation commission for adults (CEPAH) have more restrictive classification criteria for adults than for children, according to SECPAH and SECC specialists.[465]

460 Quote and data from the opinion survey Q2B: Practices and experiences of specialists working within the service for comprehensive assessment of adults with disabilities (SECPAH, N=187) and children (SECC, N=143) in 39 counties and 6 districts of Bucharest, January–February 2021.

461 The National Authority for the Protection of the Rights of the Child and Adoption - institution taken over by the current ANDPDCA, through EGO no. 68/2019.

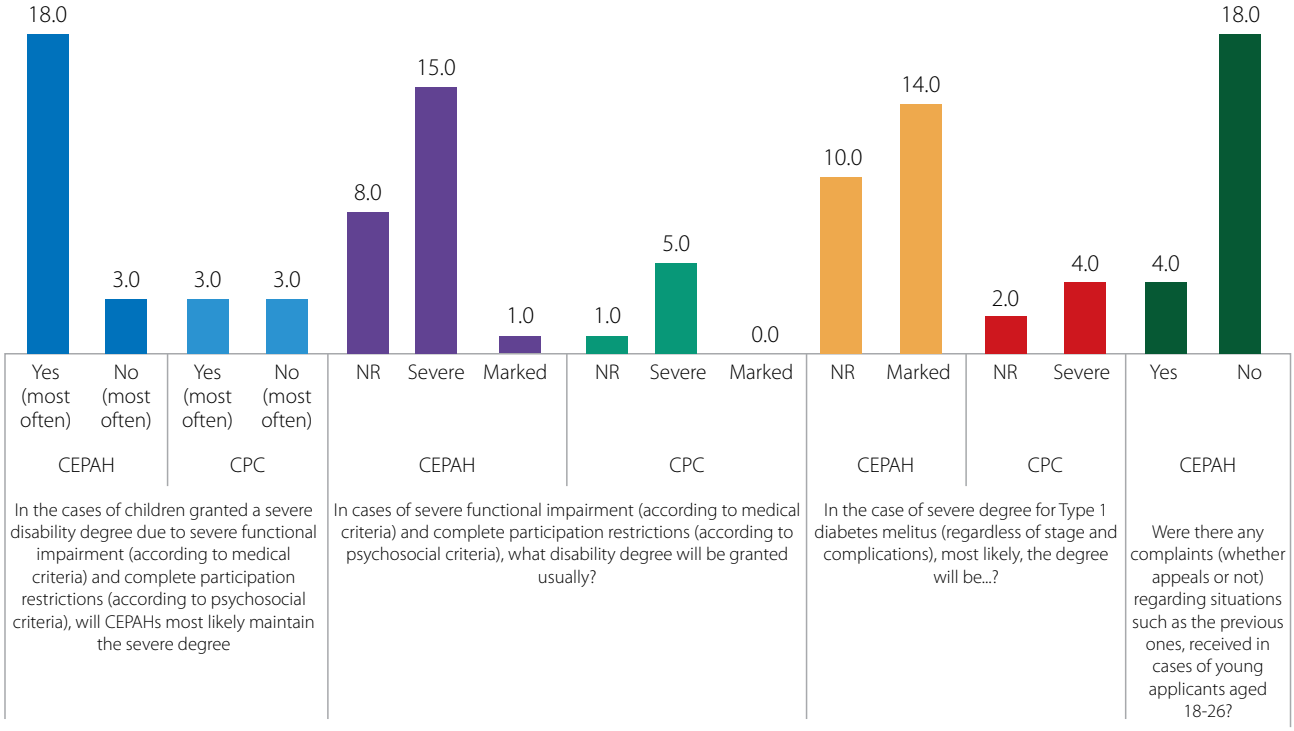
462 The definitions of the types of disability for children are indicative, because they are not provided by law.

463 SECC specialist, quoted from a Q2B questionnaire.

464 On a scale of 1 (none) to 10 (total), SECPAH specialists gave an average score of more than 8 compared to an average score of only 4 given by the SECC specialists on the extent to which they agree with the statement "the classification in the degree (and type for 18+) of disability has remained predominantly medical, although the assessment is based on medical-psychosocial criteria". Opinion survey Q2B: Practices and experiences of specialists working within the service for comprehensive assessment of adults with disabilities (SECPAH, N=192) and children (SECC, N=83) in 39 counties and 6 districts of Bucharest, January–February 2021.

465 On a scale of 1 (none) to 10 (total), SECPAH and SECC specialists responded that they agree with the statement "the members of the commission for assessing adults with disabilities (CEPAH) have more restrictive disability degree classification criteria than for children" to an extent equal to average scores around 7. Opinion survey Q2B: Practices and experiences of specialists working within the service for comprehensive assessment of adults with disabilities (SECPAH, N=184) and children (SECC, N=61) in 39 counties and 6 districts of Bucharest, January–February 2021.

Figure 51: Examples of cases and likely resolutions: comparison of the commissions for children (CPC) and adults (CEPAH) (number of responses from CEPAH/CPC presidents)



Source: Institutional study Q3A: Factual data and indicators on the activity of the commission for assessing adults with disabilities (CEPAH, N=24) and children (CPC, N=6), in 22 counties and 2 districts of Bucharest, January–February 2021.

Notes: NR = Non-response. The sum of the corresponding CEPAH bars must equal N=24. If the amount is lower, the missing cases are non-responses from the CEPAH presidents.

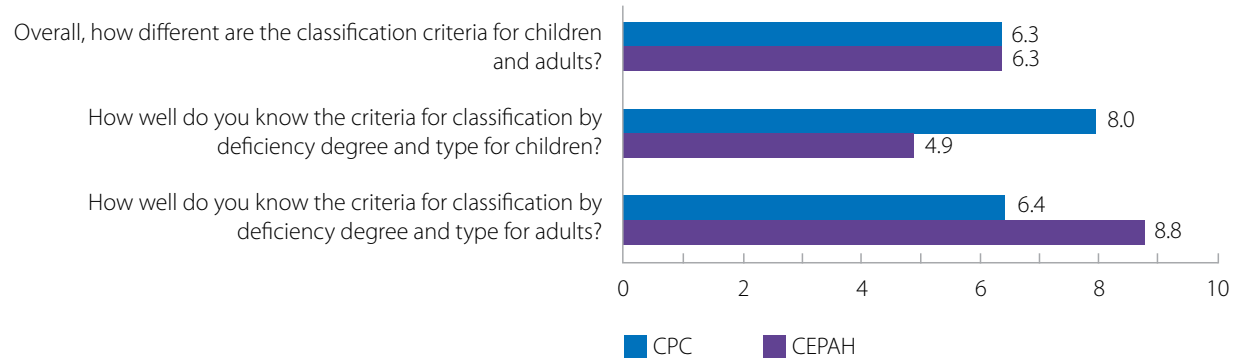
As a result, in the majority of counties studied (18 out of 24) there are complaints (whether or not appeals have been filed) about these discrepancies (see Figure 51), which shows that this issue has significant impact on a certain percentage of young people with disabilities as they transition to adult life.

Collaboration between CEPAH and CPC could be significantly improved. Lack of cooperation and mutual understanding of the work done can negatively impact young people with disabilities. As Figure 52 shows, CEPAH and CPC consider that they know well the criteria they use for disability degree classification, but their knowledge of the assessment criteria of their counterparts is limited. Thus, on a scale of 1 to 10, the average knowledge assessment score is higher than 8 on its own criteria, while for counterpart knowledge it is 6.4 for CPC and only 4.9 for CEPAH. CEPAH and CPC members agree that there are significant differences in the classification criteria for children and adults, but this is a rather subjective opinion, given the low familiarity with the other commission's criteria.

Fragmentation between the children's system and the one for adults, together with the poor integration of knowledge, results in very poor cooperation between the two commissions. Out of the 22 counties and 2 districts of Bucharest included in the institutional study Q3A, the CEPAH and CPC presidents of just one county reported that the two commissions organize joint meetings for consultation and exchange of experience.[466] And even then, CEPAH-CPC meetings take place only sometimes, when possible. In other words, in no county have the two commissions developed a pattern of cooperation based on regular meetings to discuss and find common solutions to simplify or smooth the transition of young people with disabilities to adult life. These findings were also confirmed by interviews with assessment specialists and people with disabilities.

466 This county is AG.

Figure 52: Familiarity with criteria for the classification of the disability degree, as self-assessed by CEPAH and CPC members (average values on a scale from 1-none to 10-total)



Source: Opinion survey Q3B: Practices and experiences of the members of the commission for assessing adults with disabilities (CEPAH, N=46) and children (CPC, N=30) in 24 counties and 2 districts of Bucharest, January–February 2021.

8.4. Support measures for transitioning young people with disabilities to adult life

The transition to adult life can be problematic for young people with disabilities. Romania lacks a simple procedure and good planning to support the transition to adult life, especially after the age of 18. The first legal provisions concerning this transition appeared in Law no. 448/2006 (Art. 30) on the protection and promotion of the rights of persons with disabilities. These provisions aimed "to ensure the correlation between the services in the protection system of the child with handicap and the services in the protection system of the adult with handicap." Nonetheless, most of the support measures provided were applicable to all young people with disabilities, and not just to those separated from their families and in the special protection system.

However, more recently, Joint Order no. 1985/1305/5805/2016[467] was issued, which includes, among other integrated intervention measures, a number of provisions to improve transition planning to adult life (along with other types of transitions). Thus, according to Art. 65 (1), support measures for preparing and adapting the child to the different stages of transition are included in the habilitation-rehabilitation plan (or the service plan tailored to the type of transition). More details on the transition support measures that can be included in the habilitation-rehabilitation plan (PAR) are provided in Annex 8. For young people with disabilities aged 16 and over, the PAR objective also includes the transition to adult life, and the name of the plan is changed to the habilitation-rehabilitation and transition to adult life plan. Apart from the provisions of Law no. 448/2006 and Joint Order no. 1985/1305/5805/2016, no other measures are foreseen to ensure the successful transition to adult life of young people with disabilities over 18.

Existing legislation does not provide clear guidance on how the transition should take place. Many provisions are general and do not clarify the process or responsibilities, although support measures for young people with disabilities should be implemented through cooperation between several stakeholders, such as the family, the school, including the educational counselor, together with different educational, health, or social service providers, and under the coordination of a case manager. It is also not clearly specified who is responsible for providing information, support, or preparing the child for the transition from childhood to adulthood; only that the case manager should include these measures in the habilitation-rehabilitation plan. As the measures are very broad and not concrete, the transition process is not supported by the authorities and, in most cases, is abrupt and disturbing for young people with disabilities and their families.

467 Order approving the methodology for integrated assessment and intervention for the classification of children with disabilities in a degree of disability, for the school and professional orientation of children with special educational needs, and for the habilitation and rehabilitation of children with disabilities and/or special educational needs.

The measures laid down in the legislation are not fully implemented, and are not for all young people with disabilities. In order to substantiate this result we present the main findings of the field research, organized in the order of the specific measures provided by Law no. 448/2006 (Art. 30) as being the obligation of the responsible public administration authorities.

a) Plan and ensure the transition of the young person with disabilities from the child protection system to the adult protection system, based on their identified individual needs

For young people with disabilities living in the child special protection system (separated from their family), case managers plan and ensure the transition to the adult protection system.

But for young people with disabilities living with their family:

- At national level, for only 2–3 percent of the 16–17 age group assessed in a year, the SECC obtained a statement of intent (in writing) from the parents/representatives regarding the family's plans to proceed with applying for the classification as an adult with disabilities. In fact, only two SECCs (in VL and IL) have developed such a practice. Although there is no legal requirement to do so, the practice is useful in helping young people/parents/representatives raise awareness and organize for the transition, and also SECC and SECPAH to plan activities associated with preparing and transitioning these cohorts of young people from the evaluation of children with disabilities to the evaluation of adults with disabilities.
- Out of the 31 SECCs participating in the institutional survey Q2A, only 4 reported that they carry out, at the request of parents, a simulation of possible outcomes of the disability degree classification evaluation based on the criteria and procedures used for adults (by SECPAH/CEPAH), but without having developed a dedicated tool (of any type) for this purpose. More generally, neither SECC, SECPAH, nor ANDPDCA has ever conducted any simulation on a group of young people (regardless of the group's size and selection criteria) to understand the effects of passing from childhood to adulthood, both in terms of the decline in benefits and services per child, and whether there are groups disproportionately likely to lose more than average.
- Only one SECC out of the 31 in the Q2A sample (from VS) reported that they organize ice-breakers and get-to-know-you meetings between 16–17-year-olds and their parents with SECPAH/CEPAH representatives. In the other counties, SECCs do not conduct such planning activities.

b) Ensure the continuity of services for people with disabilities

For young people in the child special protection system, continuity of services is provided for those who are transferred to the protection system for adults with disabilities, but not necessarily for those returning to the family/community.

But for the young people with disabilities in the care of the family:[468]

- Up to age 18, SECC provides children/young people with disabilities with case management, and a SPAS representative is the caseworker who is obligated to ensure the implementation of the habilitation-rehabilitation plan (PAR).[469] Although this provision is not met in all communities,[470] it can be said that the majority of young people with disabilities benefit from case management services. For example, about 90 percent of 16–17-year-olds with disabilities have completed the transition to adulthood PAR, according to data reported by SECC chiefs. When the child turns 18, Joint Order no. 1985/1305/5805/2016 states that SECC transfers the disability degree classification case to SECPAH, together with a copy of the latest disability degree reclassification file. After the transfer, only a small share of adults with disabilities living with their families (and only in some counties) benefit from a case manager or an Individual Service Plan (PIS), as demonstrated in Chapter 6. As a result, the continuity of case management services is poor for young people with disabilities in the care of their families.[471]

468 The data in the paragraphs below were reported by the SECC chiefs of 27 counties and 3 districts of Bucharest, for 2019 and 2020. Institutional study Q2A: Factual data and indicators on the activity of the service for comprehensive assessment of adults with disabilities (SECPAH) and children (SECC), January–February 2021.

469 The PAR is an appendix to the disability certificate issued by the Child Protection Commission and is monitored every six months for children in the care of the family and every three months for children in the child protection system.

470 For details, see Section 9.1.1 of Chapter 9.

471 In general, for young people from the child special protection system who transfer to the protection system for adults with disabilities,

- Discrepancies in determining disability in children and adults can lead to a sudden change in benefits and services once they turn 18. Out of the services available,[472] the loss of the right to a personal assistant is a major challenge in the transition from childhood to adulthood. Up to age 18, all children/young people with a severe disability are entitled to a personal assistant.[473] Thus, data reported by the SECC chiefs indicate that almost half of the 16–17-year-olds benefit from a personal assistant. When the child turns 18 and is transferred from SECC to SECPAH, according to the adult criteria and procedure, they may be classified with a degree other than severe, and even if they are granted the severe degree, they may or may not be entitled to a personal assistant. Loss of the right to a personal assistant means, in most cases, loss of employment for the parent employed as a personal assistant and, consequently, a significant reduction in family income. Therefore, the loss of the right to a personal assistant was mentioned in interviews with young people with disabilities as a main source of dissatisfaction and anxiety. On the other hand, in the opinion surveys, all specialists mentioned the changing conditions of the personal assistant service as a factor that has considerable negative influence on the continuity of benefits and services, and on the lives of children and their families.[474] This is all the more true because the change is not gradual, but rather abrupt, with limited support available to adjust to the new situation.
- None of the 31 SECCs participating in the institutional study Q2A conduct counseling sessions with the parents of the 16–17-year-olds, following a systematic timetable, on the advantages and disadvantages of the transition from childhood to adulthood, with support identifying alternative scenarios to follow. Additionally, no SECC organizes mediation and anticipatory labor market integration programs for the parents of 16–17-year-olds (possibly in collaboration with specialists from county employment agencies) in case they lose their personal assistant status when their children become adults.

c) Establish measures aimed at preparing young people for adult life and for independent living

Transition to adulthood is not associated with an independent living skills assessment or program that is applied uniformly across the country for all young people with disabilities. Therefore, there is no data on either the baseline level of independent living skills at a given age or on the potential for or evolution of these over time. Also, the lack of data refers to both young people in the child special protection system and those in the care of their families.

d) Carry out, in collaboration or in partnership with public or private legal persons, training programs for adult life

Concerning both young people in the child special protection system and those in the care of their families:

- Only in isolated cases are adult life preparation programs and transition measures for young people with disabilities carried out in collaboration or partnership with public or private legal entities. Over a year, only around 2 percent of the 16–17-year-olds assessed by SECC participated in such programs nationwide, and they come from only four counties and one district in Bucharest.[475] In the other counties, SECC does not run such partnership programs.

case management is provided, and the recommendations in the HRP are taken up/continued through the measures included in the Individual Service Plan (PIS), Personalized Plan for beneficiaries in residential centers (PP), Personal Future Plan for beneficiaries in sheltered housing (PPV) or in other types of tailored plans mentioned in the legislation.

472 People with disabilities in Romania receive a basic package of medical services, including regular health check-ups and disability-based medical care. Also, depending on the degree and type of disability, a person may receive home care from a personal assistant, care in a day care center, care in a residential care center, or a guardian's allowance.

473 According to Article 35(1) of the Law no. 448/2006 on the protection and rights of persons with disabilities, as amended by EGO no. 51/2017. However, there are some restrictions. For example, children placed in foster care are not entitled to personal assistant, even if they have a severe disability degree. Also, for a beneficiary of personal assistant, on the child's certificate must be written "severe degree with personal assistant."

474 On a scale of 1 (not at all negative) to 10 (completely negative), the average influence scores were: 6.9 - SECC, 7 - CPC, 8 - SECPAH, and 8.4 - CEPAH, respectively. Sources: (1) Opinion survey Q2B: Practices and experiences of specialists working within the service for comprehensive assessment of adults with disabilities (SECPAH, N=184) and children (SECC, N=165), in 39 counties and 6 districts of Bucharest, January–February 2021; (2) Opinion survey Q3B: Practices and experiences of the members of the commission for assessing adults with disabilities (CEPAH, N=43) and children (CPC, N=24) in 24 counties and 2 districts of Bucharest, January–February 2021.

475 These counties are SB, CT, B-Sector 6, IL and SV. Countywide shares range from about 6 percent to 26 percent of the 16–17 age group assessed by the SECC annually.

e) Carry out activities to inform young people with disabilities about opportunities for education, employment, access to family and social life, and various means of leisure

Concerning both young people in the child special protection system and in the care of the families:

- In Section 8.1, we showed that the information available to prepare for the transition to adult life is very unevenly distributed across the country, general in nature, and does not really support young people with disabilities or their families. Current regulations do not provide details on what type of information should be included or who should provide it. Therefore, the information is often limited to the fact that when they turn 18 they will have to apply for the type and degree of disability classification from another service (SECPAH/CEPAH).
- At national level, less than 20 percent of the 16–17-year-olds assessed by SECC in a year receive information about educational opportunities, employment, access to family and social life, or different leisure activities. These young people are in only 9 of the 31 counties studied.[476] In most counties the SECC does not provide such information.

f) Assess, on request, pupils with disabilities and special educational needs (SEN)

The SEN assessment is provided to all children and young people, upon request, by the County Centers for Educational Resource and Assistance (CJRAE) and not by the SECC.

For young people with disabilities over the age of 18, SECPAH has the obligation to make the educational assessment, even if the young person / legal representative does not request it:

- In the case of young people over 18 who are still in pre-university education, SECPAH works with educational counselors from the CJRAE network to assess the level of education in only 4 counties and one district in Bucharest,[477] out of 36 that took part in the institutional study Q2A.
- The majority of CEPAHs report that they do not issue professional orientation certificates, as shown in Section 5.2.6. Therefore, at least in recent years, extremely few 18–26 year-olds have benefited from vocational assessment leading to a professional orientation certificate.

In conclusion, the above-mentioned analysis shows that support measures for young people with disabilities do not ensure a coherent or smooth transition to adult life. On the contrary, most measures are available only in a few counties and for a small number of youth. The lack of linkage and cooperation between the children's system and the one for adults leaves youth and their families to fend for themselves with the resources they can personally mobilize. Insufficient information and anticipatory preparation, as well as a lack of advice and guidance along the way, make the transition to adulthood a turning point that has negative consequences for many areas of life, not only for youth, but also for their families. In interviews, young people with disabilities describe the transition to adult life as "abrupt," "frustrating," and "excruciating."

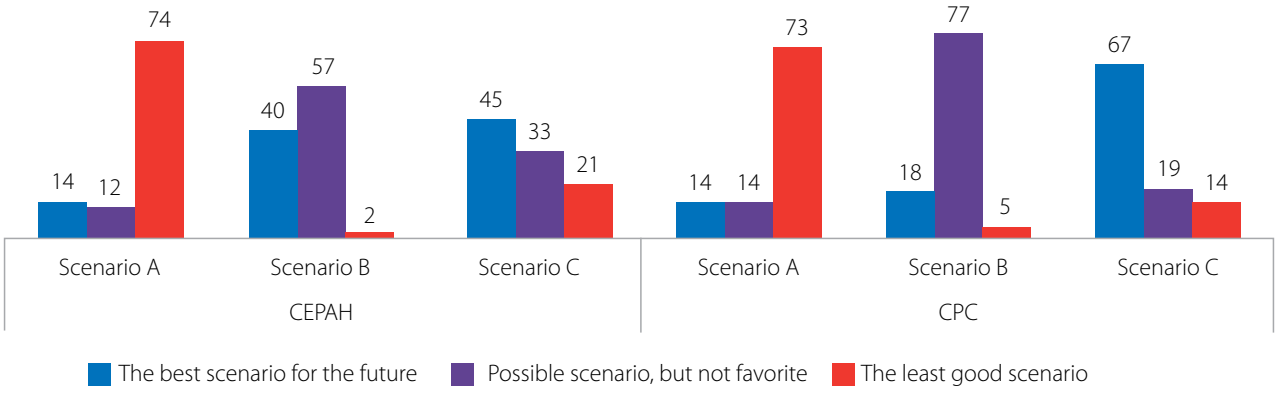
8.5. Scenarios for reforming the transition from childhood to adulthood

As previous sections have shown, it is imperative to respond to the challenges faced by young people with disabilities in their transition to adult life. This can be done by ensuring early and coordinated planning, effective information sharing and communication, and clear and transparent procedures. In fact, in the research carried out for this volume, the majority of experts, policymakers and young people with disabilities expressed the need to reform the transition.

476 The county-level shares of young people who received this information range from around 10 percent to over 90 percent in four counties, namely BH, VN, NT and B_Sector 4.

477 These are BC, BN, DJ, TR and B-Sector 6.

Figure 53: Preferred scenarios to ensure a smooth transition from childhood to adulthood for young people with disabilities, according to CEPAH and CPC members (%)



Source: Opinion survey Q3B: Practices and experiences of the members of the commission for assessing adults with disabilities (CEPAH, N=42) and children (CPC, N=22) in 24 counties and 2 districts of Bucharest, January–February 2021.

Notes: Scenario A: The current situation is maintained, but young people aged 18 to 26 are assessed on the same criteria as children (in the spirit of ICF–CY). Scenario B: Modification of the classification for adults by developing new criteria that are in the spirit of the ICF and therefore harmonized with the criteria used for children. Scenario C: There should be a special program for transition from childhood to adulthood for young people aged 16 to 26, with a distinct set of criteria and a procedure involving both SECPAH and CEPAH, as well as SECC and CPC.

Three possible scenarios for redesigning the transition process to adulthood were tested in the Q3B survey with CPC and CEPAH members. In Scenario A, no new classification criteria are developed for either children or adults. As a solution, 18–26-year-olds continue to be assessed and classified by SECPAH/CEPAH, but based on children's criteria and procedures (currently used by SECC/CPC). There is a consensus among experts that this is the "least good scenario" (see Figure 53).

Scenario B involves developing new criteria for adults that are in the spirit of the ICF, and therefore harmonized with the criteria used for children. In addition, in this scenario, for children and young people aged 16–26, an information, counseling, mediation, and job-finding support program (in the event of loss of the right to a personal assistant) is developed for both children and young people and their parents. Reform of the system under scenario B is considered "the best solution for the future" by 40 percent of CEPAH members, but only by a small share (18 percent) of CPC members. The development of support measures is seen as key, but at the same time it is perceived to be rather unrealistic under current conditions and resources available to both the evaluation services and commissions.

Scenario C proposes a different approach. Regardless of what decisions are made about the criteria and procedures for assessing and classifying children and adults—either maintaining the status quo or changing it—Scenario C proposes the development and implementation of a special transition from childhood to adulthood program for young people aged 16–26, with a separate set of criteria and a procedure involving both SECPAH and CEPAH, as well as SECC and CPC. And this special program should include information, counseling, mediation, and job-finding support items (in the event of loss of the right to a personal assistant) for both children and young people, and for their parents. Scenario C is considered "the best solution for the future" by the majority of CEPAH (45 percent) and CPC (67 percent) members. At the same time, however, most argue that the implementation of such a special program is not realistic without additional resources, especially human resources and expertise.

The three reform options are only tentative illustrative scenarios for testing practitioners' views. For the reform itself, however, other alternatives need to be designed and explored. For example, scenarios B and C may include a gradual benefit/service reduction component to be carried out from age 16 to 26. This gradual reduction could be applied to all young people or could be targeted to certain categories of young people; for example, according to their level of development of independent living skills or to those groups that are identified through a simulation as being disproportionately likely to suffer a greater-than-average decrease in benefits and services.

Conclusions of Chapter 8

1. The assessment of children for disability degree and type classification is no longer based solely on the medical model, but on the social model, which is based on human rights and takes into account the fundamental principles of the ICF. The analysis presented in this chapter revealed major discrepancies between the assessment and the classification of disability degree for children and young people up to the age of 18 and the one for adults aged 18 and over. As a consequence of these discrepancies, the transition from childhood to adulthood is often associated with changes in disability degree or even lack of classification. This can lead to a decrease in benefits, with a significant negative impact on family income and services received by young people with disabilities, which negatively impacts both their quality of life and that of their families.

2. The transition process for young people with disabilities to comprehensive assessment for adults is lacking in information, support, and advice. By the time they turn 18, young people with disabilities often find that they no longer have access to the support and services they need, and fall through the cracks of an ineffective adult protection system. Insufficient initial information about the transition process, misunderstanding of changes to the assessment system, and the absence of general counseling for young people and their families—particularly young people living with their families—makes the transition process difficult for many because it is neither transparent nor perceived as fair (or "just").

3. In Romania, the process of transitioning to adult life is not fair or transparent, and the differences in terms of disability degree classification create discrepancies in the system. For many young people with disabilities, the transition is abrupt and confusing. Current regulations provide for a variety of support measures for young people with disabilities in their transition to adult life. But, in practice, support is almost nonexistent, leaving young persons with disabilities and their families to cope with their new reality on their own. Reforms are needed to streamline the transition process by developing appropriate services to support young people and their families during the difficult transition period.

4. The transition process for young people with disabilities to adult evaluation should be streamlined by the ANDPDCA and clearly articulated in new laws and procedures, based on the following guiding principles:
   - A new procedure, possibly drafted jointly between SECC/CPC and SECPAH/CEPAH, should be introduced that benefits young people with disabilities aged 16–26 and their families. Both comprehensive assessment services and commissions for children and adults should communicate more; they should also have regular consultative meetings and share all assessment documents to facilitate the transition process. At the same time, it would be useful to organize meetings for 16–17-year-olds and their parents to break the ice and get to know SECPAH/CEPAH representatives.

- The official transition period from childhood to adulthood should be extended, tentatively from 16 to 20. In the case of young people enrolled in education, the period should be extended until they graduate or turn 26. Throughout the period of study, it should be ensured that the same disability degree classification is maintained so that the young people studying continue to receive the same benefits.
- From age 16, in addition to regular evaluations, the young person and their family should also receive information about the possible outcome of an evaluation and the criteria and procedures applied to adults (by SECPAH/CEPAH). Dedicated tools should be developed by adult assessment specialists to assist the SECC/CPC in conducting such simulations.
- In addition to information, counseling activities should be carried out with young people with disabilities and their families in order to understand the effects of the transition from child to adult, in relation to a possible reduction in benefits and services provided to the child and the possibility of a significant drop in income following the transition. Counseling sessions could also consider providing support to identify alternative scenarios that could be followed.
- Finally, to formulate new evidence-based policies, authorities should systematically collect data on young persons with disabilities aged 16–17 and 18–26, to ensure continuous and adequate monitoring of these groups' evolutions, particularly regarding their access to support for successfully transitioning to adulthood and independent living.

5

Efforts should be increased to provide adult life training programs carried out in cooperation or partnership with legal entities, public or private. These programs should focus on increasing the participation of young people with disabilities in both education and the labor market. To this end, easily accessible educational and professional orientation services should be developed to reach as many young persons with disabilities aged 16–26 from the special protection system, and their families, as possible. Also, mediation and labor market integration services (possibly in collaboration with specialists from county employment agencies) could be available under such programs for both young persons with disabilities and their parents, especially in the event of young people losing their right to a personal assistant.

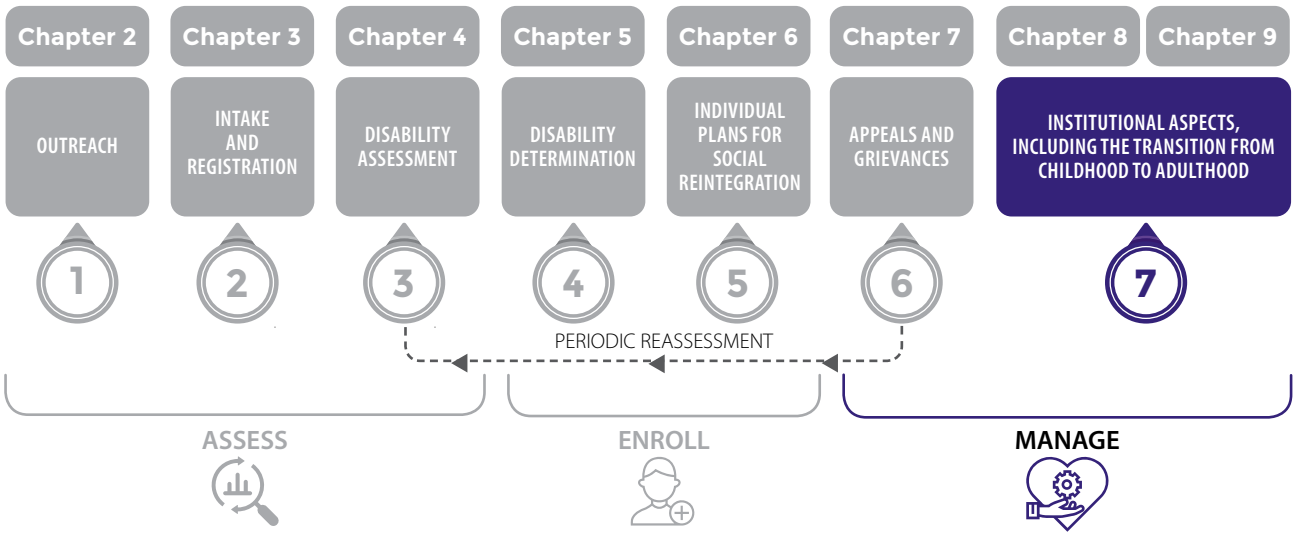
6

The transition to adult life should be coupled with a program to assess the development of independent living skills. Such a program should be applied consistently across the country for all young people with disabilities, especially those who live with family, both before and after the age of 18. Current services to develop such skills are also insufficient, especially for young people with disabilities living with their families. To facilitate the transition of young persons with disabilities to independent living, specific measures should be introduced, starting with the transition to adulthood, to reduce the burden of care for families. For example, this might include a systematic monitoring program for early identification of possible risks/vulnerabilities, or counseling and educational training programs for parents and families.

7

Support measures for young people with disabilities do not ensure a coherent and smooth transition to adult life. Most measures are available only in a few counties and for a small number of youth. The development of support measures is seen as key, but at the same time, is not possible under current conditions and resources available to both evaluation services and commissions for children and adults. Policy makers, disability evaluation structures, and NGOs need to work together to identify the main difficulties of the transition to adult life for young people with disabilities and to advocate for solutions and the subsequent adoption of new legislation.

9. Institutional aspects



This chapter analyzes the institutional aspects of the key organizational actors involved in disability assessment and determination. It starts with the public services for social assistance at the community level (SPAS), and continues with the services for comprehensive assessment for the classification of adults in degree and type of disability (SECPAH) and the corresponding commission of evaluation (CEPAH).[479] Separate sections delve deeper into each key actor's human resources, data management and information system, procedures, logistics, and other aspects that affect the disability assessment process. The next sections analyze the profile of human resources involved in all core phases of the disability assessment system, their operation in multidisciplinary teams, job descriptions/roles, workload, as well as training needs.

478 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.

479 The services of comprehensive assessment and the commission for children (SECC and CPC) are not covered, as no data were collected in this sense.

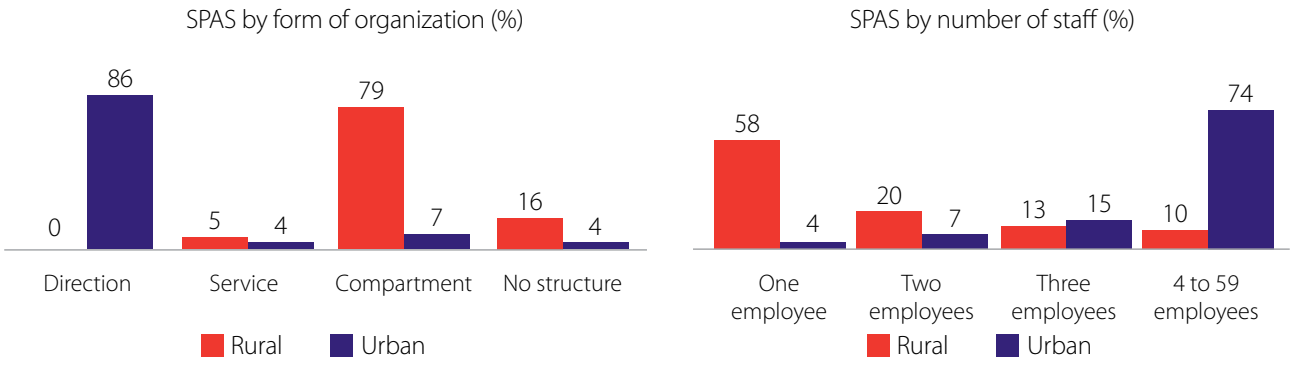
9.1. SPAS: Public services of social assistance within communities

Within the delivery chain of disability assessment, the SPAS plays the lead role in intake and registration (core phase 2). SPAS also contributes to outreach (core phase 1) and implementation of the individual intervention plans (PIS and PIRIS), case management for people with disabilities (core phase 5), and handles the actual provision of the benefits and service package. Thus, the performance of SPAS significantly influences the disability assessment process during these three core phases (1, 2, and 5).

In Romania, only about a third of the local authorities has a SPAS at the local level, accredited according to the law. SPAS can be organized in three forms: direction, service, or compartment. The Q1_SPAS survey comprises SPAS with all these forms of organization, including some municipalities that did not comply with the legal requirements.[480]

The analysis presented in the next sections is based on data from the Q1_SPAS survey, which uses a sample of localities, but it is not nationally representative (see Volume 2). Figure 54 shows that SPAS functions as a compartment with 1–2 employees in most rural localities included in the sample, whereas in urban areas, the direction is the dominant organization form of SPAS, most of which have between 3 and 59 employees. A few of the studied SPAS are not separate administrative structures, but have only one staff member who is hired by the municipality and has social work duties. Correspondingly, out of the total personnel employed in the sample of 67 surveyed SPAS, only a small proportion operate in rural areas (15 percent of the total 478 employees).[481] These human resources are analyzed in the next section.

Figure 54: Distribution of SPAS sample by organization form and number of staff (%)



Source: SPAS survey with responses from 67 localities (N=40 rural and 27 urban) situated in 26 counties; the districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January–February 2021.

9.1.1. Human Resources of SPAS

SPAS staff serve the entire community, including a variety of at-risk groups, children and their families, people with disabilities, the elderly, the long-term unemployed, victims of domestic violence, homeless, people with various addictions (alcohol, drugs, other toxic substances), victims of human trafficking, persons deprived of their liberty, and so on. In the urban SPAS, more staff are involved in social work activities: 1–10 employees in small cities and 3–59 in larger cities,[482] while rural SPAS have just 1–2 staff members.[483]

However, in both rural and urban areas, a quarter of the surveyed SPAS reported that their staff is insufficient to serve persons applying for classification into a degree and type of disability. Only a few respondents mentioned staff turnover being an issue (less than 10 percent, both in rural and urban areas).

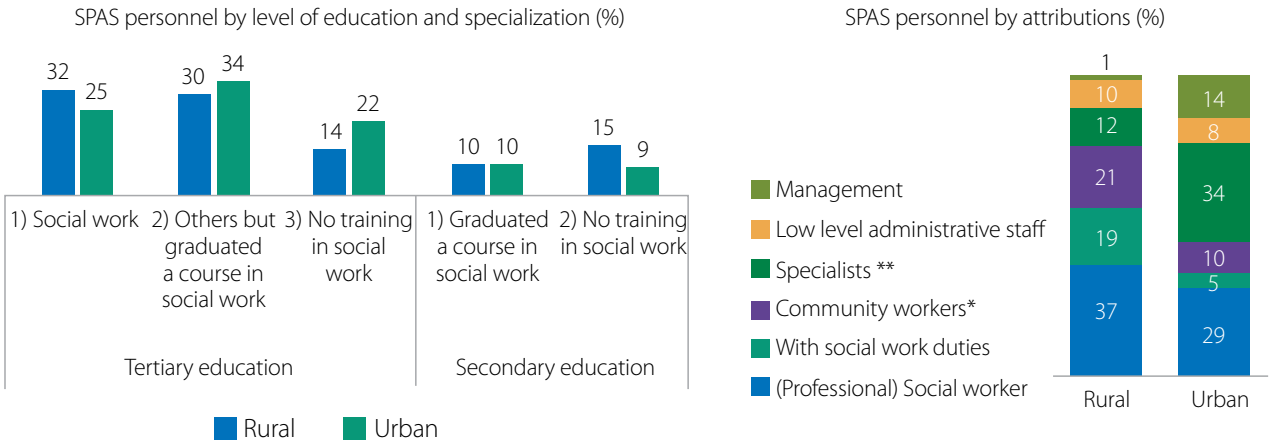
480 GD no. 797/2017 for the approval of the framework regulations for the organization and functioning of the public social assistance services and of the indicative staff structure.

481 The Q1_SPAS survey collected data only about the SPAS personnel without including the staff employed in social centers and other social services units within SPAS or other institutions subordinated to SPAS (nurseries, medical offices in schools, medico-social entities, hospitals, etc.). If social services are included, then in some larger cities the SPAS would comprise hundreds of employees.

482 About a quarter of the small cities have a SPAS like the rural ones (no structure or a compartment with 1–2 employees).

483 In less than a quarter of rural SPAS, the number of staff is higher, up to six employees.

Figure 55: SPAS personnel by level of education, specialization, and attribution (%)



Source: SPAS survey with responses from 67 localities (N=73 employees in rural SPAS and 405 employees in urban SPAS) situated in 26 counties; the districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January–February 2021.

Note: The sum of columns by rural/urban is 100 percent. * Community workers include community nurse, Roma expert, community mediator, home caregiver, school mediator. ** Specialists include public procurement adviser, legal adviser, counselor, lawyer, economist, inspector (of all kinds). Specializations other than social work include sociology, psychology, law, economy, administration and political science, engineering, geography, and others.

Staff profile

The majority of SPAS staff are women.[484] They range in age from 19 to 65 years old, and have varying experience in social work (ranging from a few months to over 30 years).[485] The large majority of the surveyed SPAS staff has completed tertiary education. Figure 55 shows that over 75 percent of staff from rural SPAS and more than 80 percent in urban SPAS graduated from a university, and most are either a professional social worker or have postgraduate courses in social work. However, both in rural and urban SPAS, only around a third of the staff with tertiary education and who are specialized in social work are members of the Romanian Social Worker National College.[486] Notably, this structure is not based on a nationally representative sample of SPAS. For comparison, according to the Social Inspection's audit, 269 out of 408 verified SPAS have no employee specialized in social work.[487]

Staff structure

SPAS staff should include at least one person responsible for social benefits and at least two persons for the provision of social services, of which at least one is a social worker, as per GD no. 797/2017, Art. 4, para. 2. At the same time, SPAS should ensure (i) one case manager responsible for every 50 cases of children for whom a service plan is being implemented; (ii) one case manager for every 100 personal assistants for persons with severe disabilities; (iii) one case manager for every 50 persons with disabilities living with family for whom an individualized plan or protection measures are implemented; (iv) one case manager for every 50 elderly people for whom an individualized assistance and care plan is being implemented; as well as (v) one person for every 300 beneficiaries of social benefits granted based on means-testing.

484 Women make up 90 percent of total staff in rural SPAS and about 75 percent in urban ones.

485 Average staff age is approximately 45 years old, while the average working experience is almost 11 years, without a significant difference between rural and urban SPAS. Standard deviation less than 9 years, regarding age, and under 7 years for work experience in social work.

486 The Romanian Social Worker National College is a public interest professional organization with judicial personality that is apolitical, autonomous, and independent. Set up by Law no. 466/2004, it defends and promotes professionals' rights and interests at the local, national, and international level.

487 ANPIS (2019: 6).

Table 11: Share of SPAS that comply with the indicative staff structure provisioned by the law (%)

	Rural	Urban
Total SPAS with valid responses in Q1_SPAS	40	27
Out of which: (%)	100	100
Have at least one employee who satisfies the legal conditions for case managers (*)	65	96
Have at least one social worker (**)	83	96
Have designated at least. . .		
- one person responsible for social benefits	85	89
- two persons responsible for the provision of social services	20	52
(1) a case manager responsible for children for whom a service plan is being implemented	70	74
(2) a case manager for personal assistants of persons with severe disabilities	55	63
(3) a case manager for persons with disabilities living with family for whom an individualized plan or protection measures are implemented	43	48

Source: SPAS survey with responses from 67 localities (N=40 rural and 27 urban) situated in 26 counties; the districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January–February 2021.

Notes: (*) A case manager should be a graduate of social work, sociology, or psychology with at least two years of work experience in social work or a graduate of tertiary education with other specializations and at least five years of work experience; (**) Social worker = graduate of social work or with tertiary education in other specializations and postgraduate course in social work.

This indicative personnel structure provisioned by the law is only partially implemented, as Table 11 shows. First, this is an effect of the small staff size at the SPAS level. Especially in rural areas, a compartment of two persons should designate so many different types of case responsible/managers as shown in Table 11, while 35 percent of the surveyed rural SPAS and even a few small cities do not have staff who meet the legal conditions for being a case manager. Furthermore, some of the SPAS that comply with the indicative personnel structure report that "it is only one person covering all these duties."[488]

Second, the requested different types of case responsible/managers, as per GD nr. 797/2017, reflect the fragmentation of the broad social protection system in sub-systems with their own legislation, staff regulation, and standards. An integrative approach would reduce the number of necessary caseworkers. Usually, a certain proportion of households tend to concentrate on several types of social and economic risks, and an integrated approach would ensure case management for all household members, whether children or adults, with or without disabilities.

Third, regulations are not sufficiently specified to allow proper implementation, monitoring, and evaluation. On the one hand, the thresholds used in the legislation are appropriate only for the larger cities. For example, in our sample, the threshold of 100 personal assistants is met only by one (out of 10) small city and 12 (out of 17) larger cities, but none of the 43 communes. Even so, 55 percent of the communes and 63 percent of the cities in the sample have appointed case managers for personal assistants of persons with severe disabilities (see Table 11). On the other hand, the meaning of "one case manager for every 50 persons with disabilities living with family for whom an individualized plan or protection measures are implemented," foreseen in GD no. 797/2017, is not rigorously defined, while the data available at the local level does not allow most SPAS to count how many people with a disability certificate are within the community. Accordingly, the SPAS representatives do not interpret or apply this specific legal provision in a uniform manner.

488 Quotation from a Q1_SPAS questionnaire from the rural area.

BOX 14 Different interpretations of the legal provisions in GD no. 797/2017 provided by SPAS representatives

Most SPAS representatives	Consider the case management standards and regulations apply only to people with disabilities living in institutions.
Other SPAS representatives	Think that this legal provision refers strictly to persons with severe disabilities and personal assistants.
Especially SPAS from rural communities	Consider that this legal provision "does not apply to us, we do all that we can, we help everyone from person to person, as human beings."[489]
Especially SPAS from large cities	"As there are no quality standards for case management for adults with disabilities living in the family, it is difficult to implement/standardize the activity in this field. For example, in our city, there were 6,122 adults with disabilities in the family, as of 30.11.2020. Hence, according to Art. 4 para. 3 of GD 797/2017, we should have designated 122 case managers!"[490] By the same logic, the Romanian Social Worker National College calculated the need for over 15,300 case managers for persons with disabilities in care of the family at the national level.[491]

Notes: a. Interview with SPAS representative from a rural area; b. Excerpt from Q1_SPAS, Direction for Social Assistance from a county seat; c. This estimate is calculated by dividing by 50 the total number of 766,449 people with disabilities living with family, as of June 30, 2020 (MMPS, Statistical Bulletin).[489]

Staff workload

The workload of staff who operate in the field of people with disabilities varies across localities.[492] In the rural areas, each SPAS member should conduct about nine social inquiries with applicants for disability assessment in a typical month.[493] Usually, as discussed in Section 3.3.2, most social inquiries (almost eight, on average) consist of home visits, and one social inquiry is based either solely on documents or on a combination of a document review and telephone, WhatsApp, or Skype interview. In urban areas, each SPAS member conducts an average number of seven social inquiries per month, out of which two are not based on home visits.[494] Besides social inquiries, SPAS should monitor children with disabilities living within the community; monitor persons with severe disabilities; and conduct case management of personal assistants, alongside several other duties.[495]

489 Interview with a SPAS representative from rural area.

490 Quotation from a Q1_SPAS, Social Assistance Directorate from a county seat.

491 This estimate is calculated by dividing by 50 the total number of 766,449 people with disabilities living in families, starting with 30 June 2020 (MMPS, Statistical Bulletin).

492 The estimate used in this report shows the number of social inquiries for applicants for disability assessment per SPAS employee, per month. This rough estimation is based on the assumption that these social inquiries are evenly distributed among the SPAS employees, which is not always the case. To control the effect of COVID-19, the estimate is based on the data for November 2019 (or a pre-COVID typical month). The estimation uses data from the SPAS survey with responses from 50 localities with all necessary data (N=30 rural and 20 urban) situated in 24 counties; the districts of Bucharest are not included since the DGASPC also plays the role of SPAS, January–February 2021.

493 In the surveyed rural localities, the number of social inquiries per SPAS member ranges between 0.5 and 34, in a typical pre-COVID month. For November 2020, the average number was reported as being higher, approximately 10.

494 In the surveyed urban localities, the number of social inquiries per SPAS member ranges between 0.65 and 27.25, in a pre-COVID typical month. For November 2020, the average number was lower, namely 5 social inquiries.

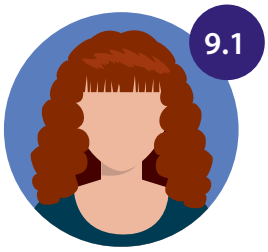
495 SPAS should provide and administer social services addressed to the child, the family, the persons with disabilities, the elderly, as well as all categories of beneficiaries provided by law, and are responsible for the quality of the services provided. Complementary to the provision of services in the field of protection of the person with disabilities, SPAS should (i) monitor and analyze the situation of persons with disabilities in the administrative-territorial unit, as well as the observance of their rights, ensuring the centralization

The available data, however, do not allow a better estimate of the workload associated with the disability assessment within SPAS.

9.1.2. Training of SPAS Personnel

SPAS personnel receive very limited training. Only two-thirds of urban SPAS and less than 20 percent of the rural SPAS have a lifelong learning plan for personnel. In the past three years, out of 478 employees who work in the surveyed SPAS, only 18 percent attended training for better intervention and teamwork, to implement integrated community services necessary to prevent social exclusion and combat poverty (Order393/630/4236/2017).[496]

In 2020, less than a quarter attended at least one training session of any type.[497] Furthermore, only 6 persons (out of 478) benefitted from training on the role and responsibilities of SPAS for classifying persons with disabilities by degree and type of disability. Only three employees were trained on how to complete the framework model[498] for the mandatory social inquiry. Just five SPAS members attended training that also included information on the framework template[499] for the social inquiry requested for the assessment of children with disabilities.



"Employees of the DGASPC working with persons with disabilities in care of the family have never been invited to meetings, trainings, workshops organized by ANDPDCA for DGASPCs.[500] Although local specialists are members of the assessment team (conduct social inquiries, reports, monitoring) and should work with SECPAH/SECC employees, so they should participate in joint training actions in order to understand everyone's role in this complex process of assessment and monitoring." (Excerpt from Q1_SPAS, Directorate for Social Assistance from a county seat)

There is also scant supervision. Less than 15 percent of the rural SPAS and fewer than 20 percent of the urban ones designated a social work supervisor for staff with secondary education. Additionally, "supervision by the national or county agencies is missing. When new regulations in the social work field are issued, usually, no meetings, experience sharing, conferences, workshops, dissemination of any kind, let alone training are organized."[501]

Regarding the ICF, SPAS personnel training is extremely limited. Out of 478 employees of the surveyed SPAS, only 5 persons have ever attended training in connection with the ICF. The SPAS representatives score the need for training on ICF, as well as on the UNCRPD, as an 8 on a scale of 1–10, on average. Nonetheless, among them is also well represented the opinion: "How would this be useful? We just have to do our job, let those from SECPAH/SECC learn about this theory, we stay focused on the reality."[502] Therefore, the current training and mindset of local level practitioners is not conducive to change and might hinder the system's reform. Training at the SPAS level is critical to promote any systemic change. To this aim, a special budget should be earmarked that considers the current market prices of accredited training providers.

9.1.3. SPAS Data Management and Information System

At the SPAS level, an information system for managing and administering the disability-related system is nonexistent, and processes are rarely

and synthesis of relevant data and information; (ii) identify and evaluate situations requiring the provision of services and/or benefits for adults with disabilities; (iii) create access conditions for all types of services corresponding to the individual needs of persons with disabilities; (iv) initiate, support and develop social services centered on the person with disabilities, in cooperation with, or in partnership with public or private legal persons; (v) ensure the share of professional staff employed in relation to the types of social services; (vi) provide counseling and information to families on their rights and obligations and on locally available services; (vii) involve the family in the care, rehabilitation, and integration of the person with disabilities; (viii) provide disability-specific training for staff, including personal assistants of people with severe disabilities; (ix) encourage and support voluntary activities; (x) collaborate with the DGASPC in the area of the rights of persons with disabilities and forward all data and information required in this area to DGSACP. As per GD no. 797/2017 for the approval of the framework regulations for the organization and functioning of public social assistance services and the indicative staff structure, including Annex 2 and Annex 3.

496 The proportions reported by SPAS were 19 percent of employees in urban and 14 percent in rural localities. The trained employees belong to a third of the urban SPAS and a fifth of the rural SPAS included in the sample.

497 Both for rural and for urban localities, the proportions reported by SPAS were 22 percent of employees, coming from 45 percent of the urban SPAS and 25 percent of the rural ones.

498 GD no. 430/2008, Annex 6. See more details in Section 3.3.3.

499 Joint Order no. 1985/2016, Annex 6.

500 According to the legislation, ANDPDCA / Higher Commission for Assessing Adults with Disabilities has no responsibilities for methodological coordination of SPAS.

501 Interview with SPAS representative from a county seat.

502 Quotation from a Q1_SPAS from a small city.

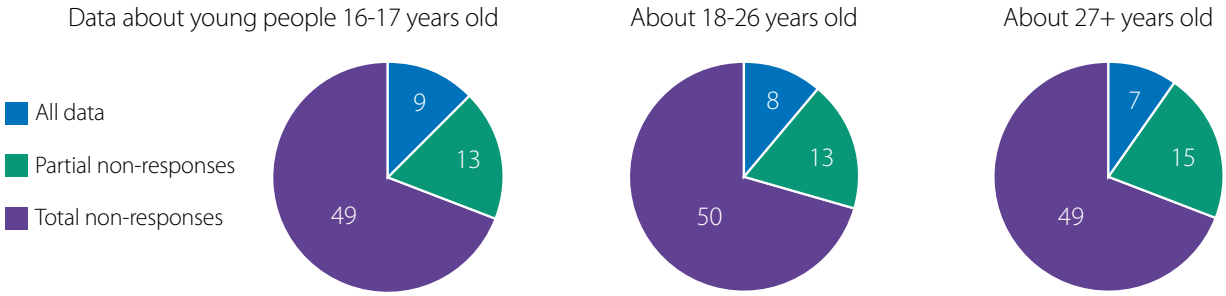
automated (if any at all). Most activities connected with the disability assessment are paper-based. Documents may be partly required/received in electronic format, but "in the end, all files and documents must also be available on paper."[503] Some communication may involve technology (telephone, electronic mail), but most relies heavily on face-to-face interactions and applicants' repeated visits to various desks.

Only a few SPAS, particularly from larger cities, have a specific procedure (or sections/chapters in the general procedure) for organizing and storing data and information.[504] The majority of SPAS keep copies of documents related to disability assessment applications for five years. A minority of them have transferred and stored those documents in electronic format,[505] while the others store them in paper format.

There is scant use of software applications that automate key functions and processes such as cross-checks, validation and verification, administration of benefits, administration of payments, beneficiary data management; much of this work is done manually. Some SPAS (30 out of 71) report having "a comprehensive database" of adults with a disability certificate living within their locality. Most of the others do not know how many persons with disabilities live in their locality, as "there is a confusion between people with a disability certificate and those with an invalidity pension, we cannot differentiate between them, we know only those receiving some sort of benefits from the municipality such as people with personal assistants."[506]

However, even SPASs that report having "a comprehensive database" actually refer to mere lists that do not support daily operations or program administration. Thus, only 11 of the 71 surveyed SPAS can use the existing database to reconstruct the history of a person with disabilities who is applying for disability (re)assessment. Also, when asked to provide data about the characteristics of persons with disabilities in their locality, most responded that data are not available (total nonresponse) or provided partial information (partial nonresponse), as shown in Figure 56.

Figure 56: How much do SPASs know about persons with disabilities who live in their locality (number of SPAS)



Source: SPAS survey with responses (N=71) from 26 counties, the districts of Bucharest are not included since the DGASPC also plays the role of SPAS; January–February 2021. The sum of values per pie is equal to the total of 71 SPAS in the sample.

The analysis of nonresponses shows that less than 10 of the surveyed SPAS can provide all requested data regarding the distribution of persons with disabilities residing in their locality by the following dimensions: degree and type of disability, the validity term of the disability certificate, gender, age, social status, vulnerable group,[507] the existence of individualized plans of intervention,[508] professional orientation certificate, and case manager. Only a few SPAS have the capacity to develop and maintain a comprehensive database of people with disabilities. A national database

503 Interview with the chief of a SPAS from a large city.

504 Only 16 SPAS out of the 67 in the sample report having such a procedure. Half of those is from larger cities. However, only 7 provided this procedure as part of the survey response package.

505 Only 11 SPAS (out of 71), of which 6 are rural and 5 are urban.

506 Interview with a social worker from a rural SPAS.

507 SPAS were asked to report how many people with disabilities within their community are (i) living with family; (ii) homeless; (iii) persons under guardianship of a family member; (iv) persons under guardianship of the local authority; (v) under trusteeship; (vi) persons with 8 classes (gymnasium) or less; and (vii) persons that cannot be moved.

508 People with disabilities who benefit from a PIRIS and a PIS, respectively, besides the disability certificate.

with a special level of accessibility for SPAS would be "much more useful and efficient, including for avoiding gaps and overlapping social benefits and services, as well as in the cases of people changing their residence from a locality to another."[509]

The results presented above are consistent with the findings of other studies.[510] For example, the Social Inspection's audit found that among 408 verified SPAS, only 282 had a registry of people with disabilities living within the locality, including information only on name/surname, disability certificate issuance date, and validity term. Nonetheless, a total of more than 16,450 adults with disabilities were missing from the existing local registries. The registered persons were those with severe disabilities with personal assistants (or an allowance for one) and adults with disabilities who applied for reassessment. To address the gap, the ANDPDCA is currently implementing an EU-funded project for developing a National Disability Management System. The project's general objective is to develop and implement a centralized national platform to collect, store, and distribute information on people with disabilities (adults and children) to central and local public authorities, individual beneficiaries, and institutional partners.[511]

Regardless of whether they have a database, some SPAS use the data collected through social inquiries for reporting and documenting public policies relevant to persons with disabilities. About a third of the sample complies with current regulations[512] and deliver to the DGASPC at the county level a quarterly report about the beneficiaries, suppliers of social services and social services administered by them, as well as the social services monitoring and assessment reports.

More generally, over half of the SPAS sampled claim to use the available data to document public policies relevant to persons with disabilities, especially to prepare local strategies and identify needs for social services. Notably, two out of every three SPAS that report using data to document programming and strategic documents lack or have only partial data about persons with disabilities in their locality.[513] Therefore, the existing documents are rarely evidence-based. In short, some SPAS lack data but make policies, while others have solid data but do not use them to make policies that target people with disabilities. However, most of those that develop local policies state that they use a participatory approach—one that involves the representatives of people with disabilities—to analyze data and define policies.

9.1.4. Material Resources

More than half of surveyed SPAS report that they lack sufficient area for offices, as illustrated in the next photos. They also lack a dedicated space to communicate confidentially with applicants, and lack sufficient storage space.

Besides the insufficient space, respondents mentioned there is a critical need for equipment (including printers, scanners, mobile phones, tablets, or laptops) to make SPAS more efficient. Most have personal computers, but many are obsolete and poorly equipped with software applications: "We would really need a software application at least for recording the social inquiries, managing the payments of social benefits, and reporting."[514]

In addition, social workers from rural areas particularly mentioned the need for a car to conduct the home visits required by social inquiries, particularly because there are no means of transportation between villages.

509 Quotation from the Q1_SPAS completed by the head of a direction for social assistance from a county seat.

510 Inspecția Socială (2020: 10).

511 http://anpd.gov.ro/web/wp-content/uploads/2019/10/ANUNT-WEB-final-ANPD-v2.pdf

512 GD no. 797/2017, Annexes 2 and 3, Art. 6, letter c.

513 Out of the sample of 71 SPAS, 39 claims to use the data collected through social inquiries for developing local policies for people with disabilities. Out of those, 26 could not provide any data regarding the characteristics of people with disabilities from their community (total nonresponse). At the same time, among the 32 SPAS that do not use the available data for documenting local policies, there are 9 SPAS with a comprehensive database regarding people with disabilities.

514 Quotation from the Q1_SPAS completed by a social worker of a social assistance direction from a county seat.

9.2. SECPAH: Services for Comprehensive Assessment of Adults with Disabilities

In Romania, there are 47 SECPAH services. The DGASPC provide these services in all 41 counties and 6 districts of Bucharest. The institutional survey Q2A collected data about SECPAH human resources, while data regarding SECC (for children) were not included. The next sections are based on responses provided by SECPAH from 35 counties and 4 Bucharest districts (Q2A and Q2A_Human capital), which, out of 346 practitioners, 201 participated in the opinion survey (Q2B).

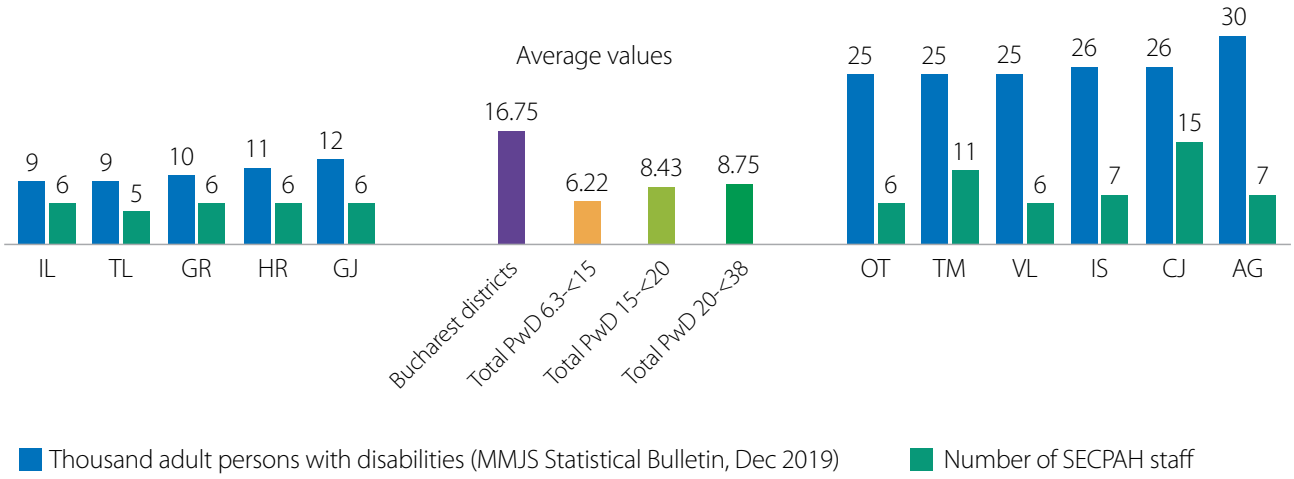
9.2.1. Human Resources of SECPAH

Within the delivery chain, the SECPAH is the key actor in conducting the disability assessment for classification into degree and type of disability (core phase 3). It also takes a lead role in elaborating and monitoring the individual intervention plans (PIRIS and PIS) and case management for people with disabilities (core phase 5). Additionally, it contributes to outreach (core phase 1) and intake and registration (core phase 2).

Staff size

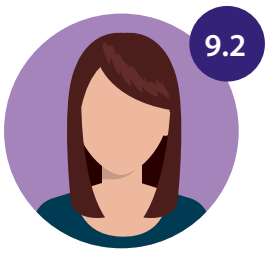
Each SECPAH employs between 5 and 22 specialists. There are significant differences between the average number of SECPAH employees depending on the size of the population of adults with a disability degree officially registered in the county (Figure 57). However, a closer look reveals that the number of specialists employed in SECPAH is more a County Council's decision rather budget-wise than based on the size of the population of persons with disabilities officially registered in a county. Thus, in some of the counties with the largest official population of adults with disabilities (such as OT, VL, IS, or AG), the SECPAH team has the same number of specialists as counties with the smallest populations (such as IL, HR, or GJ).

Figure 57: Difference between counties regarding the official population of adults with disabilities and the number of SECPAH specialists



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 35 counties and 4 districts of Bucharest, January-February 2021.

Notes: PwD = persons with disabilities. County CV with the lowest number of adult persons with disabilities in the country, as well as PH with the largest, is not included as it has not responded to the survey. The average values are calculated for clusters of counties determined according to the official population of adults with disabilities, as of December 31, 2019 (MMPS, Statistical Bulletin). The differences between averages are significant according to a One-Way Anova (p=.000).



"We, in Argeș, … have 6 people/employees with the SECPAH and a doctor. We work overtime, we work on weekends, this assessment is more than we can deal with both physically and in terms of time." (Focus group SECPAH)

In the opinion survey,[515] SECPAH practitioners (chiefs and members) consider that the number of SECPAH specialists is sufficient to serve those applying to be classified into a degree and type of disability. Nevertheless, a third of respondents consider the staff to be insufficient, and most of these complaints come from counties with a large population of persons with disabilities and a small SECPAH, as illustrated by the quote below. Staff turnover is not perceived as a problem.

Staff profile

Most SECPAH personnel are women who range in age from 22 to 68 years old.[516] Over 94 percent of SECPAH personnel have completed tertiary education, and many have postgraduate studies.[517] The average working experience is almost 7 years,[518] but there are considerable differences between counties, ranging from 2–3 years (in counties such as VL or TL) and more than 10 years, on average (in counties such as BT, IL, SJ, or IS).

Staff structure

Only a few SECPAH comply with GD no. 268/2007 (Art. 49), which stipulates that SECPAH teams should include professionals with the following specializations: social worker (with higher education); specialized doctor;[519] psychologist; psycho-pedagogue (or educational psychologist); physiotherapist; education instructor; and rehabilitation therapist/teacher. Figure 58 shows that most SECPAH teams are composed of social workers, psychologists, and specialized doctors (predominately family doctors and general practitioners).[520] Specializations like psycho-pedagogy, physiotherapy, education instructor, or rehabilitation therapist are very rare. Those specialists represent very small proportions of the total SECPAH personnel and are found in very few counties.

The incomplete structure of personnel by specializations affects how SECPAH performs the disability assessment based on the medico-psychosocial criteria. The lack of specialists to conduct the vocational, educational, and assessment of abilities and social integration means that most SECPAH in the country cannot provide a full-fledged assessment as required by the current legislation (see Chapter 4).[521]

Nonetheless, in the opinion survey,[522] SECPAH specialists consider the current personnel structure by specializations as sufficient to serve those applying for disability classification. A share of 18 percent consider the existing specializations to be insufficient and should be diversified. Even so, in some counties, the need for more specialists is acute, as emphasized during focus groups.

515 Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=198), from 36 counties and the 4 districts of Bucharest, January–February 2021.

516 The share of women is 87 percent of total staff, while the average age is approximately 44 years old (and standard deviation under 9 years).

517 Out of the total SECPAH personnel, 37 percent have a master's degree or doctorate and 57 percent have a university degree.

518 The work experience within SECPAH ranges from a few months to over 24 years.

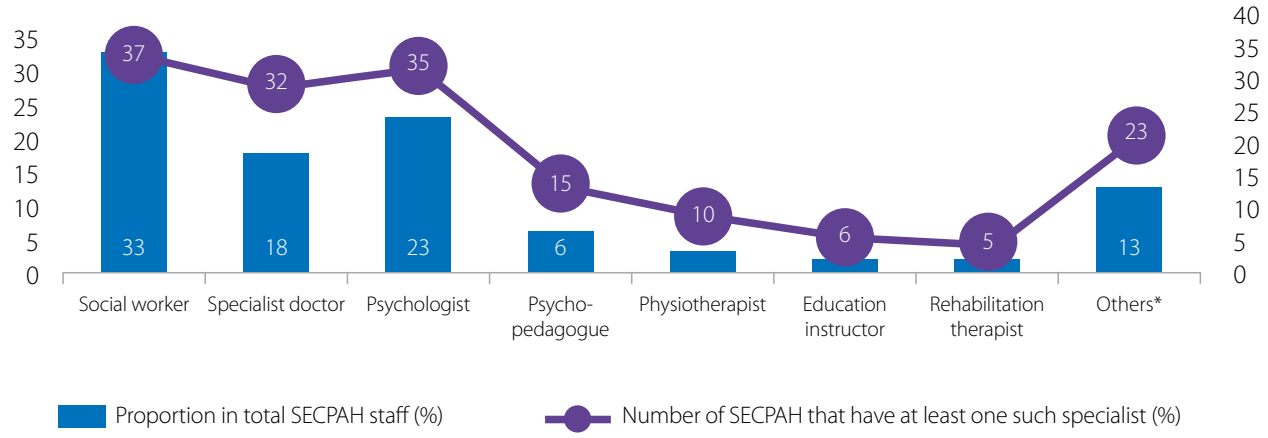
519 No requirements are provisioned in the law regarding specific physician specializations.

520 Information on the specialization of SECPAH chiefs is provided in Chapter 4, Section 4.1.2.

521 GD no. 268/2007, Art. 48.

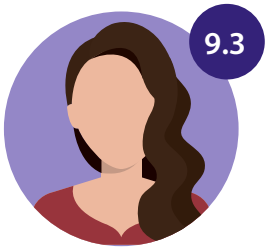
522 Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=198), from 36 counties and the 4 districts of Bucharest, January–February 2021.

Figure 58: SECPAH staff by specialization



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 35 counties and 4 districts of Bucharest, January-February 2021.

Note: *"Others" include mainly graduates of public administration, economics, and law. Physiotherapists account for 3 percent of total SECPAH personnel, while education instructors and rehabilitation therapists represent only 2 percent each.

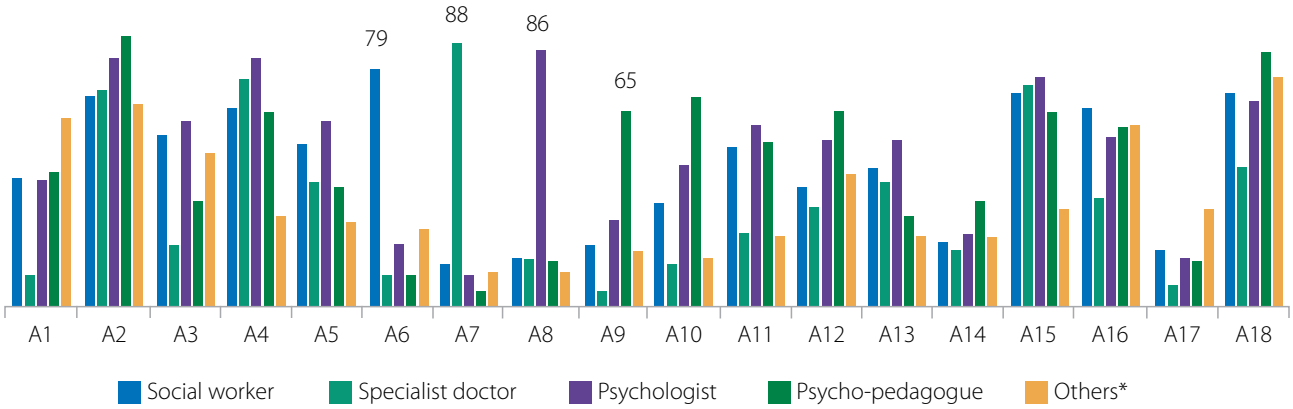


"- The staff… we struggle to do the assessment, but we do not have a physiotherapist, an educational psychologist, the doctor comes in twice a week. Nobody registers for the doctor's position, we put out a job ad. We have a specialized educator who has social assistance tasks. The team needs to be completed.
- Completing the team is absolutely necessary in our county as well. For example, my position as a psychologist is moved to a center and I am delegated to work here [with the SECPAH]. We were happy to have had two doctors at one time, but one has retired now." (Focus group SECPAH 3)

Division of tasks across the team

The division of labor across the SECPAH team varies considerably by county. In some counties, there is no division of labor; all members, regardless of their specialization, undertake all tasks, as shown in Figure 59. Also, in most counties, the social assessment (task A6) is done by a social worker; the medical assessment (task A7) is carried out by a specialist doctor; the psychological assessment (task A8) by a psychologist; and the vocational assessment (task A9) by a psycho-pedagogue. Thus, at the national level, the dominant pattern complies with the regulations, although in some counties each of these types of assessments is performed by SECPAH members with other specializations than those provided by law.

Figure 59: Division of tasks within the SECPAH team (% of category)



The SECPAH team's tasks:

A1. File registration **
A2. File initial verification
A3. Interview scheduling
A4. Assessment on premises
A5. Home assessment
A6. Social assessment
A7. Medical assessment
A8. Psychological assessment
A9. Vocational assessment
A10. Education assessment
A11. Assessment of the social skills and integration level
A12. Software data entering
A13. Assessment report (including conclusions and recommendations)
A14. PIS clearance
A15. PIRIS drawing up
A16. File management
A17. Management
A18. Other tasks

Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 35 counties and 4 districts of Bucharest, January-February 2021.

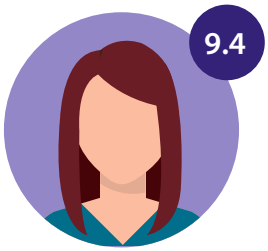
Notes: The data in the graph were reported in the table of participation in activities of SECPAH staff who collected information on the specific tasks performed by each employee, where the list of tasks was compiled in accordance with the National Framework Procedure (Annex to the Order no. 2298/2012). * "Others" include mainly graduates of public administration, economics, and law. Physiotherapists, education instructors, and rehabilitation therapists are not included due to the low number of cases (11, 7, and 6, respectively). ** According to the regulations, this task is not the responsibility of SECPAH.

Staff workload

The workload per SECPAH specialist steeply declined during the COVID-19 pandemic, with significant variation across counties (see Figure 60). In the pre-COVID period (2019), at the national level, a SECPAH specialist used to assess 762 files per year, on average. The minimum number of assessed files per SECPAH specialist in a county (Bucharest districts) was over ten times smaller than the maximum (in OT); from about 200 to over 2,100. Due to measures pertaining to the COVID-19 pandemic,[523] the average number of files assessed by a SECPAH specialist dropped to 554 (or by 27 percent) in 2020. However, the workload gap between the minimum and the maximum number of assessed files per specialist per year did not change, staying flat at about 10, from around 120 in the Bucharest districts to over 1,200 in OT county.

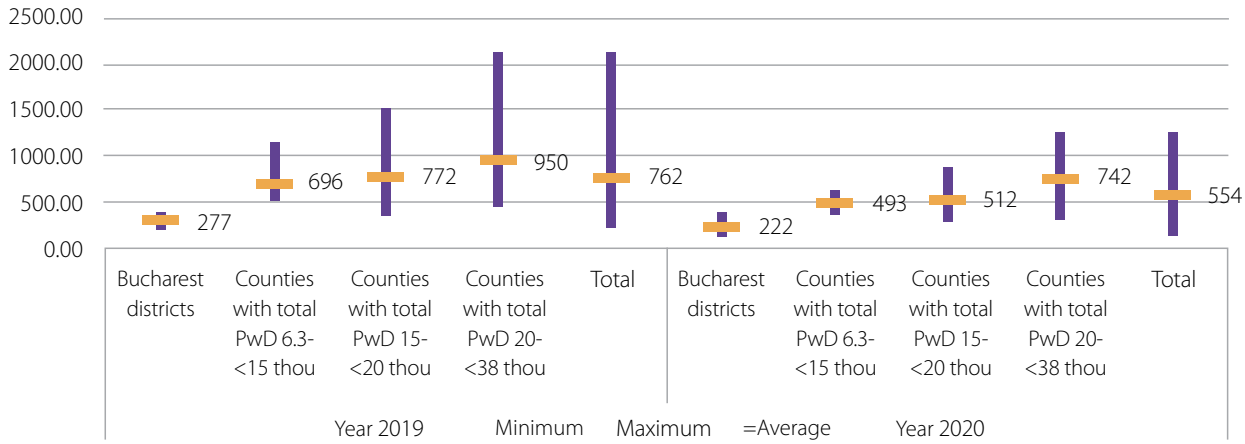
The decline in workload per SECPAH specialist was recorded in all counties, but the specifics varied widely. In some counties it almost halved, while in other counties it declined by just 7 percent. At the same time, discrepancies between counties have persisted. The largest disparities in workload are registered among counties with the largest population of persons with disabilities (compare the length of the vertical lines in Figure 60). This is because those counties have SECPAH teams with very different sizes (from 6 to 15, as shown in Figure 57) for assessing rather similar numbers of application files.

523 Law no. 55/2020, Art. 4(5).



"Our average is 50 people/day, last year we also had 80 people/day. We are completely in over our heads. People talk to the whole team in one room, collective interview, we try to have about 8 minutes/person, the procedure says 10 minutes/person." (Focus group SECPAH 1, intervention of a specialist from a county with a large population of people with disabilities and a small SECPAH team)

Figure 60: Workload per SECPAH specialist (min, max, and average number of assessed files per year)



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 35 counties and 4 districts of Bucharest, January-February 2021.

Note: Average values are calculated for clusters of counties determined according to the official population of adults with disabilities, as of December 31, 2019 (MMPS, Statistical Bulletin). The differences between averages are significant according to a One-Way Anova (p=.05).

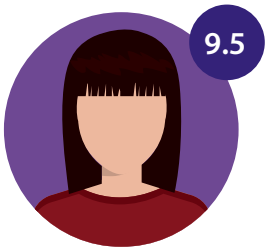
The workload per SECPAH member varies significantly according to each member's specialization. The estimates analyzed above are based on the assumption that the application files are evenly distributed among SECPAH team members. In practice, this is not necessarily the case. Several respondents reported differences between the team members depending on their specialization. For example, 32 SECPAH from the sample have at least one specialized doctor. Out of these, 16 SECPAH have only one specialized doctor, and 16 have two or more specialized doctors. In the teams with only one specialized doctor, he/she should cover the medical assessment for all application files. Consequently, the "real" workload of a specialized doctor from a SECPAH team with only one doctor equals the total number of assessed files in the county, which can reach huge numbers, such as over 7,200 per year. This means about 600 assessed files per month, which is about 30 files per working day and 3.75 files in each working hour, leaving some 16 minutes per assessed file under conditions of continuous work. This situation appears more frequent in the case of specialized doctors. Regarding the psychologists, the number of assessed files is lower because (i) fewer SECPAH have only one psychologist; and (ii) in most counties, not all files pass through a psychological assessment; only those that already have a mental or psychological impairment mentioned in the medical documents.

BOX 15

An example of how workload is calculated per SECPAH member

This example comes from a county with a medium-sized population of persons with disabilities (16,649, as of December 31, 2019), which responded to the workload topic within the Q2A questionnaire. This county has a large team with 11 members in total, which includes 1 specialized doctor, 2 social workers, 4 psychologists, and 4 members with other specializations (3 public administration and 1 engineer who is also medical assistant). According to the SECPAH calculations, in 2020, the specialist doctor's workload was 6,718 assessed files; the workload per psychologist was 2,240 files; while the workload per social worker was 1,680 files. This indicates that 1 psychologist (of 4) has attributions of a social worker, as does one member with public administration/engineering specialization. (Q2A questionnaire)

SECPAH chiefs mentioned two practices for dealing with the extreme workload. The most frequent is to delegate responsibilities among team members. For this reason, in many counties, team members of various specializations cover assessments in areas outside their expertise (which leads to the work division visible in Figure 59). The second practice, more common in counties with large populations of persons with disabilities, involves supplementing, at least temporarily, the SECPAH team with specialists from other DGASPC services, as shown in the quote 9.5 below.



"Interview duration? We manage to get an average time of 15 minutes/applicant, because we also have the staff from the centers to help the SECPAH. Besides, in order to reduce the time, all 4 specialists of the multidisciplinary team assess a person simultaneously." (Focus group SECPAH 1, Intervention of a specialist from the county with the largest population of people with disabilities in the country)

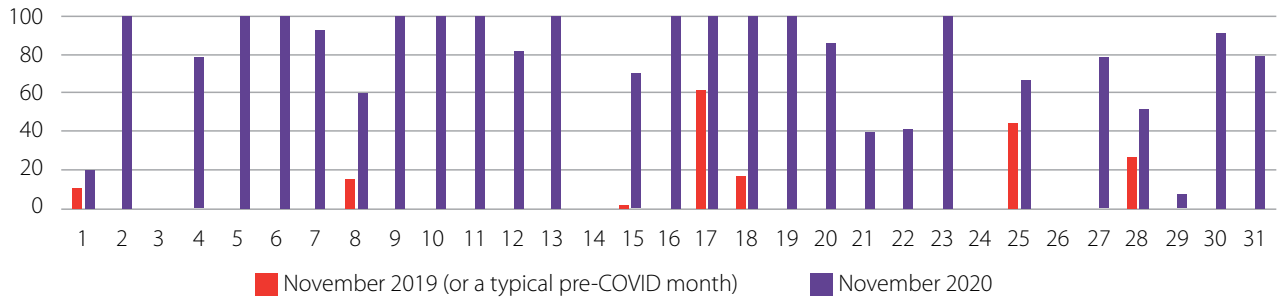
Fewer assessed files do not necessarily reflect a lower workload. In the case of home assessments (mandatory for the immobilized applicants), the round trip to the applicant's home significantly increases the assessment time. The direct interaction between an applicant and the SECPAH team lasts, on average, 15–20 minutes regardless of whether the assessment is done on SECPAH premises or at the applicant's home. In the case of home assessments, the average round trip time is around 107 minutes.[524] Correspondingly, the interview time increases from 15–20 minutes to 120–130 minutes, which significantly diminishes the number of files that could be assessed in a day. The home assessments account for approximately 12 percent of total assessed files for adult applicants in the pre-COVID period, and decreased to 6 percent in 2020.[525] For child applicants, the home assessments have continuously represented 3 percent of all assessed files in a year.

524 With a minimum of 7 minutes, a maximum of 300 minutes, and a standard deviation of 84 minutes. Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 25 counties and 2 districts of Bucharest, January–February 2021.

525 In 2019, the share of home assessment in total assessments ranged between 0 and 35 percent in the districts of Bucharest where SECPAH also plays the role of SPAS. The standard deviation, however, was smaller than the average of 10 percent. In 2020, the number of SECPAH that do not conduct home assessments increased from two in 2019 to four. The disparities in conducting home assessments across counties have also increased.

Similarly, more assessed files do not necessarily reflect a higher workload, as some assessments do not involve any face-to-face interaction with the applicant, and only involve documents or a combination of document review and interviews by phone, WhatsApp, or Skype. Such assessments protect against the spread of COVID-19 and involve less time and effort. Figure 61 displays the dramatic change in the way disability assessment has been done since the COVID-19 pandemic. If in November 2019 (or a typical pre-COVID month) assessments based only on documents (possibly through a combination of documents and telephone interviews, WhatsApp or Skype) were conducted by SECPAH in only five counties, in November 2020, most of SECPAHs used these types of assessment for most applicants.

Figure 61: Share of files assessed based on the document review, possibly combined with interviews by phone, WhatsApp or Skype and that do not involve face-to-face interaction between SECPAH team and applicant, by county (% of total assessed files)



Source: Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 27 counties and 4 districts of Bucharest, January-February 2021.

Besides the interview or document review, SECPAH specialists usually spend an additional 30 minutes per application file, as follows: (i) about 10 minutes to draft conclusions and recommendations in the comprehensive assessment report, including the recommendation for classification or non-classification into a degree and type of disability, the proposal regarding professional orientation, and the proposal to take a protection measure; (ii) approximately 5 minutes to complete the PIRIS; (iii) around 5 minutes to draft the PIS; and (iv) about 10 minutes to otherwise prepare and complete the file, as well as register and deliver it to the CEPAH secretariat.[526]

In conclusion, the workload per SECPAH member has remained high, although has decreased compared to the pre-COVID period. The drop in the number of assessed files, as well as changes to practices related to conducting the assessment (by reducing evaluations at home and proportionally increasing evaluations based on document analysis, possibly accompanied by telephone, WhatsApp or Skype), were the main causes of this change.

Table 12: In a standard hypothetical case of a person applying for classification in a degree and type of disability, how does the interaction with the specialists of SECPAH and, respectively, of SECC, usually unfold?

	SECPAH (%)	SECC (%)
1. The person interacts simultaneously with a team of specialists, in a dedicated space.	29	31
2. The person interacts simultaneously with a team of specialists, in their office (with desks, computers, files, etc.). No other persons are present.	43	39
3. The person interacts successively with a team of specialists, in a dedicated space.	5	15
4. The person interacts successively with a team of specialists, in their office; for instance, they move from one office to another for various areas of assessment. No other persons are present in that office.	13	12
5. Other	10	3
Valid responses - (%)	100	100
- N	182	160

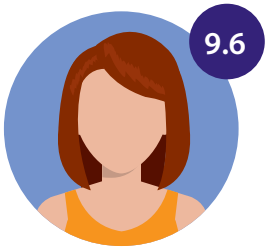
Source: Opinion survey Q2B: Practices and experiences of the practitioners working in SECPAH/SECC from 39 counties and 6 districts of Bucharest, January-February 2021.

526 Median values are used in this paragraph. The corresponding mean values are 15, 7, 7, and 15 minutes (Q2B survey).

The relatively high workload and distorted distribution among team members (by specialization) significantly affects how the assessment based on the medico-psychosocial criteria is performed. First, some of the six mandatory areas[527] of assessment are covered only superficially, for very small groups of applicants with specific characteristics, or are not covered at all. Second, the interview with the applicant is conducted collectively by the SECPAH team or under less strict conditions of confidentiality so as to reduce the interview time (Table 12). Those practices negatively affect the interaction between assessor and applicant, making interviews more cold and impersonal, which also compromises the quality of the information and the general quality of the assessment. A thorough analysis of these aspects is found in Chapter 4.

Supervision and employees' performance evaluation are limited to "internal control" from the SECPAH chief, which is done in a rather ad hoc manner.

Over two-thirds of SECPAH practitioners mentioned at least one problem related to human resources,[528] usually, the need for additional personnel. The insufficient number of specialized doctors was mentioned most frequently, followed by the lack of psycho-pedagogues and physiotherapists. Many respondents also named the lack of professional archivists, those specialized in social services, secretaries, or data entry operators as a problem.



"- We do not have an analysis of the quality of the service [SECPAH]. I do not even know what you mean. We could do an analysis compared only to our classification proposals… We were subject to a control by the Social Inspection, and we saw that the differences were very small, we had no returned files. This is all we have.

- In our county, the analysis of the service is reflected in the internal control. The head of service checks the files and makes notes about each specialist and verifies if the reports are fully completed. He also uses quarterly monitoring reports. The internal report is drawn up based on the number of files. For the internal control we have a register with monthly notes about the activity of each specialist, which I recommend as head of service, if such exist." (Focus group SECPAH 4)

9.2.2. Training of SECPAH Personnel

The second main problem mentioned in the Q2B opinion survey refers to insufficient training and the need for lifelong learning, personal development, experience sharing, and team-building activities. "Sometimes I feel trapped in my office, buried in files and daily routine. I do not see a path to develop myself or to hear how are doing things other people, in other counties, maybe we can imagine some better ways for us and for those that we serve."[529]

SECPAH personnel receive very limited training. In the sample of 32 counties and 4 districts of Bucharest, 22 SECPAH chiefs reported that their SECPAH has a continuous staff training plan. However, over the last three years, only 16 SECPAH delivered a team training session for better intervention and teamwork. Furthermore, in 2020, only about 17 percent of SECPAH personnel attended at least one training session on any topic, or at least one training session intended to help them understand SECPAH's assessment function. Moreover, trained staff are concentrated in 12 counties, rather than being more widely distributed.

The main needs for training mentioned by the SECPAH practitioners are shown in Figure 62. Professional training either in their own specialization or on disability assessment were the most frequently mentioned topics.

SECPAH personnel have very limited knowledge of and training on the ICF. According to the SECPAH chiefs, team members' knowledge of ICF is scored at 3.6, on average, on a scale of 1 to 10, with no significant differences according to specializations.[530] Under these conditions, in the past 12 months (2020), only 3.5 percent of

527 The mandatory areas of assessment are (i) social assessment; (ii) medical; (iii) psychological; (iv) vocational assessment of professional abilities; (v) assessment of the level of education; and (vi) assessment of the skills and level of social integration (GD no. 268/2007, Art. 48).

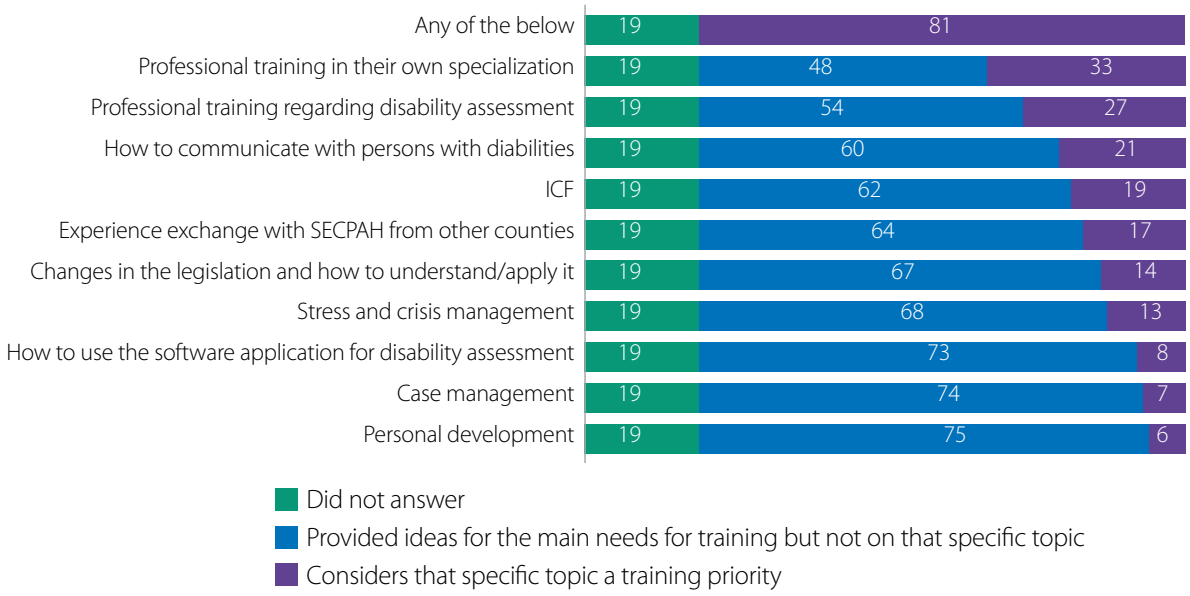
528 Opinion survey Q2B: Practices and experiences of the practitioners working in SECPAH (N=201) from 36 counties and the 4 districts of Bucharest, January–February 2021.

529 A SECPAH psychologist in her Q2B questionnaire.

530 With a standard deviation under 3. Notably, according to the SECPAH chiefs, only around 18 percent of total SECPAH personnel have knowledge about ICF that can be rated with scores between 7 and 10 (institutional survey Q2A_Human resources).

SECPAH personnel (or 12 out of 346 specialists), from only 3 counties (BH, MS, and VL), attended a training course on ICF. Furthermore, in the opinion survey, the SECPAH practitioners self-assessed that the need for training on ICF is at an average level between 7 and 8, on a scale of 1 and 10. They provide similar average scores regarding the need for training on ICF for the SECPAH team, CEPAH members, urban SPAS, and rural SPAS. Therefore, most SECPAH members lack adequate knowledge on the topic, and most are unaware of the striking change that would come from shifting the paradigm from a medical to a holistic approach. Therefore, raising awareness and training SECPAH practitioners could be a game-changer that might as well advance the reform or lead to its failure or reversal. They will not be able to accept or properly use new instruments if they do not understand the implications of the change.

Figure 62: Main training needs for SECPAH specialists (%)



Source: Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=201), from 36 counties and 4 districts of Bucharest, January–February 2021.

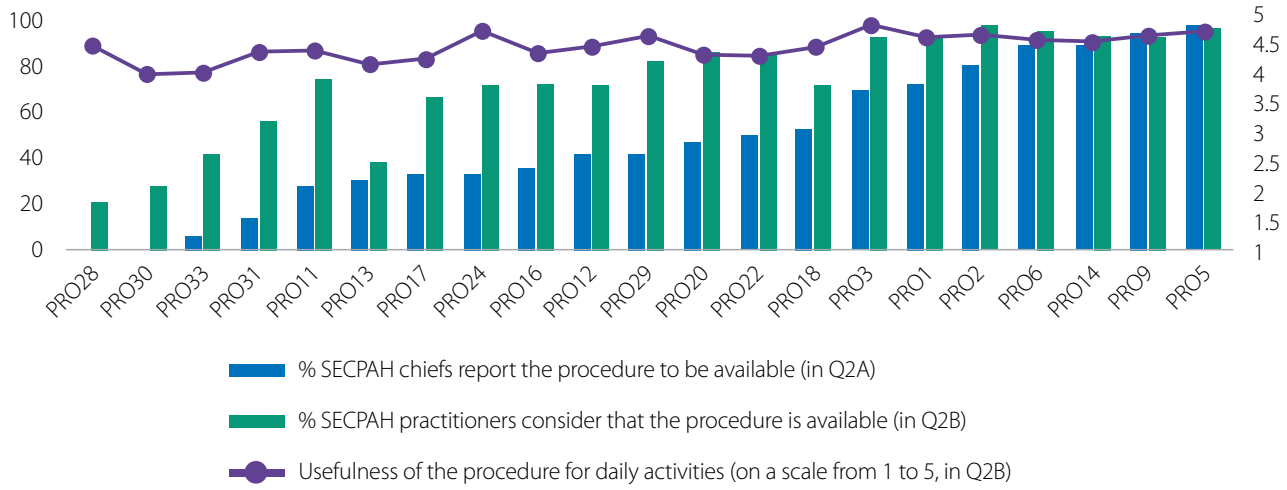
9.2.3. Procedures for Disability Assessment: An Overview

The disability assessment is not approached in a uniform way across the country. At the SECPAH level, the research carried out for this report focused on a package of 21 procedures, which were discussed in the previous chapters. However, Figure 63 shows the most deficient areas. First, half of the studied SECPAH have 6 of these work procedures at most, and three-quarters have no more than 12. Second, in most cases, the existing work procedures are sections of the general SECPAH procedure that reproduce the existing legislation without any clarification or new/specific/additional elements. Third, there are differences between the factual data reported by the SECPAH chiefs and the perceptions of the SECPAH members, but the overall patterns are consistent.

Two groups of work procedures are insufficiently developed, even though SECPAH practitioners consider them to be very useful for daily activities. The first group contains work procedures that have been developed in about a third of the surveyed counties and a large part of the SECPAH specialists perceive them as existing, yet they also mention them among the procedures that need to be further developed. This group of procedures refers to discrepancies between the assessments done by specialists outside the SECPAH and that of the SECPAH practitioners,[531] as well as cases suspected of fraud (PRO13). This group also includes the procedure regarding training and work methods in multidisciplinary teams (PRO 24).

531 Namely, procedures PRO 11, 12, 16, and 17 from the legend of Figure 63.

Figure 63: Work procedures (% of SECPAH, % of SECPAH members, and average score of usefulness)



Legend: Approved work procedure regarding …

PRO1. Information of persons requesting classification into a degree and type of disability

PRO2. Submission and registration of application files for disability assessment

PRO3. Ensuring personal data protection

PRO5. Initial verification of the application files submitted for disability assessment

PRO6. Social assessment

PRO9. Medical assessment

PRO11. For cases where the evaluation from the specialist physician's report does not match the SECPAH physician's assessment based on the documents contained in the file.

PRO12. For cases where the medical documents submitted to the file are conflicting or ambiguous

PRO13. For the situations where it is found that the medical documents submitted to the casefile are suspected to have been counterfeited (suspicion of fraud)

PRO14. Psychological assessment

PRO16. For cases where the evaluation in the psychological clinician's report does not match the evaluation of the SECPAH psychologist

PRO17. For the situations when the psychological assessment has vague or unclear conclusions

PRO18. Vocational assessment and professional skill assessment

PRO20. Assessment of the level of education

PRO22. Assessment of the social skills and integration level

PRO24. Training and working methods in multidisciplinary teams

PRO28. Activities undertaken with the children and parents, in relation to the transition to the adult life

PRO29. Certification of the type of disability

PRO30. For situations in which upon consultation for PIRIS the applicant does not agree with their representative

PRO31. Drafting the PIS

PRO33. Implementation of PIS and the steps to be taken in the cases where it is not performed

Sources: (For the dark blue bars) Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January-February 2021. (For the yellow bars and the purple line) Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=201), from 36 counties and 4 districts of Bucharest, January-February 2021.

The most deficient areas, however, comprise the work procedures that are severely underdeveloped, referring to transition from childhood to adulthood and the individualized plans for intervention (PIS and PIRIS).[532] The SECC representatives also mentioned the need for a clear procedure for activities for 16–17 years old youths and their parents concerning the transition to adult life. Besides lack of procedures, the same areas - transition from childhood to adulthood and the PIS and PIRIS - resulted as being the most problematic regarding the work instruments. Thus, the majority mentioned the following as needing to be developed (i) a tool to simulate for young people aged 16 or older, at the request of parents, the possible results of the disability assessment by applying

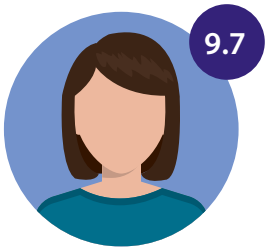
532 Namely, procedures PRO 28, 30, 31, and 33 from the legend of Figure 63.

the medico-psychosocial criteria for adults; (ii) a specific template to prepare PIS, which to be applied uniformly at national level either for all adults with disabilities or for certain categories with clearly defined characteristics; and (iii) a methodology to monitor progress in implementing the services and activities recommended in PIS/PIRIS.

The top three obstacles to SECPAH performance are (i) demotivating salaries in SECPAH; (ii) insufficient personnel, both in terms of number of staff, unsatisfactory professional training, and/or lack of certain specialties; and (iii) inappropriate working instruments and procedures.[533] Hence better work procedures and instruments could be perceived as improving the system's performance. However, these efforts should be accompanied by improvements at the staff level.

9.2.4. SECPAH's Data Management and Information System

SECPAH does not have an information system, and its processes are not automated. Most activities connected with the disability assessment are paper-based. In many counties, rigorous data about the registration and initial verification of the application files are recorded in paper registries, which are not available in electronic format. Data about dropout and exits from the system are not available (see Section 3.1). The use of technology (telephone, electronic mail) to communicate with applicants considerably increased in 2020, due to the COVID-19 pandemic (see Figure 61), yet at the national level the process still heavily relies on face-to-face interactions and the applicants' repeated visits to various desks.



"I can honestly say that I am happy that this pandemic came because it forced us to go online. Otherwise, another 1,000 years would have passed in Romania for us to do what we can now do with you and send online." (Interview with an NGO representative, Bucharest)

In our sample, 23 counties and 2 districts of Bucharest have an approved procedure to protect personal data (or a paragraph/chapter about this in the general procedure).[534] Out of those procedures, only a part covers safe handling and archiving of files (18 counties and 2 districts of Bucharest) or organization, storage, and security of data electronically (18 counties and 1 district of Bucharest). All SECPAH keep copies of the application files, but only a few have transferred and stored these in electronic format,[535] while the others store them in paper format. In most counties, SECPAH alone or in cooperation with the CEPAH secretariat manages and stores the files,[536] which increases the workload in terms of handling and loading files (from registration to assessment, from assessment to the CEPAH secretariat, from commission to storage, within storage, and so forth).

Software applications that automate key functions and processes are nonexistent, and most activities related to beneficiary data management or data validation and cross-checking are performed manually. As mentioned, the EU-Funded National Disability Management System currently implemented by ANDPDCA aims to address this specific gap.[537]

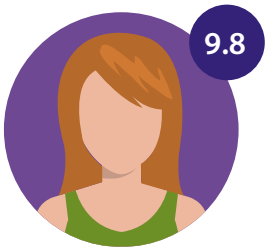
533 Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=192 valid responses), from 36 counties and 4 districts of Bucharest, January–February 2021.

534 Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January–February 2021.

535 One district of Bucharest and seven counties.

536 In counties with larger populations of people with disabilities, the management and storage of files are usually carried out by a different DGASPC service, such as Archive.

537 The general objective of the project is to develop and implement a centralized national platform for the collection, storage, and distribution of information on people with disabilities (adults and children) to central and local public authorities, individual beneficiaries, and institutional partners. For more information, see http://anpd.gov.ro/web/wp-content/uploads/2019/10/ANUNT-WEB-final-ANPD-v2.pdf



"A complex Intranet is missing. The Intranet is absolutely essential. That is how things work. All the services have access to certain information about X, Y and Z and the services communicate in a specific manner about common aspects, so it is missing, we are now stranded." (Interview with a DGASPC director)

One district of Bucharest and 22 counties benefit from a software application for disability assessment, namely D-SMART[538] or ASSYS. Versions of this software vary across counties, as do the number and type of facilities and modules available (counties with a lower budget purchased more limited versions). The software includes modules for each of the six mandatory areas for assessment. The reporting module includes the comprehensive assessment report and the individualized plans for intervention, which are automatically generated. However, only some counties purchased the reporting module.

Data entry is manual. The data that is entered into the software varies from county to county. For example, only in some counties, the specialists' interview notes are entered in the assessment software, while in others only the comprehensive assessment report conclusions are entered.[539] To reduce the assessment time per file, in the case of assessments on SECPAH premises, it is common to enter data during the interview, in the presence of the assessed person.[540] Each specialist enters their notes.[541] Data entry adds approximately 17–19 minutes to the assessment time, per file.[542]

In the existing assessment software applications, there are substantial differences between counties regarding the kind of data that is recorded. For example, from the standard framework model of the mandatory social inquiry, data on autonomy and functional status of the person and assessment of the sensory and psycho-emotional status of the person are treated as follows:[543]

- 6 counties do not enter any information, either automatically or manually
- 5 counties manually enter all information
- 9 counties and 1 Bucharest district manually enter selective information, and the selection differs from county to county
- 2 counties did not answer
- There is no county where the social inquiries to be submitted electronically and to be automatically uploaded into the assessment software.

Similar discrepancies are registered for all types of information in the disability assessment. The least recorded data in the assessment software application refer to the applicant's plans, fears, hopes, or wishes about the life he/she wants to live. Only 5 counties enter such information, and the available data are randomly selected (according to the assessor) and scattered across the existing modules. No county analyzes this data, which would be very difficult to do.

Nearly all surveyed SECPAH declare having "a comprehensive database" of adult citizens with a disability certificate living within their county.[544] Based on information from those databases, 29 counties and 2 districts of Bucharest report being able to reconstruct an applicant's history of applying for disability (re)assessment.

The quality of data in the existing databases is rather poor. Table 13 is an illustration based on an analysis of nonresponses for a few selected variables. Most of the existing databases are merely lists with only a few characteristics that allow very limited data exploration. Most counties do not record the applicant's age (or use predefined categories) so cannot provide data for the category 18–26 years,

538 Disability-Single Management, Assessment and Reporting Tool, version 7.21.01.15(301/2140).

539 Out of the 23 SECPAH that have an assessment software, 16 enter the interview notes from the assessments on SECPAH premises, while 7 enter only the conclusions for the comprehensive assessment report. In the case of home assessments, only 14 counties enter the visit notes.

540 Regarding the home assessments, data entry of the visit notes is most often done the next day, before commencing another assessment.

541 In only one county, a data operator collects the interview notes from all specialists and enters the data.

542 With a minimum of 10 minutes, a maximum of 30 minutes, and a standard deviation of about 6–7 minutes.

543 As per GD no. 430/2008 (Annex 6).

544 One county does not have such a database. Another county did not answer.

which is relevant to the transition from childhood to adulthood. Most counties do not have a unique database consolidating all information to trace applicants from entry to exit. Instead, the common practice is to collect pieces of information in various phases, by various people, and in varied formats. Data on inputs (application files) are very few and usually recorded on paper. The type of assessment (first during lifetime, reassessment regular or at the request), as well as the method of conducting the assessment (on premises, home assessment, etc.), are not systematically recorded. Even the outputs of the assessment cannot be analyzed according to these three variables to observe the aspects that distort the process and need to be corrected. For this reason, the available data allow only an indicative general view of the assessment process, including its inputs, phases, and outputs. At the same time, most of the existing databases neither support nor reflect the daily operation and SECPAH administration.

Table 13: The quality of data from the SECPAH/CEPAH databases using selected variables

		Non-responses	Valid responses	Data for …
	Total number of Q2A_SECPAH questionnaires		36	
INPUTS	Applications total	0	36	Nov-20
	Applications by types – first assessment, regular reassessment, or reassessment at the applicant's request for worsening situation	8	28	Nov-20
	Applications for youth 18-26 living in the special protection system	17	19	Nov-20
	Applications for youth 18-26 living with family	18	18	Nov-20
PROCESS	First assessments – total	9	27	2020
	First assessments – carried out on SECPAH premises	13	23	2020
	First assessments – carried out at applicant's home	12	24	2020
	First assessments – carried out in medical facilities	7	29	2020
	Total number of Q3A_CEPAH secretariat questionnaires		24	
OUTPUTS	Assessed files transmitted to CEPAH secretariat – total	1	23	2020
	Assessed files for people at their first assessment - total	14	10	2020
	Assessed files for people at their first assessment – 18-26 years old	18	6	2020
	Assessed files for people at their first assessment – 27+ years old	18	6	2020

Sources: (i) Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January–February 2021; (ii) Institutional survey Q3C: Result indicators of the disability determination process for the CEPAH secretariat (N=24), from 22 counties and 2 districts of Bucharest, January–February 2021.

Most SECPAH use assessment data to draft an annual or quarterly monitoring and evaluation report.[545] However, only 7 counties publicly disseminate this report. More generally, less than half (one district of Bucharest and 15 counties) use data to document public policies relevant to persons with disabilities, especially to prepare county strategies and identify needs for social services. A few of them (10 counties) also make available public statistics on people with disabilities. Also, very few (5 counties) involve the representatives of persons with disabilities to analyze collected data and define policies.

545 Out of the sample of 32 counties and 4 districts of Bucharest, 16 produce an annual monitoring and evaluation report, 7 quarterly, 3 biannually, 3 make it "whenever needed," and 7 not at all (institutional survey Q2A).

9.2.5. Material Resources

According to the SECPAH chiefs (in Q2A), most counties have a dedicated, confidential space in which to conduct assessment interviews (29 counties and 4 districts of Bucharest).[546]

Additionally, 66 percent of the SECPAH team members report insufficient space for offices; almost 70 percent complain of a severe lack of storage space, and 30 percent express dissatisfaction with existing computers and equipment.[547] Anecdotally, it took about 40 minutes to solve technical issues related to organizing a focus group with a SECPAH team, due to poor equipment (obsolete computers or those with nonfunctional cameras or microphones, lack of or poor Internet in some offices), and lack of space (offices too small to accommodate several people). In the end, the focus group was carried out using team members' personal smartphones.

In the case of assessments on the SECPAH premises, applicants must wait in line before the interview for about 25 minutes, on average.[548] Under these circumstances, it is relevant that nearly all SECPAH are endowed with waiting rooms that allow for distancing, have seats, and accessible toilets, but water dispensers are available in only 61 percent of the surveyed SECPAH.[549]

9.3. CEPAH: Commission for Assessing Adults with Disabilities

In Romania, 47 CEPAH evaluation commissions operate in all 41 counties and 6 districts of Bucharest. CEPAH are specialized bodies attached to the County and Local Council of the Bucharest districts. The Q3A institutional survey collected data about CEPAH activity and human resources; data regarding the CPC were not included. In addition, the Q3C survey gathered data about the CEPAH secretariat and the results of the disability determination process. The following sections are based on the information provided by these two institutional surveys, plus the Q3B opinion survey that collected the views of CEPAH members from 24 counties and 2 districts of Bucharest.

9.3.1. CEPAH's Human Resources

Within the delivery chain, CEPAH is the key actor that determines degree and type of disability (core phase 4). CEP

546 In the opinion survey (Q2B), in 7 counties and one district of Bucharest, the SECPAH practitioners provided inconsistent opinions regarding the existence of a dedicated space for the assessment interviews. In these counties, some practitioners consider that a dedicated interviewing space is available, while the others report that it does not exist.

547 Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=197), from 36 counties and 4 districts of Bucharest, January–February 2021.

548 Almost 60 percent of the SECPAH report that the applicants usually must wait in line before the assessment interview. The waiting time varies considerably, from a minimum of 3 minutes to a maximum of 240 minutes, and a high standard deviation of 42 minutes. Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=185), from 36 counties and 4 districts of Bucharest, January–February 2021.

549 Within the sample, only one SECPAH does not have a waiting room furnished with seats, four do not have an accessible toilet, and six have waiting rooms too small to allow social distancing. Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), from 32 counties and 4 districts of Bucharest, January–February 2021.

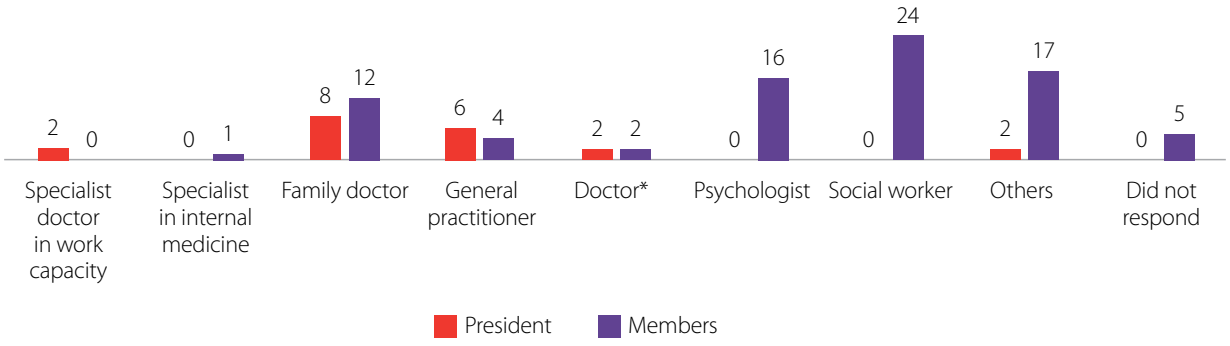
AH also has the final decision regarding the benefits and service package included in the PIRIS (core phase 5). Along with its secretariat, CEPAH also plays a significant role in responding to the courts' requests and implementing the courts' decisions related to appeals and grievances against the disability certificate (core phase 6).

CEPAH size and structure

In the Q3A survey, 19 counties and one district of Bucharest provided data about the CEPAH members. All surveyed CEPAH comply with the current regulations.[550] They comprise 5 members, but a few have 4 or 6 members.[551] In most cases, the president is a specialized doctor in family medicine, general practitioner, or is a specialist with medical expertise in work capacity (Figure 64). All CEPAH presidents interviewed declared that they completed social-medical management courses. Besides the president, the CEPAH teams have at least one psychologist and a social worker, as well as a specialized doctor appointed by the County Direction of Public Health (usually a family doctor or general practitioner) and an NGO representative who advocates for people with disabilities.

In the opinion survey,[552] the CEPAH members (presidents and members) consider there to be enough members to sufficiently serve those who apply for a disability classification. Only respondents from one county think there are not enough CEPAH staff. Similar opinions are expressed regarding the CEPAH composition by specialization. Apart from the representatives of one county, all the others think that the types of specialties under CEPAH are well suited to serve people who annually request classification.

Figure 64: CEPAH human resources by profession and position within the commission (number of persons)



Source: Institutional survey Q3A: Facts and indicators regarding the activity of the commission for assessing adults with disabilities (CEPAH), from 19 counties and 2 districts of Bucharest, January-February 2021.

Note: *Did not provide information about the specialization. The sum of bars is 101 CEPAH members.

Nevertheless, in the view of a paradigm shift from a medical to a holistic approach, the current combination of technical expertise is not aligned with the ICF, both at the CEPAH and SECPAH level. Family doctors and general physicians predominate, while there are very few specialists with medical expertise in work capacity or in physical and rehabilitation medicine (PRM) (see Figure 64 and Section 9.2.1). More such specialists would help improve the use of the comprehensive assessment tools, and make better services/benefits recommendations to persons with disabilities.

550 Law no. 448/2006, Art. 85(4) and GD no. 430/2008.

551 Two of the 20 CEPAH have six members (AG and MM), while one has four members.

552 Opinion survey Q3B: Practices and experiences of the CEPAH members (N=65), from 24 counties and 2 districts of Bucharest, January–February 2021.

BOX 16 Reasons to include physicians specialized in physical and rehabilitation medicine (PRM) in CEPAH and SECPAH

The model known as "functional" focuses not on the disease but on the patient, describing the functioning limitations and environmental factors (personal and environmental). This is precisely the paradigm of interest to PRM physicians, since the focus of the intervention is not merely the etiological reason for disease but its impact on an individual's functioning. This model is more relevant to the description and analysis of chronic conditions and their treatment because it considers the situation of disability as a mismatch between an individual, the environment, and its personal projects. Therapeutic interventions do not aim to cure the patient only by treating the disease and impairments but also by limiting activity and restricting participation. Therefore, the actions of PRM focus on three targets: (i) the individual, by promoting not only the repair process (disease and impairments) but also the compensatory processes (intrinsic, compensation developed by the individual; or extrinsic, with external devices); (ii) the environment (physical, personal, professional, etc.); and (iii) individual projects (education, work, personal and social life) that will be modified and adapted.

The medical specialty of PRM has adopted the ICF developed by the WHO. This classification includes a new approach to persons with disabilities relying on a multidimensional approach. An example of the application of this approach is the identification of a lesion (etiology) using modern imaging techniques that allow practitioners to see details of the injured tissue and identify undamaged structures that could be used for rehabilitation. For the PRM physician, the challenge is to consider these findings to propose rehabilitation methods that could favor plasticity and regeneration. The second aspect is the assessment of different body structures and functions using the clinical examination and selective assessment scales. For the PRM physician, one objective is to measure the severity of the impairment and to make precise correlations between impairments and underlying lesions. This anatomic-clinical approach is particularly important in musculo-skeletal and neurological disorders, as well as cognitive losses due to focal lesions. The third aspect is the assessment of limitations in activity. This is at the core of PRM, which considers the remaining abilities of a person with disabilities to be more important than impairments in body structures and functions. This is a more positive vision relying on the activity itself. The fourth level corresponds to the assessment of social consequences of the injury or disease. In this context, the previously used terms "disadvantage" and "handicap" have been replaced with the more positive term "participation," placing the patient in the context of his/her personal, professional, and social life.

The ICF also constitutes a good model for rehabilitation strategies. The dimensions of the ICF can also refer to distinct targets or outcome measures for rehabilitation. The "body structure/impairment" can correspond to the possibility of stimulating the undamaged structures with a technique or a treatment stimulating plasticity capabilities. The "body function/impairment" can refer to the recovery of a function such as strength, coordination, or dexterity in the case of motor function; discrimination or identification in the case of sensory function; and planning, verbal comprehension, memorization for cognitive functions. The "activity/limitation" can refer to the reduction of the disability and the possible generalization of functional recovery to other activities, and the enhancement of activity limitation by compensation.

The "participation/restriction" corresponds to the reduction of the disadvantage by social interventions based on recognition and inclusion considering personal and environmental factors. The "contextual factors" and their possible role of facilitators and/or barriers, must be considered. In the context of ICF, it must also be considered that the development of the capacity does not necessarily correspond to the final performance of the patient, that should in any case be the end of the PRM action.

This multidimensional approach to the disease and its consequences for diagnosis, treatment, and rehabilitation reinforce the acceptance that PRM may be considered as a medicine of the "whole human" complementing the medicine or specialties of organs.

Source: European Physical and Rehabilitation Medicine Bodies Alliance (2018).

Profile of CEPAH members

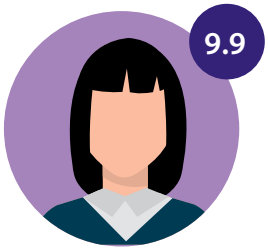
The 20 CEPAH included in the sample that provided data about their human resources have a total of 101 members. Women predominate among the CEPAH members (71 percent), with a university degree or postgraduate studies,[553] and have between 1 month and over 20 years' experience within CEPAH.[554]

CEPAH is a decision-making body for classifying adults by degree and type of disability. The average CEPAH member's experience—of about 7 years—indicates that most commissions have stable teams that carry out the decisional activities. In the past four years (2017–20), 17 of the 24 CEPAH participating in the Q3A survey modified their nominal membership. Modifications to the commission's composition were rare, and did not occur according to a pattern (like every year or every two years).[555] Also, changes to the CEPAH nominal membership may occur through the application of the regulations according to which the members who fail to attend two consecutive meetings without good reasons must be replaced.[556] This regulation is not applied in 7 (out of 24) counties, while in the other counties no unexcused absences were recorded during the 2017–20 period. So, there was no replacement of any CEPAH member due to absences. Correspondingly, the turnover of members is not perceived as a problem (within the Q3B opinion survey).

The NGO representative within CEPAH

In all surveyed counties, CEPAH includes an NGO representative as a member.[557] These are social workers or have other specializations (such as law, military studies, or high school graduates), with high stability, participating in the commission for more than 9 years, on average.[558]

In some counties, applicants with types of impairments other than visual or auditory do not benefit from representation within CEPAH. In just 9 counties (out of 24), the CEPAH frequently collaborates with an NGO representing or advocating for persons with disabilities, usually the county subsidiary of the association of the blind or deaf. However, all CEPAHs studied have a representative of the NGOs as a member. According to the CEPAH presidents, the NGO representative has "the same responsibilities as any other member." Yet, cases have been reported in which the NGO representatives limit their involvement within the CEPAH to applicants with the type of disability served by that specific NGO (such as only those with visual impairments, or only the deaf).



"Participates in meetings, expresses viewpoints about the degrees of disability and the PIRIS, signs the certificates and the PIRIS."

"Fulfills tasks common to the members, as provided by law, notifies cases subject to debate before the CEPAH, popularizes the activity of the committee at community level and that of the organizations having made this proposal, monitors the observance of the rights of persons with disabilities."

"Representation of the members of the association [of the blind] and only them."

"Represents the rights of persons with disabilities in general and, in particular, those of persons with hearing impairments, being also authorized as a sign language interpreter." (Excerpts from Q3A questionnaires)

553 Out of the 101 CEPAH members, 52 completed a faculty degree, 42 completed a master's degree or doctorate, 3 completed high school, and 4 did not answer.

554 The average experience within CEPAH is 82 months, with a standard deviation of 62 months.

555 Out of the 17 CEPAH, 8 changed only one time in the past four years one or more members, 5 modified twice, and 4 altered three times their composition through a County or Local Council decision, respectively, of the Bucharest district, as per GD no. 430/2008, Art. 8(2).

556 According to GD no. 430/2008, Art. 9.

557 As per Law no. 448/2006, Ch. VII, and the implementation guidelines dated March 14, 2007, for the implementation of the provisions of Law no. 448/2006 on the protection and promotion of rights of persons with disabilities, Art. 54(1), 54(2), and 55.

558 A value of 111 months, with a standard deviation of 86 months. Institutional survey Q3A: Facts and indicators regarding the activity of the commission for assessing adults with disabilities (CEPAH), from 19 counties and 2 districts of Bucharest, January–February 2021.

In the opinion survey Q3B,[559] over 80 percent of CEPAH members declared to know how the NGO representative is appointed within CEPAH. In most cases, "he/she is simply appointed by the County Council." About half of those think this mechanism should be maintained. The other half think it should be changed, for example, by using some objective selection criteria, an open process of selection, or an annual rotation system involving the various NGOs that operate within the county.

Also, over 85 percent of CEPAH members say they know the specific role and responsibilities that the NGO representative currently has within CEPAH. Furthermore, 73 percent consider the NGO representative in CEPAH to adequately represent and promote the rights of persons with disabilities in their county (providing an average score of 8.3, on a scale of 1 to 10).[560] Nevertheless, almost half believe that the specific allocation of roles and responsibilities should be kept as they are, whereas the other half would change the role of the NGO representative in two ways: by (i) introducing "an express procedure for reporting the cases of breach of rights or problems, especially those that should lead to changes to the regulations in force;"[561] or (ii) selecting only social workers enlisted in the Romanian Social Worker National College from NGOs accredited to provide social services.[562]

Most interviewed NGOs point out that the mechanism for appointing the NGO representative is not transparent. Some do not even know who the NGO representative in their county is. In their view, the NGO representatives in CEPAH "tend to make a role confusion and forget that they should foremost watch and guarantee the observance of the rights of persons with disabilities and to make sure that their voices are heard."[563] All CEPAH presidents say (in the Q3A institutional survey) that there has never been a case in which the NGO representative from CEPAH reported a case of rights violation in the disability determination process, for which other NGOs needed to be involved to solve or remedy the situation. This means either that the decision-making process works perfectly or that the representation mechanism is not working at all.

CEPAH workload

Regarding the CEPAH workload, Figure 65 shows there is no correlation between the total number of files to be assessed and the total number of CEPAH meetings (ordinary and extraordinary) for conducting the disability determination process. Accordingly, irrespective of the number of files, the total number of CEPAH meetings varies between 4 and 21 per month, both in the pre-COVID period and in 2020, as the analysis in Chapter 5 shows.[564]

CEPAH members (including the president) are entitled to a sitting allowance equivalent to 1 percent of the County Council president's allowance,[565] which varies substantially across counties; for example, between 100 lei (in GL and HD) and 187 lei (in DB). It appears that randomly increasing the number of meetings only deepens the existing discrepancies, as shown in Table 14.

559 Opinion survey Q3B: Practices and experiences of the CEPAH members (N=65), from 24 counties and 2 districts of Bucharest, January–February 2021.

560 With a standard deviation of 2.2. Opinion survey Q3B: Practices and experiences of the CEPAH members (N=48 valid responses), from 24 counties and 2 districts of Bucharest, January–February 2021.

561 Excerpt from a Q3A questionnaire.

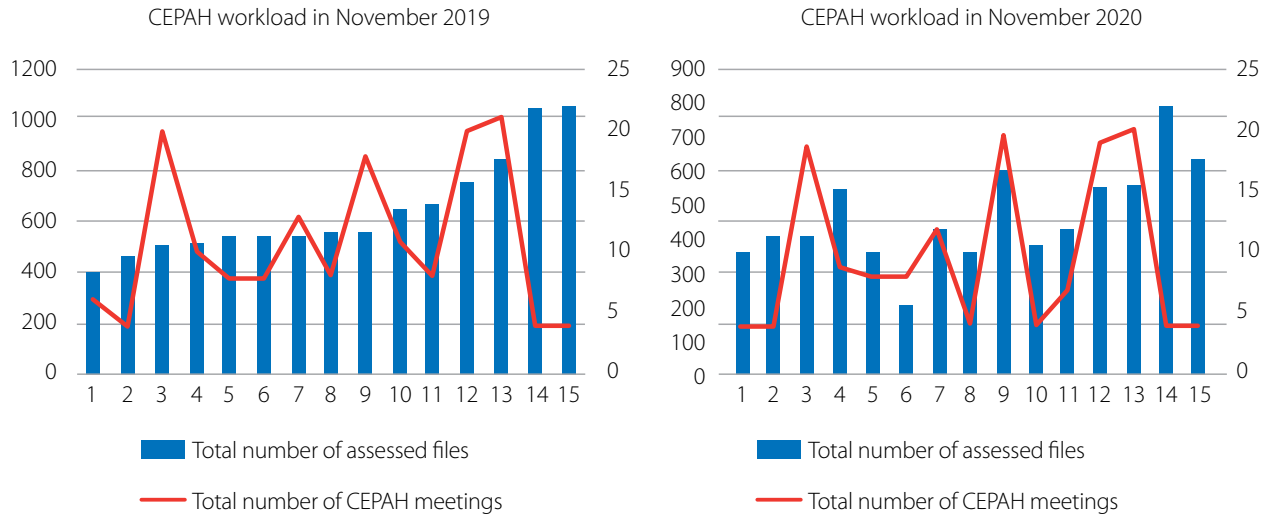
562 The other half of CEPAH members consider that the concrete role and responsibilities of the NGO representative within CEPAH should be kept as they are at the moment.

563 Interview with a national NGO.

564 With an average of 11 meetings in November 2019 and 10 meetings in November 2020.

565 Law no. 136/2012 for the approval of EGO no. 84/2010 that completes and modifies Law no. 448/2006.

Figure 65: CEPAH workload per month



Source: Institutional survey Q3A: Facts and indicators regarding the activity of the commission for assessing adults with disabilities (CEPAH), from 15 counties that provided all necessary data, January-February 2021.

Note: The counties are ordered according to the number of files that CEPAH had to assess in November 2019.

Table 14: Comparison of monthly payments for CEPAH members, November 2020

	Ordinary meetings (number)	Sitting allowance (lei/meeting)	Payments for ordinary meetings (lei)	Extraordinary meetings (number)	Sitting allowance (lei/meeting)	Payments for extraordinary meetings (lei)	Total
County 1	4	187	748	0	187	0	748
County 2	3	187	561	1	187	187	748
County 3	4	100	400	15	100	1,500	1,900
County 4	4	100	400	15	100	1,500	1,900
County 5	4	100	400	0	100	0	400
County 6	4	100	400	0	100	0	400

Source: Institutional survey Q3A: Facts and indicators regarding the activity of the commission for assessing adults with disabilities (CEPAH), from 6 selected counties that provided all necessary data, January-February 2021.

Except for the president,[566] CEPAH members have at least one full-time job aside from their activities with CEPAH. Thus, according to the labor regulations, they hold part-time work contracts of 2–3 hours per day for their CEPAH activity. Correspondingly, they work on CEPAH activities up to 50–60 hours per month.[567] As the average number of files per meeting varies widely across counties (from 21 to 200),[568] CEPAH members spend between a mere 1.3 minutes and 9 minutes (with an average of 3.5 minutes) on evaluating a file.[569] To take decisions regarding disability classification

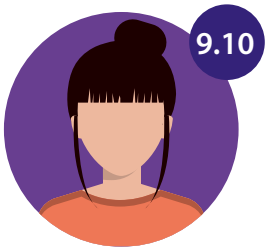
566 The CEPAH president is part of the DGASPC staff, without being a public servant.

567 The CEPAH presidents provided data about the number of ordinary and extraordinary meetings, the duration, and the number of files per meeting (institutional survey Q3A). In several counties, their estimations far exceeded 50–60 hours per month for meetings, which indicates that many of them have performed this exercise for the first time with this research.

568 The average number of files per meeting varied widely from 25 to over 250 in November 2019 and from 21 to almost 200 in November 2020. The average number of files per meeting was determined as the number of assessed files received from SECPAH divided by the number of CEPAH meetings.

569 The estimation is based only on the valid estimates provided by 8 (out of 24) counties.

and services/benefits in less than 5 minutes is extremely hasty, given that files contain many hard copy documents. Due to this workload, it is understandable why the CEPAH solutions are the same as the SECPAH recommendations for over 90 percent of the application files.



"County 1: The workload is very high, we have 800-900 files/month, we have 2 meetings/week. Of 3 hours. Files cannot be examined only during these meetings. Everyone examines the files, but in order to cope with the workload, I, as president, being here for 8 hours/day, examine the files. With regard to everything that is special, I discuss with my colleagues. We have many files returned to the SECPAH. After we see the files, a decision is made, and the secretary of the committee types it and the files are then passed to each member for signing. In the case of contradictory opinions, we have constructive discussions, especially about the files on mental illnesses and then we discuss with the psychologist, with SECPAH, we reach a conclusion. We take the arguments beyond the emotional sphere and we make the decision on the spot. We also have working meetings with SECPAH, usually one meeting per month." (Focus group CEPAH 1)

9.3.2. Training of CEPAH Members

CEPAH members receive extremely limited training. In the sample of 24 CEPAH, only 2 counties have a continuous training plan for members. In the past three years (2018–20), only one CEPAH organized a team training session about the collaboration between commission members, its functioning and duties, and only 2 CEPAH held a team training session about handling specific cases. Out of 120 members in the 24 surveyed CEPAH, only 8 specialists (from 4 counties) participated in at least one training session about using the medico-psychosocial criteria, only 2 persons (from 2 counties) took part in a practice exchange, and only 10 members (from 5 counties) participated in training on the UNCRPD. In 2020, only 7 CEPAH members from 3 counties benefited from at least one training session of any type.

CEPAH staff have limited knowledge of the modern approach to disability and the ICF. Out of 120 members, only 8 (from 8 counties) have ever participated in ICF training. According to CEPAH members' self-assessment, their knowledge about UNCRPD ranks a 7.7 and about the ICF is 5.8, on a scale of 1 to 10.[570] Also, in the Q3B opinion survey, CEPAH members define insufficient training as the main problem, especially about ICF, UNCRPD, and how to use the medico-psychosocial criteria, and mention as a priority the need to share experiences and engage in team-building activities. In their opinion, the need for ICF training is an 8-9 (on a scale of 1 to 10), not only for them but also for the SECPAH teams, as well as for urban and rural SPAS.

The weak collaboration between the CEPAH and NGOs representing people with disabilities (only 9 counties out of 24 frequently collaborate with an NGO) has been discussed. Furthermore, in terms of knowledge transfer, only half of CEPAH members are familiar with analyses, reports, and dissemination activities that NGOs have developed about protecting people with disabilities and recommending measures to improve their living conditions, in the county or at the national level. However, even the informed members consider that such activities have been of little relevance and usefulness for the CEPAH activity (an average score below 5, on a scale of 1 to 10).[571]

9.3.3. CEPAH Secretariat

The CEPAH secretarial work is carried out by DGASPC staff.[572] In two counties there is no CEPAH secretariat, whereas in the other counties it is comprised of 1–9 persons appointed by the DGASPC director. The number of personnel in the CEPAH secretariat is not correlated with either the size of the country's registered persons with disabilities population, the number of application files for evaluation, or the number of practitioners

570 With standard deviation values of 1.6 and 2.5, respectively. Opinion survey Q3B: Practices and experiences of the CEPAH members (N=55 valid responses), from 24 counties and 2 districts of Bucharest, January–February 2021.

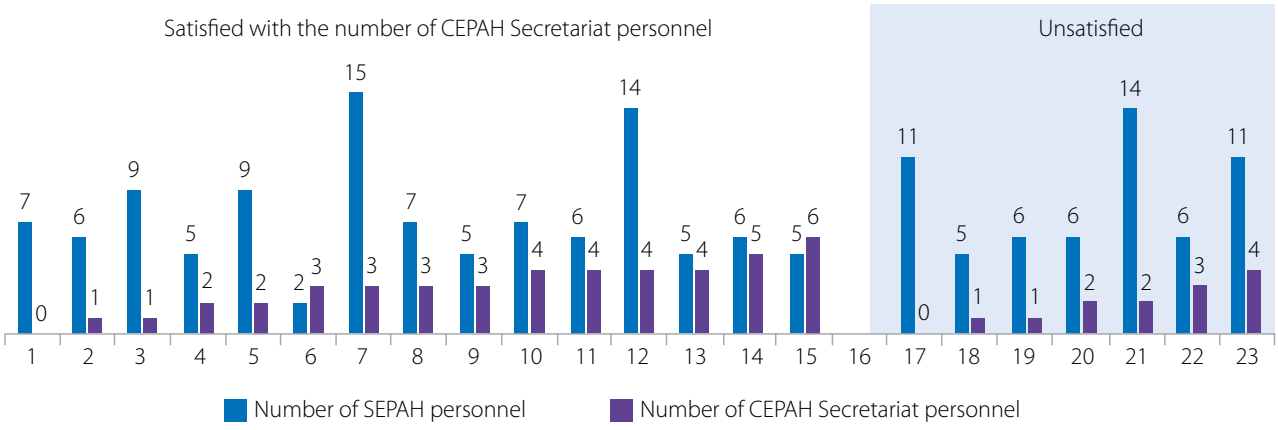
571 Opinion survey Q3B: Practices and experiences of the CEPAH members (N=65), from 24 counties and 2 districts of Bucharest, January–February 2021.

572 Law no.136/2012 for the approval of EGO no. 84/2010 that completes and modifies Law no. 448/2006 / Art. 8, para. 4, GD no. 430/2008.

employed in SECPAH (see Figure 66). At the same time, some CEPAH presidents think a secretariat of 1–3 persons is sufficient for the commission's efficient functioning, while others consider it too small to properly function.

The CEPAH secretariat has duties both in relation to the applicants/beneficiaries and the commission, as already mentioned in Section 1.2.1. Regardless of the number of personnel, in half the counties, the CEPAH secretariat has additional duties. They send the list of beneficiaries of a disability certificate to the payment agencies immediately after issuing the disability certificates. Depending on the county, the secretariat also administers the database (software application), communicates with the statistical offices from various institutions, enters data in the National Electronic Registry (of ANDPDCA), manages the mail, answers petitions and notifications, and archives and stores beneficiaries' files.

Figure 66: The number of personnel of the SECPAH and the CEPAH secretariat in selected counties, by the CEPAH presidents' satisfaction * with the number of personnel of the secretariat



Sources: (i) Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH), January–February 2021; and (ii) Institutional survey Q3C: Result indicators of the disability determination process for the CEPAH secretariat, January-February 2021.

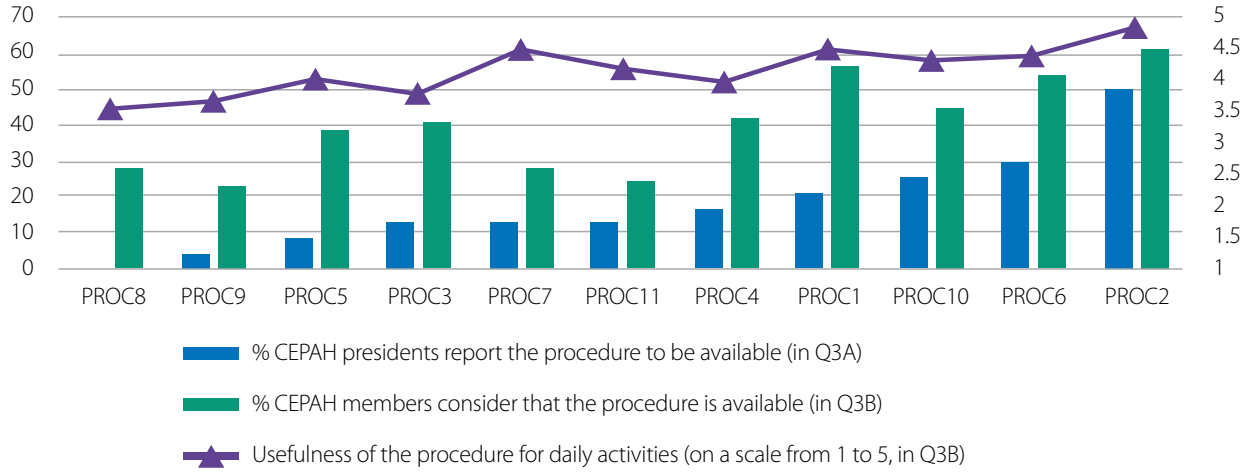
Note: The graph shows the situation in 22 selected counties that provided all necessary data. * Satisfaction = The president of CEPAH and/or the CEPAH secretariat responded that the existing personnel is sufficient in number for the efficient functioning of the CEPAH secretariat. Dissatisfaction = secretariat is reported to be understaffed.

9.3.4. Procedures for Disability Determination: An Overview

There is no unified approach to disability determination across the country as the determination-specific working procedures are developed in very few counties (see Chapter 5). At the CEPAH level, the research carried out for this report has focused on a package of 11 procedures,[573] which were discussed in the previous chapters. The overview presented in Figure 67 reveals the most deficient areas. First, 30 percent of the studied CEPAH have none of the considered procedures, while another 50 percent have 1–3 of those procedures. Second, in most cases, the existing work procedures are sections of a general CEPAH procedure that reproduce the existing legislation without any clarification or new/specific/additional elements. Third, there are differences between the factual data reported by the CEPAH presidents and the perceptions of the CEPAH members, which indicates that most CEPAH members have very limited knowledge of their work procedures.

573 A 12th procedure about issuing a disability certificate to apply the provisions of Art. 58 or 59 in Law no. 263/2010 on the public pensions system was also included in the Q3A questionnaire but not in Q3B.

Figure 67: Work procedures (% of CEPAH, % of CEPAH members, and average score of usefulness)



Legend: Approved work procedure regarding …

PROC1. The way files to be discussed in a certain CEPAH meeting are determined

PROC2. Ensuring personal data protection

PROC3. Regarding situations in which the assessment in specialized physician report does not match the assessment of the physician(s) in CEPAH based on the documents contained in the file

PROC4. Regarding situations in which medical documents have either vague or unclear conclusions/diagnoses or inconsistent conclusions/diagnoses (when asked for or when two or several reports are provided by different specialized physicians)

PROC5. Regarding the situation in which CEPAH members have suspicions about the accuracy of medical documents

PROC6. The manner of classification by degree and type of disability

PROC7. Regarding situations in which the CEPAH members disagree about the classification by degree and type of disability in a case

PROC8. The participation of applicants in CEPAH meetings

PROC9. For situations in which upon consultation for PIRIS the applicant does not agree with his/her representative

PROC10. The admission in residential or day centers of individuals with certificates valid for 1 or 2 years

PROC11. The implementation of PIRIS/PIS and what to do if it is not implemented

Sources: (For the dark blue bars) Institutional survey Q3A: Facts and indicators regarding the activity of the commission for assessing adults with disabilities (CEPAH), from 22 counties and 2 districts of Bucharest, January-February 2021. (For the yellow bars and the purple line) Opinion survey Q3B: Practices and experiences of the CEPAH members (N=65), from 24 counties and 2 districts of Bucharest, January-February 2021.

In the case of CEPAH, most of the considered procedures are perceived as useful and would need to be developed. According to CEPAH members, somewhat less important seem to be only the procedure regarding applicants' participation in CEPAH meetings (PROC8) and the procedure for situations in which, upon consultation for PIRIS, the applicant does not agree with his/her representative (PROC9).

9.3.5. CEPAH's Data Management and Information System

After SECPAH finalizes the disability assessment, application files are transmitted to CEPAH for disability determination. In all counties, files are mostly in paper format. Only three counties have at least some of the documents in electronic format. The CEPAH secretariat registers and manages the files during the disability determination phase. Once CEPAH decides, the secretariat issues the disability certificate to applicants (either they received classification or non-classification into a disability degree). After the disability certificates are released, either the CEPAH secretariat (in 60 percent of the counties) or SECPAH (in 40 percent of the counties) manages and archives the files. Thus, the entire process is paper based. At the end of this process, only 4 counties (MH, DJ, TL, and GJ) have all the documents transferred and stored electronically. Also, only about half the counties have an approved procedure (or paragraph in

the general procedure) to ensure personal data is protected (PROC2 in Figure 67).

Data management is highly fragmented, not only between but within counties. In most counties, CEPAH shares with SECPAH the same "comprehensive database" of adult citizens with a disability certificate living within their county. Nevertheless, in three counties, CEPAH and SECPAH hold separate databases, while in others only SECPAH (or only CEPAH) record data in such a database. Further, regarding the software application, by consolidating the data reported in the three institutional questionnaires (Q2A, Q3A, and Q3C), findings show that: (i) about 15 percent of counties lack software for disability assessment and determination; (ii) approximately a third of counties have software that is used both by SECPAH and the CEPAH secretariat; and (iii) over half the counties have software that is used exclusively by SECPAH or the CEPAH secretariat. D-SMART is the most popular software that is based on manual data entry. The National Electronic Registry is just one dataset in which each county should enter selected data, and not a working instrument for SECPAH/CEPAH.

The quality of data in the existing databases is rather poor. Out of 47 CEPAH in Romania, the secretariats of 27 CEPAH responded to the Q3C survey,[574] which asked a series of interrogations of the county database. There were a significant number of nonresponses. Below are several examples of indicators that cannot be extracted in most counties.

Indicator: In your county/district, according to the records of the CEPAH secretariat, which was for November 2020 the …	**Answers can be found in …**
Total number of Professional Orientation Certificates issued?	8 counties
Number of disability certificates issued for male/women from rural/urban areas?	11 counties
Number of disability certificates issued for people from rural/urban areas with a validity period of 1 year, 2 years, or permanent?	10 counties
Number of disability certificates issued for people 65+ years old?	18 counties
Number of disability certificates issued for male/female 65+ years old?	15 counties
Number of disability certificates issued for people 65+ years old living in rural/urban areas?	8 counties
Number of disability certificates issued for young people 18-20 years old?	17 counties
Number of disability certificates issued for male/female 18-20 years old?	15 counties
Number of disability certificates issued for people 18-20 years old living in rural/urban areas?	9 counties
Total number of disability certificates issued for individuals with protective action irrespective of the type of placement service (centers, protected housing, etc.)?	6 counties
Number of disability certificates issued for people with disabilities living with family, from urban/rural areas?	1 county
Number of disability certificates issued for men/women with disabilities living with family?	2 counties
Number of disability certificates issued for people with disabilities of any age group living with family?	2 counties
Number of disability certificates issued for people in prison?	3 counties
Number of disability certificates issued for individuals hospitalized in psychiatric facilities?	2 counties
Number of disability certificates issued for homeless people?	0 counties
Number of disability certificates issued for people who cannot move?	0 counties
Number of disability certificates issued for individuals under public guardianship (who are covered by a court judgment on judicial protection of incapable adults, which appoints the local authorities as guardian)?	0 counties

574 Institutional survey Q3C: Result indicators of the disability determination process for the CEPAH secretariat, from 25 counties and 2 districts of Bucharest, January–February 2021.

The CEPAHs use the data collected through assessments less than SECPAH. Over 80 percent of CEPAH draft an annual or quarterly monitoring report, but only 20 percent of them make it public.[575] Also, less than a fifth uses the data to document relevant public policies for persons with disabilities or to identify needs for social services. In other words, only a small part of the information is available in electronic format, while the rest of the documents and reports cannot be easily found. They do not involve the representatives of persons with disabilities in the analysis of collected data.

9.3.6. Material Resources

From the CEPAH secretariat's point of view, there is sufficient office/space and enough computers;[576] more printers and office supplies are needed. Half of the interviewed CEPAH members report the need for a larger space for the commission meetings, as well as more computers, printers, and data entry operators.[577] In seven counties, applicants/beneficiaries can consult their files, on request, after CEPAH finalizes the assessment, but only two counties benefit from a space dedicated to this aim.

575 Institutional survey Q3A: Facts and indicators regarding the activity of the commission for assessing adults with disabilities (CEPAH), from 22 counties and 2 districts of Bucharest, January-February 2021.

576 Less than a quarter mentioned those aspects as being problematic. Institutional survey Q3C: Result indicators of the disability determination process for the CEPAH secretariat, from 25 counties and 2 districts of Bucharest, January–February 2021.

577 The other half say that they have all they need. Opinion survey Q3B: Practices and experiences of the CEPAH members (N=65), from 24 counties and 2 districts of Bucharest, January–February 2021.

Conclusions of Chapter 9

SECPAH and CEPAH, at the county level, and SPAS, at the community level, represent the key organizational actors involved in disability assessment and determination for adults in Romania.[578]

1

SPAS: In Romania, at present, only about a third of the local authorities have a SPAS at the local level that is accredited according to law. In the urban SPAS, there are more staff involved in social work activities, with 1–10 employees in small cities and 3–59 in larger cities. Rural SPAS have only one or two staff. The indicative staff structure of SPAS, as per GD no. 797/2017,[579] is only partially implemented. The highest deficit is registered among persons responsible for providing social services and case managers responsible for children and adults with disabilities in care of their families. The workload in the disability field varies considerably across localities.

2

SECPAH:[580] The number of specialists employed per SECPAH ranges between 5 and 22. The analysis showed that the size of SECPAH staff is more a budget decision of the County Council than one pertaining to the size of a county's registered population of persons with disabilities. SECPAH personnel are mainly women between 22 and 68 years old who are graduates of tertiary education, many of whom have postgraduate studies. Only a few SECPAH comply with GD no. 268/2007 (Art. 49) regarding the staff specializations. Specialists like psycho-pedagogues, physiotherapists, education instructors, and rehabilitation therapists account for very few of the total SECPAH staff and are found in a small number of counties. The incomplete personnel structure in terms of specialization affects how SECPAH performs the disability assessment based on the medico-psychosocial criteria and most SECPAH in the country cannot provide a full-fledged assessment as designated by the current legislation.[581]

The workload per SECPAH member varies significantly according to each member's specialization; specialized doctors have the highest workload. The workload per SECPAH specialist sharply declined during the COVID-19 pandemic, with a significant variation across counties. The drop in the number of assessed files, as well as changes to practices involved in conducting the assessment (by reducing home assessments and doing more assessments based on document review plus phone, WhatsApp, or Skype interview when possible) were the leading causes of this change. Nonetheless, the workload has remained relatively high, which, together with the distorted distribution across team members, significantly affects how the assessment is performed. The main problem related to human resources is the need for additional personnel. The insufficient number of specialist doctors was mentioned most frequently; psycho-pedagogues and physiotherapists are also needed. Many respondents also mentioned needing more professional archivists, social service workers, secretaries, and data entry operators.

578 The services of comprehensive assessment and the commission for children (SECC and CPC) are not covered, as no data were collected in this sense.

579 Art. 4, para. 2.

580 In Romania, there are 47 services for the comprehensive assessment for the classification in degree and type of disability for adults (SECPAH). The DGASPC provides these services in all 41 counties and 6 districts of Bucharest.

581 More details are available in Chapter 4.

3

CEPAH:[582] All surveyed CEPAH comply with current regulations.[583] The average experience per CEPAH member (of about seven years) indicates that most commissions have stable teams that carry out the decisional activities. In all counties studied, CEPAH includes an NGO representative as a member. In some counties, the NGO representatives limit their involvement to applicants with the type of disability served by that specific NGO. The mechanism of how the NGO representative is appointed within CEPAH is not transparent. Changing the appointment mechanism and an NGO representative's specific roles and responsibilities might improve the disability assessment process and its outcomes.

Two counties have no CEPAH secretariat, while in other counties, it is made up of between 1 and 9 persons appointed by the DGASPC director. The number of personnel in the CEPAH secretariat is correlated neither with the size of the county's population of registered persons with disabilities nor with the number of application files for evaluation or the number of practitioners employed by SECPAH.

Regarding the CEPAH workload, there is no correlation between the total number of files to be assessed and the total number of CEPAH meetings (ordinary and extraordinary) for conducting the disability determination process. Randomly increasing the number of meetings only deepens the existing discrepancies. Due to the high workload, CEPAH takes decisions on classification by disability degree and the services/benefits included in the individualized plans (PIRIS) in less than 5 minutes, based on files that include many paper-based documents. Consequently, the CEPAH solutions are the same as the SECPAH recommendations for over 90 percent of the application files.

4

Technical expertise: In the view of a paradigm shift from a medical to a holistic approach, the current combination of technical expertise is not aligned with the ICF, at the level of CEPAH and SECPAH. Family doctors and general physicians predominate, while specialists with medical expertise in work capacity or in physical and rehabilitation medicine are very rare. More such specialists would improve the use of the comprehensive assessment tools and improve recommendations for better services/benefits.

5

Staff training: SPAS, SECPAH, and CEPAH all have minimal staff training. At the SPAS level, only 6 persons (out of 478) benefitted from training about the SPAS's role and duties for classification by degree and type of disability. Only 3 employees were trained on how to complete the framework model[584] for the mandatory social inquiry. The current training and mindset of local level practitioners is not conducive to change, and might hinder the system's reform. Training at the SPAS level is critical for promoting any systemic change.

ICF-related training is also extremely limited. At the SPAS level, out of 478 surveyed employees, only 5 have ever attended training in connection with the ICF. Among CEPAH, out of 120 members, only 8 (from 8 counties) have ever participated in ICF training. The SECPAH staff's knowledge about the ICF is too limited to fully understand the systemic transformations that would come with changing the paradigm from a medical to a holistic one. Therefore, raising awareness and training among SECPAH and CEPAH practitioners could be a game-changer, as it might advance or undermine the reform. They will not accept or properly use the new instruments if they do not understand the implications of the change. To this aim, a special budget should be earmarked that considers current market prices of accredited training providers.

582 In Romania, 47 evaluation commissions for the classification in degree and type of disability for adults (CEPAH) operate in all 41 counties and 6 districts of Bucharest. CEPAH are specialized bodies with no legal personality, attached to the County and Local Council of the Bucharest districts.

583 Law no. 448/2006, Art. 85(4) and GD no. 430/2008.

584 GD no. 430/2008, Annex 6.

6

Work procedures: There is no unified approach to disability determination across the country. The SECPAH work procedures for disability assessment are only partly developed. The severely underdeveloped work procedures refer to how to treat discrepancies between the assessments done by specialists outside the SECPAH and that of the SECPAH practitioners, how to identify and correct suspected cases of fraud, training and working methods in multidisciplinary teams, transition from childhood to adulthood, and individualized plans for intervention. Also, very few counties base their disability determination on specific CEPAH work procedures. In the case of CEPAH, most of the considered procedures are perceived as useful and would need to be developed. Improving the working procedures and instruments could be perceived by SECPAH and CEPAH specialists as a way to boost system performance but should be accompanied by changes at the staff level.

7

Data management and information system: There is no information system for managing and administering the disability-related system, and processes along the entire delivery chain are rarely automated (if at all). Most activities connected with the disability assessment are paper-based. To address the gap, the ANDPDCA is currently implementing an EU-funded project to develop the National Disability Management System.[585]

Software applications that automate key functions and processes such as cross-checks, validation and verification, benefit management, payment administration, and beneficiary data management are manual or nonexistent. In the existing assessment software applications, counties have substantial differences in what kind of data is recorded. Similar discrepancies are registered regarding all types of information used in the disability assessment. In many counties, rigorous data about the registration and initial verification of the application files are recorded in paper registries, and are not available in electronic format. Data about dropout and exits from the system are not available. The least recorded data in the assessment software application refer to the applicant's plans, fears, hopes, or wishes about the life he/she wants to live. The quality of data in the existing databases is rather poor. Most of the existing databases are merely lists with only a few characteristics that allow very limited data interrogations. Data management is highly fragmented, not only between but also within counties (among SECPAH, CEPAH, and its secretariat).

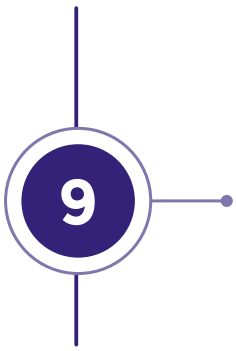
8

Use of data for public policies: The collected data are used for internal reporting and less often for documenting disability-related public policies, especially to prepare local strategies and identify needs for social services. At the local level, some SPAS do not have data but make policies, while others have solid data but do not use them to make policies pertaining to persons with disabilities. Most SPAS report using a participatory approach by involving the representatives of persons with disabilities to analyze collected data and define policies. At the county level, the monitoring reports of both SECPAH and CEPAH are rarely publicly disseminated. Less than half of SECPAH and less than a fifth of CEPAH use data to document relevant public policies for persons with disabilities, and very few use a participatory approach.

Access to and quality of data on the situation of people with disabilities in Romania should be improved. A separate study should be launched to examine ways to increase the availability and use of disability data. Therefore, anonymized and possibly aggregated national and regional data from SECPAH and CEPAH should be made available for research and policy making.

At the SECPAH/CEPAH level, no IT/data management/data analysis specialist

585 The general objective of the project is to develop and implement a centralized national platform to collect, store, and distribute information on people with disabilities (adults and children) to central and local public authorities, individual beneficiaries, and institutional partners. More details at http://anpd.gov.ro/web/wp-content/uploads/2019/10/ANUNT-WEB-final-ANPD-v2.pdf



is provided, nor are data operators. Poor data management, poor data quality, and poor use of data are predictable in the absence of these human resources and under conditions of very high workload.

Material resources: Insufficient office/storage space and equipment (including printers, scanners, mobile phones, tablets, or laptops) are mentioned as a critical factor for improving efficiency at both SECPAH and SPAS levels.

10. Conclusions and recommendations

Attempts have been made to align the procedures and instrumentation of Romania's disability assessment to the ICF, with limited success. In present, the instrumentation is still not evidence-based, or psychometrically sound, and diverse information from various sources has no identifiable impact on the decision of disability determination. In the end, the lack of quantifiable criteria leaves room to a predominantly medical-based disability assessment. The Romanian disability assessment should be modified to perform the assessment and determination more effectively in accordance with best international practices. To this aim, many important issues must be resolved, including revamping the assessment methods and tools, redesigning the process and procedures, enhancing the flow, availability, and usability of data, aligning services provided to persons with disabilities, and aligning assessors' capacity and knowledge base with the ICF standards.

10.1. Challenges and binding constraints to adopting a holistic approach to disability assessment and determination

1. Challenges of disability assessment and determination

The procedure and instrumentation of the SECPAH comprehensive disability assessment do not align with the ICF principles. The ICF principles require disability assessment to include both medical and functional components, defining the criteria and decision-making process. According to the ICF approach, physicians should evaluate an applicant's impairments at the level of body functions and structures according to items related to ICF categories. The other aspect of decision-making should assess the applicant's activity limitations and participation restrictions using functional and environmental factors. Ideally, a group of qualified practitioners should work together to establish and adopt the ICF principles.

The SECPAH comprehensive assessment is predominantly based on medical criteria and, in the absence of quantifiable psychosocial criteria, cannot accurately capture neither the persons with disabilities' needs nor participation restrictions or activity limitations (functional assessment). The regulation on the medico-psychosocial criteria uses ICF terminology in the arrangement of chapters, grading options, and in the Activities/Participation component. But, merely using ICF terminology does not mean it embodies the ICF model of functioning

586 In this report, the term "certificate" means "disability certificate." Any other type of certificate discussed is referenced by full name.

and disability. The medico-psychosocial criteria constitute essentially a standard Baremic instrument that has been extended by including Activities and Participation domains, as well as professional skills.

Thus, the existing criteria is not aligned with the ICF understanding and operationalization of disability (in terms of deficiency or limitation in the performance of functioning).

The current method of establishing the disability degree based on the medico-psychosocial criteria is rather arbitrary and empirical because it is not based on a solid methodology from a scientific point of view - either based on evidence or a robust methodological form of consensus. The SECPAH assessment does not take into account all the health conditions simultaneously of the person in determining the disability degree, although comorbidities are common, especially for the elderly. Most of the tools used in any of the six mandatory assessment areas[587] - social, psychological, vocational or professional skills, education level, social skills/integration level – do not have scientific validity for disability assessment, nor do they align with the ICF. In practice, SECPAH teams usually rely to a small extent on information provided by social inquiries, even if they conform to the standard framework model.[588]

The CEPAH decision is not different from the SECPAH comprehensive evaluation. The disability determination is done solely based on the document review, and the commissions rarely see the applicants. The duration of the commissions' decision-making process per case is approximately 5 minutes, which does not allow for proper deliberation or comprehensive, evidence-based decision-making. Under these conditions, CEPAH decisions are the same as SECPAH recommendations for over 90% of cases. Therefore, the process can be considered redundant. In addition, in Romania, unlike other countries, over 90 percent of applicants are classified into a disability degree. It is generally sufficient to have a relevant medical condition and submit an application to get certified.

There is no unified approach to disability determination across the country. The SECPAH work procedures for disability assessment are poorly developed. The most deficient are the work procedures on how to treat discrepancies between assessments by specialists outside the SECPAH versus the SECPAH practitioners, how to identify and correct cases suspected of fraud, how to develop training and working methods in multidisciplinary teams, and how to handle the transition from childhood to adulthood and develop individualized plans for intervention. Also, disability determination is based on specific CEPAH work procedures that are only applied in very few counties. In CEPAH, most of the procedures are perceived of as valuable and would need to be developed.

The decisional process within SECPAH and CEPAH lacks transparency and is less participatory than provisioned by the law. The absence of procedures or guiding rules is accompanied by a lack of records regarding how or why decisions were made, without providing applicants with a clear explanation for why a disability degree was conferred (or not conferred). There is no uniform procedure by which the SECPAH team should conduct a comprehensive assessment, and procedures vary between counties in several respects. In some counties, each expert (doctor, psychologist, social worker, psycho-pedagogue) sees the person individually, who is interviewed or subjected to assessments with standardized testing tools. In other counties, a SECPAH team panel interviews the person for 5–10 minutes, without using specific instruments. Moreover, in the ICF-based conceptual model, key elements include a partnership between the person and the service provider. Thus, regardless of the person's age or health status, the service provider takes into account the person's routines/lifestyle, concerns, fears, and plans with reference to all areas of life (health, education, work and social activities). From the ICF perspective, most of the tools used in Romania for both assessing and determining disability, and for assessing service needs, are still too focused on medical aspects, are insufficiently participatory, and based on models that need to be revised to include the person's resources, the way he/she wants to live, and environmental factors, in addition to needs identified by the assessment.

587 GD no. 268/2007, Art. 48.

588 GD no. 430/2008, Annex 6.

2. Challenges of institutions and human capital

Generally, SPAS and SECPAH lack sufficient professional staff, while the size of CEPAH is unrelated to the size of the population of persons with disabilities officially registered in the county. The main problem related to human resources is the need for additional personnel. Only about a third of the local authorities has a SPAS that is accredited according to law. The highest deficit is in persons responsible for providing social services and case managers responsible for children and adults with disabilities living with their families. Only a few SECPAH comply with the requirements regarding staff specializations; some SECPAHs include employees who do not meet the study requirements mentioned in the law. Specialists such as psycho-pedagogues, physiotherapists, education instructors, and rehabilitation therapists account for a very small proportion of the total SECPAH staff and are found only in few counties.

Regarding a paradigm shift from a medical to a holistic approach, the current combination of technical expertise is not aligned with the ICF, either at the CEPAH and SECPAH level. Family doctors and general physicians predominate, while specialists with medical expertise in work capacity or in physical and rehabilitation medicine (PRM) are very rare.[589] More such specialists would improve the use of the comprehensive assessment tools and improve recommendations for better services/benefits for persons with disabilities.

Staff who serve persons with disabilities have a very high workload, which varies considerably across specialization, county, and locality. While SECPAH staff workload declined during the pandemic, it remained relatively high. The workload per SECPAH member differs considerably according to the member's specialization, with specialized doctors registering the highest workload. Generally, the workload is very high in CEPAH, especially since the members of the commissions have at least one full-time job in addition to their activities in CEPAH. The discrepancies between counties are significant and depend both on the number of persons with disabilities in the county and on the size and composition of SECPAH/CEPAH. Similarly, the workload in the disability field varies considerably across localities.

3. Challenges of interaction with the applicants and information management

A management information system for the disability-related system is nonexistent, and processes are not automated along the entire delivery chain. Most activities connected with the disability assessment and determination are paper-based.[590] Software applications that automate key functions and processes have limited functionalities or are nonexistent. Therefore, most activities—such as cross-checks, validation and verification, administration of benefits, administration of payments, and beneficiary data management—are manual. Counties have substantial differences regarding the kind of recorded data in the existing assessment software applications. In many counties, rigorous data about the registration and initial verification of the application files are recorded in paper registries, and are not available in electronic format. Data about dropout and exits from the system are not available. The quality of data in the existing databases is relatively poor. At the SECPAH/CEPAH level, no IT/data management/data analysis specialist is provided, nor data operator. Poor data management, poor data quality, and poor use of data are predictable in the absence of these human resources and under conditions of very high workload.

In Romania, the uptake and registration phase is much more burdensome than in many other countries. International experience shows that most countries have implemented various measures to minimize the number of papers an applicant should submit. In more advanced administrative systems, a person can register electronically for the disability assessment and medical documents are pooled from an e-health system, while a social inquiry (if needed) is obtained through institutional protocols with no involvement, cost, or effort required on the part of the applicant. Romania should strive to advance on this path.

589 However, the legislation (Art. 49 of GD no. 268/2007) mentions "specialized doctor" without any other specific requirement or restriction.

590 To address the gap, the ANDPDCA is currently implementing an EU-funded project to develop the National Disability Management System.

The collected data are used for internal reporting and rarely to document public policies and identify social service needs relevant to persons with disabilities. At the local level, some SPAS do not have data but make policies. Others have solid data but do not use them to make policies that target persons with disabilities. Still, most SPAS report using a participatory approach by involving the representatives of persons with disabilities to analyze collected data and define policies. At the county level, the monitoring and evaluation reports of both SECPAH and CEPAH are rarely publicly disseminated. Less than half of SECPAH and less than a fifth of CEPAH use data to document relevant public policies for persons with disabilities, and very few use a participatory approach.

4. Challenges of outreach

Lack of proper disability outreach programs limit resources available for people with disabilities. Many persons with disabilities in Romania do not have access to the same educational and labor market opportunities as their peers without disabilities. The outreach programs fail to facilitate the inclusion of persons with disabilities into society, and do not provide them with more options or offer proper assistance. For many persons with disabilities, the stigma associated with the disability is critical to their participation. Proper attention and outreach programs can mitigate the impact of the stigma and reduce social avoidance, stereotyping, and, in many cases, discrimination and condescension.

The existing interface between people and institutions is a "weak link" of the disability system. The information provided is incomplete and poorly adapted according to the various types of disabilities and the vulnerable groups that face social risks. The main risk of communication gaps at this phase is that the target population will be missed, be unaware of the program, or will not understand the program and fail to register. More efforts are needed to meet the UNCRPD (Art. 9) requirement to ensure accessibility to information and communication to enable persons with disabilities to fully enjoy all human rights and fundamental freedoms.

5. Challenges of service needs assessment and case management

In Romania, the needs assessment of persons with disabilities is not done with adequate evaluation tools and according to a specific methodology. The individual rehabilitation and social integration program (PIRIS) and the individual service plan (PIS) are the only instruments that include conclusions on the the person's need for services. The PIRIS specifies the activities and services the adult with disabilities needs for social integration. PIS specifies intervention and support for adults with disabilities, through which the activities and services recommended in PIRIS are carried out. The services and actions included in PIRIS and PIS adequately reflect the results of the medical and psychological assessments, but less often the results of the assessment of vocational, educational, and skills and social integration level.

The existing individualized plans (PIS and PIRIS) are of poor quality, and their content is not entered into the SECPAH/CEPAH database(s), while case management for adults with disabilities is still in an early stage of development. From the ICF perspective, both PIRIS and PIS are still overly focused on needs, especially the medical ones, insufficiently participatory and based on templates that need to be revisited to include the person's resources, the way he/she wants to live, and environmental factors, in addition to the needs identified through assessment. Thus, PIRIS, as they are now, are weakly linked to the assessment conclusions and do not represent anything in terms of an intervention plan. Also, the existing PIS are just lists of general recommendations that do not comply even with the basic standards of proper information, let alone orienting or referring persons with disabilities to the necessary services. In addition, there is no M&E mechanism connected to PIS and PIRIS. Consequently, data from PIRIS are not recorded or analyzed to identify the social services needs of persons with disabilities at the county level. Therefore, PIRIS/PIS can become effective only if the available menu of benefits and services covering the variety of needs of persons with disabilities is extended, services become available, especially in rural areas, case management for adults with disabilities is developed, and a mechanism for monitoring PIRIS/PIS implementation is put in place.

6. Challenges of transition of young people with disabilities to adult life

The transition process for youth with disabilities is poor in terms of information, support, and counseling. As young people with disabilities turn 18 years old, they often find themselves cut off from their current support and services, and fall through the cracks of an inefficient adult care system. The lack of information on the transition process, lack of understanding of the changes to the assessment system, and absence of general counseling make the transition process especially difficult for many families.

Romania lacks a fair and transparent transition process, and differences in the determination process lead to discrepancies in the system. The transition is abrupt and disorientating for many young people with disabilities. The law defines the support during the transition period, but it is almost nonexistent in practice, leaving youth with disabilities and their families alone to struggle with their new reality. Reforms are needed to streamline the transition process and develop appropriate services that support children and their families during the difficult transition period.

Disability in children is no longer assessed solely based on the medical model, but on the elements of the social model that take basic ICF principles into account. While this report does not set the criteria for children's assessment, there are significant differences between the disability assessment for children and adults. Transition to adulthood results, in some cases, in changes to the degree of disability or even a denial of a new disability certificate. This may directly affect benefits and impact the family's income and services, which negatively impacts the quality of life of both young people with disabilities and their families.

7. Challenges of appealing the disability certificate

The process of appealing the disability certificate is flawed. The provisions concerning appeals were modified by EGO no. 51/2017 with the declared purpose to simplify the appeal procedure and facilitate persons with disabilities' direct access to the administrative litigation courts. The analysis presented in Chapter 7 shows, however, that: (i) the appeal process is largely unpredictable, and the information provided at the DGASPC level does not, in most cases, help improve predictability, although some CEPAH developed good practices for providing information, advice, and support; (ii) Romania's disability certificate appeal mechanism does not include a continuous learning dimension and does not follow the transparency principle; (iii) administrative litigation departments currently do not process appeals against disability certificates with urgency; (iv) persons with disability and NGOs express their dissatisfaction or even drop the appeal because of the cumbersome procedure and the costs it entails; (v) court judgments regarding appeals against the disability certificates are highly subjective, for two main reasons: the lack of information or specialty support regarding disabilities and medico-psychosocial criteria available to the courts, and the lack of training on these topics, among both judges and lawyers. Therefore, the new legislative framework did not achieve its declared purpose to facilitate access to justice for people who are not satisfied with the disability degree assigned to them, and it does not support a correct, informed, or respectful appeal process. The appeal process cannot be improved by changes made only in the administrative litigation courts. Major changes at the DGASPC level are also needed, by creating a complaint and appeal redress mechanism to act as a "verification factor" for the SECPAH/CEPAH and an alternative route for people who are not satisfied with the disability degree assigned to them.

10.2. Key policy recommendations

Romania's disability assessment, determination, and needs assessment processes should be more effectively aligned with the ICF principles. We envision three main pillars of the proposed reforms:

A. improve disability assessment and determination by introducing the ICF framework;
B. improve access to services tailored to a person's specific needs; and
C. integrate all disability-related systems.

Pillar A. Improve disability assessment and determination for adult persons, by introducing the ICF framework

A.1. Integrate functioning into disability assessment and determination

The current six-part, comprehensive assessment of disability should be replaced by a medical assessment augmented by a functioning-based assessment score from a psychometrically sound instrument, one that is fully aligned with the ICF model of functioning and disability and is standardly and consistently used in every county.

Modernizing Romania's disability assessment system requires that functioning information be integrated into the assessment process in a meaningful and scientifically sound way. Yet for a variety of reasons, this does not occur in the current system: (i) the medico-psychosocial criteria purports to assess selected domains of Activities and Participation from the ICF, but this information is not validly collected, nor is it used in the assessment; (ii) the social inquiry collects some information about functioning and the applicant's environment, but this information is not systematically collected, nor is there a clear procedure on how to use this information in the evaluation process, i.e. in the six mandatory assessment areas;[591] (iii) valid psychological instruments are sometimes used, but as with information about vocation, education, and social integration, the functioning information is sporadically and inconsistently collected; and (iv) none of the functioning information that is collected has any meaningful impact on the final assessment, which is predominantly done by a medical specialist. Therefore, the first and most essential reform required to modernize disability assessment is to collect functioning information in a consistent manner that is standardized for all counties and is scientifically sound. Second, this information must have a genuine, transparent, and measurable impact on the final disability assessment in all cases and for all counties in the same manner.

Instead of six areas of comprehensive assessment, the system should consistently collect functioning information using a single, standardized, psychometrically sound instrument. This instrument must be scientifically appropriate for creating a summary or "whole person" disability score, preferably on an integral scale. Such an instrument can produce a proper functioning score that can be systematically integrated into the medical evaluation for a final disability assessment result. This substantial change in instrumentation will, of course, require changes in the responsibilities and procedures used by both the SECPAH and CEPAH commissions.

The current medico-psychological criteria should be revised (possibly with the Activity—Limitation and Participation—Needs component), by updating the medical information and modifying it to allow for joint evaluation of multiple health conditions, multimorbidity, and alignment with the ICD-11.

The current medico-psychosocial criteria are primarily based on the Baremas method.[592] As a general matter, the Baremic approach is inconsistent with the model of functioning and disability found in the ICF. Nonetheless, medical and psychological information about the applicant is essential for disability assessment, as it determines levels of intrinsic health capacity that are determinants—along with environmental factors—of disability. Specifically, it is vital for disability assessment—and the subsequent provision of supports and services—to have medical information such as frequency of symptoms, chronicity and long-term outcomes, and other prognostic factors. In addition, in its current format, the medico-psychosocial criteria includes Functional Parameters, which are valuable as they ensure standardized medical evaluation of symptoms, and risk factors.

591 GD no. 268/2007, Art. 48.

592 The Baremas method consists of using reference scales, to which values or percentages are attached, to define impairment, according to the Council of Europe (2002: 13).

The medico-psychosocial criteria require permanent updating to ensure it reflects state-of-the-art in the medical field, but also a continuous approach to the concept of disability, so that the assessment to establish both the real need for support and functional potential of the person. For the purposes of disability assessment, it would also be valuable for the medico-psychosocial criteria to be modified in two additional respects: (i) as it is currently designed, the medico-psychosocial criteria cannot properly assess multimorbidity, i.e., the common situation in which an individual experiences more than one disease or health problem, which may interact to compound the effects on his or her level of functioning; (ii) in the future, Romania can benefit from a more robust electronic health information collection system in which health and functioning information can be standardly collected and reported in a manner comparable across the country and internationally. This will require standardized terminology and coding capacity to ensure interoperability. The ICF provides such informational infrastructure for functioning information. Still, for medical information, the M-PC will, in time, need to be updated so that it is aligned with the current version of the International Classification of Diseases, ICD-11.

A.2. Redesign and develop clear procedures that respect ICF principles

Ensuring that assessment tools and procedures are applied uniformly at county level and a possible revision of the current institutional arrangement is a necessity from a human rights perspective and should be a key priority in policy reforms.

New disability assessment and determination procedures based on the ICF principles urgently need to be designed and implemented. Currently, the disability assessment and determination processes are not always clear or consistent across counties. It is important to emphasize that the need for cross-country consistency—both in terms of instrumentation and procedures—is fundamentally a matter of human rights: people who are similarly situated and experience similar levels of disability must, for reasons of justice and equity, be assessed similarly. It is unfair and discriminatory to do otherwise. This is mandated by all human rights treaties and by the United Nations Convention on the Rights of Persons with Disabilities. Redesigining the disability assesment and determination procedure provides an opportunity to introduce a more meaningful and comparable instrument, which offers a new approach to the disability determination process. The new procedures should be developed in a collaborative process featuring practitioners, social workers, international ICF experts, policy makers, and disability advocates.

The role and responsibilities of CEPAH, in relationship to SECPAH, for the disability assessment process should be clarified and standardized across counties. The government should conduct a general review of the roles and responsibilities of CEPAH and SECPAH in the context of modernizing disability assessment. Such a review should consider the need to set a single institutional location for disability assessment that should be, to every extent possible, standardized in instrumentation and procedure across all counties in Romania. In this review, the focus should be on the potential added value of the CEPAH commission, and avoid duplication or redundancy with SECPAH. Improving the working procedures and instruments will enhance the system's performance.

A.3. Invest in skills development

Investing in human capital and developing ICF training courses is crucial to explain the correct use of the ICF as a classification and to show its impact and usefulness on daily practice, particularly in multidisciplinary teams.

Aligning the procedures, instrumentation, and disability assessment criteria to the ICF has implications for human capital requirements. As a rule, when a jurisdiction moves from the medical approach to a holistic, multidimensional ICF functioning approach, there are also changes in qualifications and expertise requirements for assessors. Traditionally, this change is within the purview of rehabilitation professionals, who are explicitly trained in the domain of functioning. Physical and rehabilitation medicine professionals have both the conceptual and clinical expertise to assess functioning based on appropriate and sufficient documentation and evidence. Other rehabilitation professionals—physiotherapists, occupational therapists, educational and vocational therapists—are equally well versed in the ICF notion of functioning and disability, whether or not they have the full clinical experience and expertise to assess disability as a summary measure, rather than in terms of specific functioning domains such as mobility, independent living, or employment. In some countries, community nurses, social workers,

and other health and social professionals may be relied on.

Alignment to the ICF framework requires the assessment process to benefit from medical expertise, but it should not be solely determined by it. International experience shows that countries use a multidisciplinary team that includes physicians, nurses, rehabilitation professionals, and social workers. The theory is that a multidisciplinary team would ensure that the full range of determinants of disability—medical, rehabilitative, environmental, and social—will be taken into account. At a minimum, all assessors, or members of assessment teams or committees, should be fully aware of and trained in the ICF understanding of functioning and the need to address disability as a global, summary experience, shaped by both health and environmental determinants. A more robust reform to fully adopt an ICF approach to disability assessment would be to shift the required knowledge base, clinical expertise, and professional experience of assessors from a solely medical perspective to a combination of medical and broadly rehabilitative focus that includes functioning and contextual factors (environmental and personal).

The reform should be accompanied by improvements at the personnel level. Therefore, raising awareness and training SECPAH and CEPAH practitioners could be a game-changer. Other measures needed related to human resources include:

- All SECPAHs in the country should be able to provide a full-fledged assessment as designated by the current legislation. To this aim, additional personnel should be hired, including enough specialized doctors, especially in physical medicine and rehabilitation, as far as possible.
- Completing the SECPAH/CEPAH composition with a legal adviser could improve the transparency of the decision-making process.
- In parallel, workload should be reduced and balanced across the specialists. One possible solution includes mentioning in the legislation/methodological guide the necessary time for assessment per case.

The number of CEPAH members and that of the personnel designated in the CEPAH secretariat should be correlated with the size of the county's registered population of persons with disabilities or the number of application files in need of evaluation, or the number of practitioners employed by SECPAH.

Staff training should be extended to all SPAS, SECPAH, and CEPAH. Training on ICF should be carried out for all staff at SPAS, SECPAH, and CEPAH, and opportunities to exchange experience and teambuilding should be multiplied. Judges and other relevant personnel should also know the ICF practices and methodologies. For some groups of specialists (e.g., occupational therapists), training on the ICF should be aligned with the curricular content of their licensure.

A.4. Improve interaction with applicants by improving data management

Digitizing and improving interoperability of the databases will increase transparency at all levels of the disability determination process, streamline and improve workflows, and significantly improve the system's performance.

The ICF provides an appropriate platform to digitally collect and store health and functioning information in a manner that guarantees semantic interoperability across other existing platforms. ANDPDCA, in collaboration with all stakeholders, should ensure that all commonly used health and rehabilitation data collection tools translate to ICF classifications, so that new ICF-based data are compatible with previously collected clinical data and other legacy databases. This is a precondition to successfully develop an e-health and health information system. The fact that ICF is an international standard ensures that national health information is comparable to similar data in other countries.

As ICF-compatible instrumentation data become available, more accurate national statistics on all aspects of disability can be collected and stored. A consistent flow of administrative data, coded by ICF classifications, is essential to track and monitor all forms of disability programming. As these databases expand, it will be possible to analyze trends in disability benefit applications, success rates, and other parameters. Eventually it will be possible to correlate disability rates with underlying health conditions and socio-demographic trends, such as aging patterns and economic conditions, to identify pathways for policy development and planning.

At the first encounter with the applicant, there is a need for an approved procedure, steps, or rules for conducting the social inquiry for disability assessment. Moreover, it is vital to

collect and maintain information on all applicants, not just those who eventually become beneficiaries. As such processes are typically not automated, an information system for managing and administering the disability-related system should be developed by ANDPDCA along the entire delivery chain.

- It is vital to connect several existing database registries and make data available, such as the number of people diagnosed by a specialized physician as suffering from a medical condition connected to the disability criteria, the number of people who asked for/received a medical letter from their family doctors, or the number of people who sought to obtain medical documents to apply to the disability certificate, for a certain period.
- SPAS's and SECPAH/SECC's access to the national registers and administrative should be ensured, to reduce applicants' efforts to obtain the necessary documents and, at the same time, to allow cross-checking by institutions.
- Software applications that automate key functions and processes—such as cross-checks, validation, and verification, administration of benefits, administration of payments, beneficiary data management—should be improved or created.
- Clear guidance should be given to counties on what data must be collected, and software for data capturing should be created. For instance, SPAS and SECPAH/SECC should systematically collect, record, and analyze data about intake and registration, including on the phenomenon of drop-out/refusal during the process in order to identify system dysfunctions that become access barriers to disability assessment.
- Generally, the quality of data and consistency in the existing databases should be improved by clear guidance, methodological notes, validation, and proper software. Most of the existing databases are merely lists with only a few characteristics that allow very limited data interrogations, and data management is highly fragmented between and within counties (among SECPAH, CEPAH, and the CEPAH secretariat).
- Adding an IT/data management/data analysis specialist or even a compartment for this purpose within SECPAH could improve data management, quality, and use in the process of formulating policies and plans for the development of services for persons with disabilities, at county and national level.

Pillar B. Improve access to services tailored to the needs of persons with disabilities

B.1. Make disability outreach a priority

Romania should clearly articulate a viable outreach strategy and programs to reach people with disabilities. The persons with disabilities population is diverse, and includes women, men, children, youth, elderly, people from different ethnic groups, people living in large cities and those in remote rural areas, people living with family and those in residential institutions, patients in psychiatric facilities or those in detention, homeless people without a fixed address, and people in families with varied socioeconomic status and conditions. These groups may require particular adaptations or accommodations to ensure they are reached and served. Communication must be available in ways so that persons with disabilities are aware, informed, able, and encouraged to engage. Evidence shows that in the absence of a well-thought through outreach strategy, social protection programs may run the risk of exacerbating exclusion errors for lack of information and skepticism. A proactive outreach effort can help to manage expectations, minimize grievances, and develop better mutual understanding to avoid the risk of negative spiral, program failure, external manipulation, loss of credibility, and politicization. It is essential that people with disabilities participate in developing information and communication strategies and programs.

While further analysis is needed in this area, some of the policy measures could be summarized as follows:

- It is crucial to systematically evaluate the effectiveness of existing efforts. The ANDPDCA should undertake a comprehensive assessment of outreach programs and practices to gauge future training and development needs and share best practices in this area. The ANDPDCA should undertake further research to design specific strategies, including comprehensive outreach, improving services and access.

- Joint outreach programs should be undertaken at CEPAH, and SECPAH that also comprise tools to support SPAS. A technical expert panel comprised of interagency representatives should be formed to develop and pilot outreach guidelines.
- One method to considerably enhance the outreach used in some countries is to introduce a standardized form (such as a green form) that must be completed by any specialized physician once he/she establishes a medical diagnosis connected with the disability criteria. For example, this could be done by establishing a list of disease codes to be jointly approved by the MoH and the MMPS. In addition, the "green form" may be accompanied by a brochure with the core information required to be delivered by the medical unit. The introduction of such a measure would not only have the potential to improve the initial information of all categories of the population, but would also increase access to disability assessment while restricting the opportunities to obtain/provide medical documents prone to fraud regarding the accuracy of the information they contain.
- The persistent core message of "handicap" needs to be changed to "disability" to support reforms that shift the system from a medical to a holistic approach. This is not possible without legislative change both in the Constitution and in public policies documents. But equally, sustained information, education and communication campaigns are needed to change the perception of current beneficiaries, as well as the general perception of disability as a "handicap" and of the disability certificate as compensation for medical conditions.
- The ANDPDCA website should include a dedicated page, updated permanently, including complete and fully accessible information on the disability assessment for children and adults, to fill the gaps from the DGASPC and SPAS websites and to ensure all citizens have equitable access to information.

B.2. Improve needs assessment and develop case management for adults with disabilities

Improving needs assessment and case management is as important as improving disability assessment and determination, as without this step the ultimate goal of increasing persons with disabilities' access to services and benefits, and thus contributing to increasing their quality of life, cannot be reached. The policy measures needed in this regard include:

- Improving case management is an important reform that should be undertaken to ensure it is an integral part of the disability assessment and determination system. Case managers engage with persons with disabilities to coordinate appropriate environmental interventions and support and mobilize personal resources. Case managers must focus not only on a person's impairment of function or activity limitations, but also on the barriers and challenges created by the external environment. Thus, case managers use the ICF framework, integrated and multidisciplinary, to developing person-centered intervention plans.
- The needs assessment instruments PIS and PIRIS should be made compulsory and improved. Both should become obligatory for all individuals classified with degree of disability. The instruments must be standardized and harmonized based on a PIS template and a revised PIRIS format, as well as a specific methodology aligned to the UNCRPD and ICF. A mechanism to monitor PIRIS/PIS implementation should be put in place and frequently evaluated. The monitoring results could also help identify development needs for persons with disabilities services. Over time, as the services become available, Romania may also consider conditioning the benefits and services provided based on the effective implementation of the recommendations in the individualized plans (PIRIS/PIS), especially regarding recovery and rehabilitation.[593]
- The benefit-service package connected to the disability assessment should be extended. Services should become available countrywide, including in the remote and rural areas. ANDPDCA should also explore the possibility of introducing new support measures, such as grant programs to adapt houses or cars to meet a particular person's needs.

593 Currently, the legal provisions stipulate only that the persons with disabilities and their caretakers are obligated to fully carry out the services and activities included in PIS, but there are no consequences for failing to do so. That is because too few adults with disabilities have appointed a case manager or benefit from a PIS, and services for persons with disabilities are very poorly developed, inaccessible, or even non-existent in many parts of the country.

- Developing ICF-based rehabilitation services, both medical and vocational, represents a top priority for reforming the disability system and making effective individualized plans. Improving the access of persons with disabilities to existing services is equally important. More efforts should be made at the county level to develop partnerships, communication, and collaboration between DGASPC/SECPAH and the other service providers (public and private) to create a functional network instead of the existing clusters of isolated services. Developing an integrative platform with information about lifelong benefits and services available to persons with disabilities coordinated by the ANDPDCA could add considerable value in this respect.

B.3. Make the transition from childhood to adulthood gradual

The transition of young with disabilities to the disability assessment for adults should be streamlined by the ANDPDCA, clearly articulated in new laws and procedures based on the following guiding principles:

- A new, possibly drafted jointly between SECC/CPC and SECPAH/CEPAH, should be introduced that benefits youth aged 16-26 years old and their families involved in the transition process. The comprehensive assessment services and the assessment commissions for children and adults should hold regular consultative meetings and share all assessment documents. Joint meetings should be held between youth with disabilities and their families and the representatives of SECPAH/CEPAH.
- Increase the formal transition period from childhood to adulthood, tentatively from 16 to 20 years old. For young people enrolled in education, the period should be further extended until they receive their degree or turn 26 years old. Maintain the degree of disability as long as the child is in school, so they continue to receive the same benefits.
- From age 16, in addition to regular evaluations, the young person and their family should also receive information and advice about the possible outcome of an evaluation and the criteria and procedures applied to adults (by SECPAH/CEPAH). Dedicated tools should be developed by adult assessment specialists to assist the SECC/CPC in conducting such simulations.
- In addition to information, counseling activities should be carried out with young people with disabilities and their families in order to understand the effects of the transition from child to adult, in relation to a possible reduction in benefits and services provided to the child and the possibility of a significant drop in income following the transition. Counseling sessions could also consider providing support in identifying alternative scenarios that could be followed.
- Efforts should be increased to provide adult life training programs carried out in cooperation or partnership with legal entities, public or private. These programs should focus on increasing the participation of young people with disabilities in both education and the labor market. To this end, easily accessible educational and professional orientation services should be developed to reach as many young people with disabilities aged 16–26 from both the special protection system and their families as possible. Also, mediation and labor market integration services (possibly in collaboration with specialists from county employment agencies) could be available under such programs for both young people with disabilities and their parents, especially in the event of young people losing their right to a personal assistant.
- The transition to adult life should be coupled with a program to assess the development of independent living skills. Such a program should be applied consistently across the country for all young people with disabilities, especially those who live with family, both before and after the age of 18. Current services to develop such skills are also insufficient, especially for young people with disabilities living with their families. To facilitate the transition of young people with disabilities to independent living, specific measures should be introduced, starting with the transition to adulthood, to reduce the burden of care for families. For example, this might include a systematic monitoring program for early identification of possible risks/vulnerabilities or counseling and educational training programs for parents and families.

B.4. Facilitate persons with disabilities' access to address the courts directly, and develop a complaint and appeal redress mechanism

To improve the process of appealing the disability certificate, the analysis presented in this report highlighted the following measures:

- Drafting guidelines ("how to appeal the disability degree certificate") to be universally distributed could improve the predictability of appealing the disability certificate if the guidelines were developed nationally and provided to all DGASPCs in the country. Simply delegating a new requirement to county level, without increasing the available institutional resources, would only increase stress and noncompliance.
- The CEPAH secretariats should continue to receive and register appeals against the certificates, even under the terms of the new legal framework. In addition, they should collect data that could inform statistics, case studies, or more detailed information about how certain cases are dealt with, which is important for proving the mechanism's legitimacy and improving confidence about its efficiency.
- Also needed is a standardized template for substantiating the decision regarding classification/non-classification or degree of disability that should be completed by SECPAH or CEPAH and can be used by the courts. For this measure to be implemented in all counties, solutions must first be found to supplement staff and balance the workload at SECPAH and CEPAH levels. One solution would be to include a legal adviser in SECPAH/CEPAH membership, who could be responsible for: drafting the explanatory statements/substantiations for CEPAH decisions, ensuring the quality of CEPAH meeting minutes, informing and advising persons challenging the certificate, providing expert opinions for the courts, and coordinating the grievance redress mechanism related to disability assessment and determination (if such a mechanism were to be set up). In this way, a legal adviser could bring value and transparency to the decision-making process for disability degree classification.
- To minimize subjectivity in court judgments regarding appeals against the disability certificates, courts should receive support in terms of information, or specialty support regarding disabilities and medico-psychosocial criteria. Additionally, training on these topics should be provided both to judges and lawyers. ANDPDCA could also identify and train experts who can provide assistance to the courts.
- Developing, at the DGASPC level, an actual complaint and appeal redress mechanism that respects the principles of accessibility, equity, predictability, transparency, and continuous learning could be a way to support those who disagree with the assigned disability degree and reduce the number of appeals filed in court. And for those people who would still file in court, the DGASPC, through a dedicated department, could provide guidance services and refer people to free legal assistance, maybe under a collaboration protocol with the Bar Association and with NGOs, and prepare for the courts a list of necessary procedural adaptations for each person, based on data in their file and on interactions with the person and their family. This new redress mechanism should not be a return to the pre-2017 situation, with a sole commission at the national level working with insufficient resources, but should be based on a network of county and regional institutional structures. Furthermore, the new mechanism should not prevent citizens from pursuing their rights and interests using any other route (administrative law proceedings or other official litigation mechanisms), at the national or local level, nor are they meant to replace the judicial system or any other form of legal action.

Pillar C. Integrate all disability-related systems

The disability system in Romania is characterized by marked fragmentation. The disability assessment represents an on-demand, single-program system (the process is initiated by individuals) and allows dynamic inclusion (people can apply, ask for assistance, or update their information at any time). However, the invalidity system exists in parallel, and there is a separate disability system for children. The existence of many other program-specific delivery systems for most of the benefit-service packages attached to the disability certificate (for example, most of the health-related ones) deepen the fragmentation. It is costly and inefficient for people to navigate each program separately, provide the same information and documentation over and over, and wait in long lines at different offices. Inefficiencies also result in duplications or gaps in coverage, overlapping processes, wasted resources, making it difficult to keep track of which clients have received which services or how social protection resources are used. The integration of all disability-related systems in Romania is out of the scope of this report and these advisory services. Nonetheless, it remains a factor that must be considered when designing the new set of instruments and procedures to change the paradigm in the field of disability.

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Annexes

Annex 1. List of interviewed NGOs

Nr. Crt.	Name of NGO	County	Type
1	Asociația Nevăzătorilor din România	Timiș	Local
2	Asociația Națională a Surzilor din România	București	Local
3	Asociația Handicapaților Neuromotor din România	Arad	Local
4	Asociația Distroficilor Muscular din România	Covasna	Național
5	Asociația Persoanelor cu Talasemie Majoră	București	Național
6	Asociația Nevăzătorilor din România	Brașov	Local
7	Asociația Red Ribbon	Suceava	Local
8	Asociația Viața și Speranța	Giurgiu	Local
9	Asociația Pacienților cu Afecțiuni Neurodegenerative din România	București	Național
10	Asociația Down Plus București	București	Local
11	Asociația Pacienților cu Afecțiuni Autoimune	București	Național
12	Asociația Pacienților cu Afecțiuni Autoimune	Cluj	Regional
13	Asociația Help Autism	București	Regional
14	Asociația Autism România	București	Local
15	Asociația Națională pentru Copii și Adulți cu Autism din România	București	Național
16	Fundația Pentru Familia Creștină	Mureș	Local
17	Asociația Tonal	Sibiu	Local
18	Asociația Pro ACT Suport	București	Regional
19	Asociația Ceva de spus	Timiș	Local
20	Fundația de Abilitare Speranța	Timiș	Local

Annex 2. Key regulations in the field of disability

Law no. 554/2004	Administrative Disputes Law 554/2004
Law no. 448/2006	Law 448 dated the 6th of December 2006 on the protection and promotion of rights of persons with handicap, republished, as amended and completed
GD no. 268/2007	GD 268/14 March 2007 to approve the Implementation Guidelines for Law 448/2006 on the protection and promotion of rights of persons with handicap, as amended and completed
Order no. 762/1.992/2007	Joint Order of the Minister of Labor, Family and Equal Opportunities and of the Minister of Public Health 762/1.992/31 August 2007 to approve the medical and psycho-social criteria based on which the classification by degree of handicap is established, as amended and completed
GD no. 430/2008	GD 430/16 April 2008 to approve the Implementation Guidelines for the organization and functioning of the Commission for Assessing Adults with Handicap, as amended and completed
Order no. 2298/2012	Order of the Minister of Labor, Family and Social Protection 2298/23 August 2012 on the approval of the Framework Procedure for Assessing Adults for the Classification by Level and Type of Handicap
Order no. 1261/2016	Order of the Minister of Labor, Family, Social Protection and Elderly 1261/2016 on approving the Rules for the Organization and Functioning of the Higher Commission for Assessing Adults with Handicap
Order no. 1985/1305/5805/2016	Joint Order of the Minister of Labor, Family, Social Protection and Elderly, the Minister of Health, and the Minister of National Education and Scientific Research 1985/1305/5805/2016/4 Oct. 2016 approving the methodology for assessment and integrated intervention in order to formally establish children with disabilities' level of disability, and school and professional orientation of children with special education needs, and empowering and rehabilitation of children with disabilities and/or special education needs
Order no. 1306/1883/2016	Joint Order 1306/1883/2016 for approval of biopsychosocial criteria for establishment of the degree of handicap for children with disabilities and their modalities to put into practice
GD no. 797/2017	GD 797/8 November 2017 on approving the framework rules for the organization and functioning of social assistance public services and indicative personnel structure
Order no. 393/630/4236/2017	Order of the Minister of Labor and Social Justice of 13 March 2017 to approve the Cooperation protocol with a view to implementing the integrated community services required for preventing social exclusion and combating poverty
EGO no. 51/2017	EGO 51/2017 to amend and complement certain pieces of legislation;
GD no. 502/2017	GD 502/13 July 2017 on the organization and functioning of the Commission for Child Protection
GD no. 140/2018	GD 140 of 21 March 2018 to approve the service packages and the Framework Contract regulating the conditions based on which medical assistance, medicines and medical devices are granted in the social health insurance system for the years 2018–19, as amended and supplemented
ANDPDCA Order no. 136	Order 136/30 January 2020 of the ANDPDCA President on the Regulation on the organization and functioning of the National Authority for the Rights of Persons with Disabilities, Children and Adoption

Annex 3. NGOs for persons with disabilities in Romania

Setting up and operating NGOs in Romania is governed by Ordinance no. 26/2000 on associations and foundations. Thus, NGOs are forms of association freely established by individuals or legal entities to promote civic values, principles of democracy, and the rule of law. There are three forms of association under Ordinance no. 26/2000: associations, foundations, and federations.

The Romanian movement for persons with disabilities includes organizations representing persons with disabilities according to the type of disability—physical, visual, auditory, intellectual, rare diseases, chronic diseases, HIV/AIDS, etc.; organizations for persons with disabilities ran by the parents of these persons; and organizations that provide social or rehabilitation services to persons with disabilities. The main role of these organizations is to promote and protect the rights of persons with disabilities in the fight to eliminate barriers to education, health care, employment, and social participation.

Disability NGOs focus on several domains: protection of the rights of children with disabilities; protection of the rights of adults with disabilities; school and social inclusion for children with disabilities/promoting inclusive education; provision of services to children, young persons, and/or adults with disabilities; provision of services for adults with intellectual disabilities; sheltered homes and independent living; social integration, professional training, and labor market inclusion of adults with disabilities; etc.

Below are some of the organizations working in the field of disability and social services. We specify that the list is not exhaustive, but rather has an illustrative role for what the movement of people with disabilities in Romania means.

Organizations Providing Representation

National Disability Council in Romania (CNDR) is a federation made up national representative organizations that protect and promote the rights of persons with disabilities. CNDR contains member organizations (with voting rights) and a network of observing members (without voting rights). Full members are:

- Romanian Blind Association (ANR), with 35 branches, representing 91,569 visually impaired adults and 2,757 children;
- Romanian National Association of the Deaf (ANSR), with 37 branches, representing 21,697 adults and 2,019 children with hearing impairments;
- Romanian Association of Persons with Motor Neuron Disabilities (AHNR), with 8 member associations in the counties of Arad, Argeș, Caraș-Severin, Cluj, Hunedoara, Ialomița, Mehedinți, Sălaj;
- Romanian Association of Persons with Muscular Dystrophy, representing the interest of 35,000 persons diagnosed with forms of muscular dystrophy;
- Romanian Association of Blind Disabled Veterans (AIRNR);
- National Information and Cooperation Network for the Inclusion of Children and Young Persons with Special Educational Needs (RENINCO Association), with 16 member organizations;
- Romanian National Association for Children and Adults with Autism, with 7 branches;
- "Ridică-te și umblă!" (Rise and walk!) Association, with offices in 25 counties.
- Romanian Association Supporting Children with Physical Disabilities (ASCHFR) develops programs aimed at and involving children and young persons with physical and/or associated disabilities and their families to facilitate social inclusion. ASCHFR has 9 branches, one in each of the following counties: Argeș, București, Buzău, Călărași, Giurgiu, Neamț, Olt, Prahova, and Vâlcea.

Among the observing members of CNDR are: Down Plus Bucharest Association; Light Into Europe; Wings Association; ASPIIR - Association of People with Inflammatory Bowel Diseases in Romania; CONIL Association; Association of disabled people "Sporting Club" Galati; Association of Patients with Autoimmune Diseases - APAA; Romanian Foundation for the Visually Impaired "Friends of the Blind"; Maternity, Advocacy, Medicine, Education Association M.A.M.E .; ENABLE Romania Foundation; Romanian Association of Forensic Psychiatry; THEOEMYDOR Association; Romanian Transplant Association; Federation of Personal Assistants' Unions for People with Disabilities; Always Together for People Sports Association; Romanian Hemophilia Association; Dystonia Association.

Romanian Blind Association (*Asociaţia Nevăzătorilor din România*) (ANR) is a nationwide nongovernmental organization recognized as a public interest organization under GD no. 1033 of September 9, 2008, operating under Government Ordinance no. 26 of January 30, 2000.[594] ANR is registered as legal entity as per Civil Decision 3288 of September 27, 1956, issued by the former 23 August People's Tribunal, Bucharest. It is the successor of the Romanian Blind Society (*Societatea Orbilor din România*) founded by Queen Elisabeth of Romania.[595] The Romanian Blind Association represents the interests of blind persons across the country, being recognized as an organization representing Romanian blind persons both by Romanian authorities and international organizations of blind persons; it is member of the European Blind Union, World Blind Union, Romanian National Disability Council, and European Disability Forum.

Romanian Association of the Deaf (*Asociația Națională a Surzilor din România*) (ANSR) is a nongovernmental, independent, nonprofit, politically and religiously nonaffiliated organization, a legal entity with public interest status, protecting and promoting the rights and social, professional, cultural and educational interests of persons with hearing impairments (deaf, deaf-mute, hearing loss) towards social inclusion and equal opportunity. To finance its specific activities, the organization receives funding from central and local authorities, as well as individuals and legal entities. Given its purpose, the Romanian National Association of the Deaf is an organization representing the interests of hearing impaired persons across the country, being the successor of the Romanian Amicable Society of the Deaf-Mute (*Societății Amicale a Surdo-muților din România*),[596] and of the Romanian Popular Republic Association of the Deaf-Mute (*Asociației Surdo-muților din Republica Populară Română*),[597] which amounts to almost one century of activity in the service of hearing impaired Romanians.

The Romanian Coalition of Associations of Patients with Chronic Diseases (COPAC) aims to support consistent and effective actions by patients and patient associations to protect and promote patient rights. In 2010, COPAC held the first National Convention of Patient Associations as an opportunity for representatives of patient associations across Romania to enter dialog with the authorities. The event is now COPAC's most well-known brand, bringing together over 150 representatives of patient associations every year, currently in its ninth year of existence. Some of the COPAC member organizations are: National Union of Organizations of Persons Living with HIV/AIDS; Romanian Multiple Sclerosis Association; Romanian National Alliance for Rare Diseases; Romanian Transplant Patients Association; Association of Persons with Thalassemia Major; Baylor Black Sea Foundation; Romanian Hemophilia Association; Association Supporting Patients with MDR Tuberculosis; Prader Willi Association Romania; Romanian Rare Cancers Association; Romanian Oncological Patients Association; ART Cluj Transylvanian Association of Patients with Inflammatory Rheumatic Disorders; Federation for Rights and Resources for Persons on the Autism Spectrum; Copilul Meu Inima Mea (My Child My Heart) Association; OncoHope Association; Romanian Association of Scleroderma Patients; Association of Children and Young Persons with Diabetes ASCOTID Mureș; Association of Pulmonary Hypertension Patients.

Romanian National Alliance for Rare Diseases (ANBRaRo) was established in August 2007 at the initiative of Prader Willi Association Romania, as part of a project funded by CEE Trust. 32 founding members joined efforts to create the Alliance—rare diseases organizations and groups of patients with diseases so rare that there was no dedicated association. ANBRaRo aims to develop and carry out lobby and advocacy activities to improve the quality of life for Romanian patients living with rare diseases. Its purpose is to increase community responsibility in relation to patients suffering from rare diseases through the involvement of social actors in the field—the patients, their families, and the authorities. Its general objective is to improve the quality of life for Romanian patients living

594 Government Ordinance no. 26 of January 30, 2000 on associations and foundations, published in the Official Gazette of Romania no. 39 of January 31, 2000, as amended and supplemented by Law 246 of July 18, 2005, published in the Official Gazette of Romania no. 656 of July 25, 2005.

595 As evidenced by the records attesting its subsidizing by the state as per the Official Gazette no. 194 of November 27, 1909, and the Memorandum of Association approved by Royal Decree 3159 of November 11, 1910, and published in the Official Gazette no. 180 of November 14, 1910.

596 Constituted under the Memorandum of Association authenticated by Ilfov County, Notary Section, under no. 328 of January 5, 1920.

597 Recognized by Decision of the Council of Ministers no. 1153 of July 20, 1952, and Civil Decision 1909 of August 15, 1953, of Tudor Vladimirescu People's Tribunal, Bucharest.

with rare diseases. Members: ASCID – Center for Information and Improvement of Quality of Life for Patients with Muscular Dystrophy and Ventilated Patients; AntiParkinson Association; "Sufletul Lalelelor" (Soul of Tulips) Association for Patients with Parkinson's and Other Neurodegenerative Disorders; Association of Children with Mitochondrial Diseases; Romanian Association of Children with Hunter Syndrome; Romanian Association of Cystic Fibrosis; Bucharest Multiple Sclerosis Association; Romanian Multiple Sclerosis Association (ASMR); DMD Care Association; Cehu Silvaniei Down Syndrome Association; Gaucher Association Romania; Inima Copiilor (Children's Heart) Association; Mini Debra Association; Romanian National Myasthenia Gravis Association; Association of Little Persons; Romanian Association of Patients with Hereditary Angioedema; Romanian Association of Patients with Fabry Disease; FLAMA Association of Patients with Autoinflammatory Diseases; Association of Patients with Hemolytic-uremic Syndrome; Association of Patients with Thalassemia Major; Romanian Association of Patients with Neuroendocrine Tumors; Association of Patients with Pulmonary Hypertension; Association Parent Project for Research and Assistance in Muscular Dystrophy; Romanian Association of Patients with Glycogenosis; PKU Life Association Romania; Prader Willi Association Romania; Prader Willi Association Bucharest; Romanian Association of Patients with Primary Immunodefficiencies (ARPID); Romanian Rare Cancers Association (ARCrare); Romanian Hemophilia Association; "Fragile People" Romanian Osteogenesis Imperfecta Association; Romanian Peripheral Neuropathy Association; Romanian Spina Bifida and Hydrocephaly Association; SM Speromax Alba; SMACare Association (Spinal Amyotrophy); Smiling Faces Association Romania; Werdnig Hoffman Association; Charcot Marie Tooth Romania Association; Bucuria Copiilor (Children's Joy) Association; "Mastocytosis Support Romania" Association; Williams Syndrome Association Supporting Persons with Williams Syndrome; Foundation for the Protection of Adults with Congenital Heart Diseases; Romanian Foundation for Lysosomal Storage Diseases; Neuro Move CMT; Save the Children Organization – Timiș County Organization; Romanian Network of Hereditary Angioedema; Sense International (Romania); Romanian Society of Genetic Medicine.

FEDRA (Federation for Rights and Resources for Persons on the Autistic Spectrum) aims to create and maintain an appropriate environment that encourages and supports persons with autism spectrum disorders (ASD) and their families.

RO-TSA Network, with over 60 organizations focusing on autism, was created as part of the project Enhancing Participation of NGOs and Social Partners in Promoting Alternative Public Policies for Children with ASD launched by Help.

AUTISM ROMANIA is the first association of parents of children with autism in the country, which is not affiliated to FEDRA or RO-TSA, but still plays an important role in the movement of people with disabilities in Romania.

National Union of Organizations of Persons Living with HIV/AIDS (UNOPA) is the only Romanian nongovernmental federation bringing together organizations of persons living with HIV/AIDS, focusing on advocacy to promote and protect the rights of Romanians infected and living with HIV/AIDS.

Ceva de Spus (Something to Say) is the self-representation organization of persons with intellectual and physical disabilities, and it is very active in the public policy field.

Federation of Organizations of Parents Caring for Children with Disabilities. Members of the Federation: Surâsul Albastru (Blue Smile) Association Iași; Enable Association Romania Iași; Cutezătorii (The Brave) Association Iași; Star of Hope Foundation Romania; Renașterea Speranței (Hope Renewed) Association Iași; ANCAAR Iași ; Romanian National Association of the Deaf – Iași branch; Ne Trebuie Speranța (We Need Hope) Association Botoșani; Mereu Împreună (Always Together) 2008 Association Dorohoi; Univers Plus Foundation Piatra Neamț; Riana Association Piatra Neamț; Luceafărul (Morning Star) Association Piatra Neamț; Dar din Dar (Give and You Shall Receive) Association Hârlău; Vino și Vezi (Come and See) Association Vaslui; Salut Prieteni (Hello Friends) Association Pașcani; "Pentru Noi" (For Us) Association Bârlad; Căsuța cu Miracole (House with Miracles) Târgu Neamț; Support for Autism Association Bucharest.

Sporting Club Galați Association of Persons with Disabilities (APH) has been operating since February 1992 under Law 21/1924 amended by GD 26/2000 and under other legislation. Sporting Club Galați APH is a nongovernmental, apolitical and humanitarian legal entity. Sporting Club Galați APH was the first nongovernmental social and sports organization to organize sports competitions for persons with mobility impairment, Danubius Cup, the first one taking place in 1992. Sporting Club Galați APH has 723 registered members and an accredited day center that provides services to

around 100 beneficiaries every month. The services are aimed at persons with physical and associated disabilities residing in Galați or in Galați County. Persons with disabilities in a crisis situation or at risk of poverty and/or risk of marginalization or exclusion from family and community are given priority as beneficiaries of the center's free services. Persons in crisis situations coming from rural areas are also given priority, since they have more difficulty accessing these types of services; accommodation is offered to them throughout the period of medical consultation, as well as to students with disabilities from rural areas who attend classes over the weekend, driving school students; they receive wheelchairs and walkers as donations.

WINGS (ARIPI) Association represents people with mental health problems in Romania. The activities of the association take into account the social reintegration of people who have or have had mental health problems; advocating for the observance of the general, special rights and human dignity of persons who have or have had mental health problems; harmonization of legislation in line with WHO and EU recommendations on mental health issues; the involvement of the media in explaining the complexity of the phenomenon generated by the disease; organization of seminars in the field of mental health; partnerships with other NGOs and authorities; involvement of central and local authorities in community therapy.

The Society of Locomotor Disabilities from Romania carries out activities of socio-professional reintegration of adults with locomotor disabilities, specific programs of adapted transport, PC operation courses, sports team, rehabilitation, training and recreation center, theater troupe, legislative counseling and guidance professional, tourism. The organization publishes the only monthly magazine in the country made entirely by people with disabilities "The Winner".

Organizations Providing Social Services

Federation of Non-Governmental Organizations Providing Social Services (FONSS) currently numbers 37 nongovernmental organizations, Romanian legal entities that provide social services to vulnerable groups, all of them recognized for their activities in their respective fields.

Dizabnet Network, represented by Dizabnet Federation, was established in 2007 and works as a communication and representation platform for social services providers in the field of disability, complementing the activities of organizations representing the interests and rights of persons with disabilities as provided in international documents, especially the UN Convention on the Rights of Persons with Disabilities. The Federation includes 5 founding organizations, and the extended network of service providers 117 member organizations—public and private organizations/institutions, sheltered facilities, individual offices, as well as independent or academic experts. It is the network of service providers with the largest coverage in its field. According to Dizabnet's vision, services for persons with disabilities are key instruments for promoting social inclusion and their improvement and upgrading will contribute substantially to an increase in the quality of life of Romanians with disabilities and of community good governance.

Alături de Voi (By Your Side) Foundation Romania (ADV) is a nongovernmental organization operating as a work integration enterprise, established in 2002 by Holt International Children's Service USA whose mission is social inclusion for persons with disabilities and other vulnerable groups. ADV Romania is based in Iași and registered as a Romanian foundation; it is independent from government authorities and its assistance and actions are not conditioned by affiliation with particular ideologies, doctrines, or religions. From May 2019, ADV Romania has been a full member of the EASPD (European Association of Service Providers for Persons with Disabilities), which covers over 15,000 support services for persons with disabilities across the European Union.

ADV Romania has set up 3 social enterprises, being awarded the prize Social Entrepreneur of the Year 2016 in the EY Entrepreneur of the Year international competition. These are: (i) UtilDeco was established in 2008 and has created over 100 jobs over time, of which a minimum 40 percent for persons with disabilities. It provides document archiving and storage services/ protective equipment manufacturing services/ online shop; (ii) JobDirect was established in May 2016 as an Employment and Workplace Assistance Agency. It offers assessment, examination, counseling, professional training, mediation and labor market inclusion services, namely job coaching, to persons with disabilities or members of vulnerable groups; and (iii) WISE.travel was established in August 2016, originally as UtilDeco Travel; since June 2018, it has been issued a new license as tour operator under the brand name WISE.travel. It offers travel and event organization services, donating 50 percent of its profit to NGOs and Social Enterprises.

Romanian Association of Persons with Disabilities (APHR) is a nongovernmental, community-oriented, apolitical organization, an autonomous legal entity, operating in the socio-cultural, educational, sports and humanitarian fields, for an indeterminate period of time, with public interest status, promoting the principles of freedom and democracy. To carry out its activities, it receives funding from central and local authorities and from individuals and legal entities. The association has also set up and manages the PRO MED Home Health Care Center.

Motivation Romania Foundation was established in 1995 to provide assistance to Romanian children and adults with disabilities. It provides services covering a wide range of needs, from adapted equipment for various mobility impairments to medical rehabilitation and coaching for independent living provided by a coach in a wheelchair. On February 15, 2020, Motivation Romania Foundation celebrated 25 years of running programs to help Romanian children and adults with disabilities—25 years, 25,000 lives changed for the better. Some of Motivation's wheelchair user beneficiaries have become independent living coaches, technicians assessing, prescribing, and customizing wheelchairs, Motivation regional team managers or managers in the organization.

Hope Habilitation Foundation Timișoara is a nongovernmental organization working for over 20 years to provide assistance to children with special needs and their families. Its aim is to ensure inclusive education for these children in mainstream schools and kindergartens and to change attitudes towards and stereotypes about them. Over time the Foundation acted locally, supporting the children by providing direct services aimed at children, parents, and teaching staff. In the past years the Foundation contributed to drafting the Methodology for establishing, organizing and operating Habilitation and Educational Support Centers (C.A.S.E.) for children and young people.

Pro ACT Suport Association was established in April 2011, its aim being to improve the quality of life for vulnerable persons by providing social services and promoting good practice in the socio-cultural and educational fields.

Estuar Foundation was created in September 1993 by the Scottish association Penumbra and the Romanian League for Mental Health, being the first Romanian organization to build a network of community day and home care services accredited and recognized locally, nationally and internationally, aimed at Romanian adults with mental health issues. Estuar Foundation is a member of: Mental Health Europe; FOND (Romanian Federation of Non-Governmental Organizations for Development); Romanian Good Practice Coalition; NGO Coalition for Structural Funds.

Betania Association in Bacău. Betania Association was granted public interest status in September 2004,[598] being the first organization to obtain this status in Bacău County. This came as a recognition of both the role the Association has played in the community and the quality of the services provided to a diversity of beneficiaries. Over time the organization has created a number of services, some of them available for the first time nationally or at least regionally, such as the Center for the Inclusion of Young Persons or the Dolphin Center for children with autism. Betania Association has been providing community support for two decades, with thousands of beneficiaries in humanitarian, educational and health-related projects. Betania Association is accredited by the Accreditation Committee of Bacău County as provider of the following social services: Center for the Inclusion of Young Persons; Delfinul (Dolphin) Center for children with autism; Center for Counseling, Information and Support to families in crisis situations; Center for Assistance to Human Trafficking Victims. In addition, Delfinul (Dolphin) Center is certified to provide specialized social services.

Star of Hope Association, a nongovernmental organization with offices in Iași, was established in 1998 with support from the Swedish organization Star of Hope International. Star of Hope Sweden has been present in Romania as early as the days of the 1989 Revolution (in Timișoara) and financing Star of Hope Romania ever since by raising both private funding and funding from the Swedish government (through SMC/SIDA). Star of Hope Romania is a partner of Star of Hope Norway and Star of Hope USA.

598 Under GD no. 1481/2004, published in the Official Gazette no. 848 of September 15, 2004.

Annex 4. Outreach

Annex 4. Table 1: Disability information available on municipality (SPAS) and NGO websites, from 39 counties and 6 districts of Bucharest

	Yes, full information on municipalities' websites, to the best knowledge of …		Yes, full information on NGO websites, to the best knowledge of …	
Information about …	**SECPAH**	**SECC**	**SECPAH**	**SECC**
Total number of respondents, out of which …:	201	187	201	187
(%)	100	100	100	100
a. What does the file contain and how should it be prepared	64	37	19	10
b. How and where the application and file are submitted	66	37	20	9
c. Information about how to access SECPAH	59	20	14	6
d. What does the comprehensive assessment consist of, and how is this done	33	21	10	6
e. How are the degree and type of disability established	22	13	10	3
f. Which are the related benefits and services	47	22	12	8
g. How to challenge the disability certificate, including how and where this can be challenged, and how to apply for, and obtain, legal assistance	25	17	7	7
None of the above	17	9	60	27
All of the above	16	5	4	1
Do not know/did not answer on this topic	12	52	12	52

Source: Opinion survey Q2B: Practices and experiences of the practitioners working in the comprehensive disability assessment services for adults (SECPAH, N=201) and children (SECC, N=187), from 39 counties and 6 districts of Bucharest, January–February 2021.

Annex 4. Table 2: SPAS and SECPAH that provide standardized application forms on the municipality/DGASPC websites (number of SPAS/SECPAH)

	URBAN		RURAL				COUNTY
	Larger cities	**Small urban**	**Communes type 1**	**Communes type 2**	**Communes type 3**	**Total sample of SPAS**	**SECPAH (within DGASPC)**
Total number of cases, of which … Posted on the municipality/ DGASPC websites the standard application form …	18	10	12	15	16	71	36
a. for adults (GD no. 430/2008, Art. 6)	10	3	3	5	9	30	36
b. for children (Joint Order no. 1985/1305/5805/2016)	10	4	3	6	9	32	31
c. for social inquiry (for SPAS)	13	6	5	7	9	40	

Source: SPAS survey with responses from 26 counties, January–February 2021. Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH, N=36) and for children (SECC, N=32), from 32 counties and 4 districts of Bucharest, January–February 2021.

Notes: Small urban = small cities up to 20,000 inhabitants as of January 1, 2020; larger cities = cities with >20,000 inhabitants as of January 1, 2020; rural = communes of all types; communes type 1 = communes developed and close to the county seat; communes type 2 = other communes (typical rural localities); communes type 3 = communes underdeveloped and remote.

Annex 4. Table 3: SPAS and SECPAH with a communication procedure (number of SPAS/SECPAH)

	URBAN		RURAL				
	Larger cities	Small urban	Communes type 1	Communes type 2	Communes type 3	Total sample of SPAS	COUNTY SECPAH (within DGASPC)
Total number of cases, of which …							
Have an approved procedure, or a paragraph of a general procedure concerning provision of …	18	10	12	15	16	71	36
a. information about the disability assessment							26
b. information on social risks and the rights of persons with disabilities	9	0	3	2	2	16	
If YES							
Provided the procedure in the survey response package	6	0	1	1	1	9	9

Source: SPAS survey with responses from 26 counties, January–February 2021. Institutional survey Q2A: Facts and indicators regarding the activity of the services for comprehensive disability assessment for adults (SECPAH, N=36) and for children (SECC, N=32), from 32 counties and 4 districts of Bucharest, January–February 2021.

Notes: Small urban = small cities up to 20,000 inhabitants as of January 1, 2020; larger cities = cities with >20,000 inhabitants as of January 1, 2020; rural = communes of all types; communes type 1 = communes developed and close to the county seat; communes type 2 = other communes (typical rural localities); communes type 3 = communes underdeveloped and remote.

Annex 5. Comprehensive assessment by SECPAH

Annex 5. Table 1: Medical assessment from a psychosocial perspective, according to SECPAH specialists

On a scale of 1 to 10:	Average	Standard deviation	N
STRUCTURES AND FUNCTIONS			
EVM16. To what extent do the medical documents on file allow a good assessment of the impairments to body structures and body functions (which do you consider close to reality)?	8.08	1.29	157
ACTIVITY LIMITATIONS			
EVM18. To what extent do the medical documents on file allow a good assessment of the limitations of the person's activity (comprehensive, sufficiently detailed, which do you consider close to reality)?	7.72	1.64	158

Source: Opinion survey Q2B: Practices and experiences of specialists working within the service for the comprehensive assessment of adults with disabilities (SECPAH), in 39 counties and 6 districts of Bucharest, January–February 2021.

Annex 5. Table 2: Psychological assessment from a psychosocial perspective, according to SECPAH specialists

On a scale of 1 to 10:	Average	Standard deviation	N
EVP11. To what extent do the documents on files allow a good assessment of functioning from a psychosocial perspective (activities and participation)?	7.72	1.89	150
EVP12. But more specifically, to what extent do the tools used by the psychologist allow an assessment that you consider complete, detailed, close to reality, of psychosomatic aspects, behavior, personal and social autonomy of the person?			
ACTIVITY LIMITATIONS			
1. in a standardized context (capacity)	7.02	2.81	108
2. in their living environment (performance)	7.11	3.17	100
PARTICIPATION RESTRICTIONS			
4. General tasks and requests	7.29	2.79	102
5. Communication	7.50	2.81	109
9. Relationships and interactions with others	7.55	2.79	110

Source: Opinion survey Q2B: Practices and experiences of specialists working within the service for the comprehensive assessment of adults with disabilities (SECPAH), in 39 counties and 6 districts of Bucharest, January–February 2021.

Annex 5. Table 3: Vocational or professional skills assessment from a psychosocial perspective, according to SECPAH specialists

EVV8. On a scale of 1 to 10, to what extent do the vocational assessment and professional guidance documents on file allow an accurate (detailed, close to reality) assessment regarding …?	Average	Standard deviation	N
ACTIVITY LIMITATIONS			
1. in a standardized context (capacity)	5.87	2.92	137
2. in their living environment (performance)	5.69	2.90	138
PARTICIPATION RESTRICTIONS RELATED TO:			
3. Learning and applying knowledge	5.78	3.11	137
4. General tasks and requests	5.67	3.00	137
9. Major areas of life: work, education	6.01	2.97	138
ENVIRONMENTAL FACTORS THAT CAN ACT AS BARRIERS OR FACILITATORS on the labor market:			
11. Products and technologies	5.39	3.14	140
12. The person's natural environment, environmental changes	5.37	3.29	140
13. Support and human relations	6.36	3.06	140
14. Attitudes	5.27	3.43	140
15. Support services, systems or relevant occupational policies	4.81	3.25	140

Source: Opinion survey Q2B: Practices and experiences of specialists working within the service for the comprehensive assessment of adults with disabilities (SECPAH), in 39 counties and 6 districts of Bucharest, January–February 2021.

Annex 5. Table 4: Education level assessment from a psychosocial perspective, according to SECPAH specialists

EVE8. On a scale of 1 to 10, to what extent do the documents on file allow an accurate (detailed, close to reality) assessment regarding …?	Average	Standard deviation	N
PARTICIPATION RESTRICTIONS RELATED TO:			
3. Learning and applying knowledge	5.83	3.10	140
9. Major areas of life: education	6.00	2.99	134
ENVIRONMENTAL FACTORS THAT CAN ACT AS BARRIERS OR FACILITATORS in education:			
11. Products and technologies	5.79	3.11	140
12. The person's natural environment, environmental changes	5.56	3.12	140
13. Support and human relations	6.52	2.84	140
14. Attitudes	6.17	3.17	140
15. Support services, systems or relevant educational policies	5.76	3.22	140

Source: Opinion survey Q2B: Practices and experiences of specialists working within the service for the comprehensive assessment of adults with disabilities (SECPAH), in 39 counties and 6 districts of Bucharest, January–February 2021.

Annex 5. Table 5: Assessment of social integration level and skills from a psychosocial perspective, according to SECPAH specialists

On a scale of 1 to 10, to what extent are the data obtained from the social inquiries sent by SPAS sufficient to allow a detailed and accurate assessment of the level of social integration (degree of dependency) …?	URBAN			RURAL		
	Avg.	Std. dev.	N	Avg.	Std. dev.	N
EVA5. Specifically, to what extent do the available data allow a good assessment of:						
Mobility — person with disabilities' mobility needs, and the aids needed with assistive devices and systems	7.9	1.9	167	7.3	2.1	166
Self-care — autonomy in daily activities of body hygiene, intimate hygiene, dressing/undressing, serving and feeding	8.4	1.7	167	7.6	1.9	166
Self-support — household activities, i.e. cooking, washing, shopping, paying bills, etc.	8.3	1.6	169	7.5	1.9	167
Communication — use of means of communication	8.3	1.8	168	7.6	2.0	166
Interactions with others	8.0	1.9	169	7.3	2.1	167
Participation in education, work, leisure activities	7.4	2.1	169	6.7	2.3	167
Civic, cultural, other community activities	6.8	2.5	169	6.0	2.6	167
EVA7. But more specifically, for a possible argumentation of the need for institutionalization or home care, to what extent do the data on file allow a correct assessment (in line with reality) regarding the person's participation in:						
Intimate relationships and support networks — The network of family, friends and neighbors, the support they provide	7.7	2.0	170	7.2	2.1	168
Household life — Household activities, food preparation, cleaning, shopping, income management, complying with medical advice	8.2	1.6	170	7.7	1.8	168
Community, social and civic life — Use of transport means, leisure, civic, cultural and/or sporting activities	7.3	2.2	171	6.8	2.2	169
Attitudes — Family, neighborhood, and community attitudes towards persons with disabilities and the need for protection against discrimination	6.8	2.7	170	6.2	2.7	168

Source: Opinion survey Q2B: Practices and experiences of specialists working within the service for the comprehensive assessment of adults with disabilities (SECPAH), in 39 counties and 6 districts of Bucharest, January–February 2021.

Notes: Avg = average; Std. dev.=standard deviation.

Annex 6. Example of an Individual Service Plan (PIS)

Serviciul Evaluare Complexă a Persoanelor Adulte cu Handicap şi Monitorizare	PROCEDURA OPERAŢIONALĂ PROCEDURA PRIVIND EVALUAREA/REEVALUAREA MEDICO-PSIHO-SOCIALĂ A PERSOANELOR ADULTE CU HANDICAP	Cod: PO.49.01 Ediția I/ Revizia 3

Anexa nr.5

Nr. _____/_____

PLAN INDIVIDUAL DE SERVICII

Numele şi Prenumele persoanei cu handicap _____
Reprezentant legal al persoanei cu handicap _____
Data realizării planului_____

SERVICII				
Tipul evaluarii	**Instituţia responsabilă**	**Obiective generale**	**Perioada de desfăşurare**	**Persoana responsabilă**
Protecţie şi / sau **Asistenţă socială** a persoanei cu handicap	☐ Familie ☐Centru de zi ☐Centru rezidenţial ☐ Altele	☐ socializare si petrecerea timpului ☐ socializare şi activităţi de terapie ocupaţională liber ☐ îngrijire şi supraveghere permanentă specializată ☐ sprijin şi ajutor în gospodărie	☐ 6 luni ☐ 12 luni ☐ Permanent	☐ Familie ☐ Alţi specialişti
MEDICALE	Instituţie Medicală Specializată	**DISPENSARIZARE** ☐ Recuperare medicala ☐ Alergologie ☐ O.R.L ☐ Geriatrie ☐ Chirurgie ☐ Oftalmologie ☐ Neurologie ☐ Cardiologie ☐ Pneumologie ☐ Nefrologie ☐ Oncologie ☐ Ortopedie ☐ Reumatologie ☐ Hematologie ☐ Psihiatrie ☐ Diabetologie ☐ Medicină internă ☐ Psiholog ☐ Boli infecţioase ☐ Urologie ☐ Altele	☐ 6 luni ☐ 12 luni ☐ Permanent	Medic de Specialitate

Tipul evaluarii	Instituţia responsabilă	Obiective generale	Perioada de desfăşurare	Persoana responsabilă
PSIHOLOGICE	Unitatea medicală Cabinet ONG ☐ Furniz. de servicii sociale	Dispensarizare psihiatrie Consiliere psihologică Consiliere de familie ☐ Psihoterapie ☐ Nu este cazul	☐ Permanent	Psihiatru Psiholog Psihoterapeut ☐ Alţi specialişti
VOCAŢIONALE	☐Unit. de învăţământ ☐Unit. economică ☐Loc de munca protejat ☐Unit. protejată ☐Atelier protejat ☐ ONG ☐Furniz. de formare profesională ☐Agenţia locală pt. ocuparea forţei de muncă ☐Centru de consiliere	☐ formare profesională ..... ☐ formarea, dezvoltarea şi perfecţionarea abilităţilor sociale şi profesionale în conformitate cu capacitatea fizică şi intelectuală existentă ☐ adaptarea cerinţelor educaţionale la nevoile şi particularităţile individuale ☐ valorificarea potenţialului de muncă existent ☐ loc de muncă corespunzător ☐ adaptarea rezonabilă a locului de muncă ☐ terapie ocupaţională ☐ terapie prin muncă ☐ informare, consiliere şi orientare profesională ☐ medierea angajării ☐ consiliere post-angajare ☐ asistarea angajării ☐ reconversie profesională ☐ reabilitare psiho-socială ☐ (re) integrare socială ☐ Nu este cazul	☐ 6 luni ☐ 12 luni ☐ Permanent	Specialiştii în domeniu: - Psihopedagog - Profesor de specialitate - Instructor ergoterapeut - Pedagog de recuperare - Consilier orientare privind cariera - Consilier vocaţional - Mediator - Agentul economic (angajatorul) - Alţi specialişti

Avizat,
Director General Adjunct,

Medic Specialist: _____

Asistent social:_____

Aprobat,
Sef Serviciu,

Psiholog:_____
Consilier vocational:_____
Alţi specialişti:_____

Annex 7. Profile of persons who filed appeals and won

Profile of those who filed and won appeals against the disability degree and type certificate, November 2020, case study for Suceava county (% of total)

	W1. Total appeals filed, out of which:	W2. Appeals with a final ruling in favor of the person with disability:
CH5. Total number of appeals	187	51
	100%	100%
DEGREE		
a. minor	0.0	0.0
b. medium	6.4	3.9
c. marked	25.7	27.5
d. severe	17.1	17.6
e. severe, with personal assistant	50.8	51.0
TYPE		
aa. physical deficiency (code 1)	46.0	47.1
bb. somatic deficiency (code 2)	14.4	23.5
cc. hearing deficiency (code 3)	0.5	0.0
dd. visual deficiency (code 4)	5.9	3.9
ee. mental deficiency (code 5)	15.0	11.8
ff. psychic deficiency (code 6)	4.8	7.8
gg. associated deficiency (code 7)	9.1	5.9
hh. HIV/AIDS (code 8)	0.0	0.0
ii. rare diseases (code 9)	3.7	0.0
jj. deaf-blindness (code 10)	0.5	0.0
VALIDITY TERM		
x. 1 year	96.3	86.3
y. 2 years	0.0	0.0
z. permanent	3.7	13.7
RESIDENCE AREA		
u. urban	35.3	35.3
r. rural	64.7	64.7
GENDER		
f. female	44.9	47.1
m. male	55.1	52.9
AGE		
v1. 18–20 years	1.1	9.8
v2. 21–26 years	10.2	3.9
v3. 27–34 years	11.2	7.8
v4. 35–44 years	8.6	17.6
v5. 45–54 years	14.4	27.5

	W1. Total appeals filed, out of which:	W2. Appeals with a final ruling in favor of the person with disability:
v6. 55–64 years	17.1	13.7
v7. 65–74 years	20.3	15.7
v8. 75+ years old	17.1	3.9
COMMUNITY GROUPS		
g0. total persons with disabilities in the family	67.9	88.2
g1. homeless persons	0.0	0.0
g2. persons under interdiction – with a family member as guardian	6.4	9.8
g3. persons under interdiction – with the local public authority as guardian	0.0	0.0
g4. persons under interdiction – with an NGO as guardian	0.0	0.0
g5. persons with maximum 8 grades education	16.6	43.1
g6. immobilized persons	19.8	29.4
INSTITUTIONALIZED PERSONS		
g7. persons under a protection measure*	0.0	0.0
g8. persons hospitalized in psychiatric hospitals	0.0	0.0
g9. persons in prisons	0.0	0.0
LAWYER ASSISTANCE		
CHA4a. no lawyer assistance	50.8	62.7
CHA4b. free public lawyer assistance	3.7	3.9
CHA4c. with chosen counsel (selected by the person)	45.5	33.3

Source: Institutional survey Q3D: Appeals against the disability degree and disability type certificates (CEPAH Secretariat), January-February 2021.

Notes: The significantly higher values are marked in yellow. *Individuals with protection measure irrespective of the type of placement service (centres, protected housing, etc.)

Annex 8. Support measures for transitioning young people with disabilities to adult life

Below are the main support measures, as set out in Order no. 1985/1305/5805/2016.

Art. 55 (4)	The overall objective of the habilitation-rehabilitation plan is personal and social development, maximization of potential, acquisition of personal and social autonomy of the child for social inclusion. In the case of children over the age of 16, the objective of the plan will also include the transition to adult life. In the case of children in palliative care, at home care or care in hospice-type center, the objective of the plan will include maintaining the quality of life/slowing the deterioration of health.
Art. 65 (6)	(3) Support measures for the transition from puberty to adolescence can be: a) preparation of the child through information appropriate to age, maturity degree and type of disability by family and teachers; b) health education in the form of an optional subject or offered by other educational, health care or social service providers; c) counseling from the educational counselor or other educational, health care or social service providers; d) development of independent living skills within services or courses. (4) Support measures for the transition from middle school to high school or vocational school may be those referred to in paragraph (3), plus school and professional orientation. (6) Support measures for the transition to adult life may be those referred to in paragraph (4), plus measures aimed at the transition to the protection system for adults with disabilities: a) preparation of the child/young person through information appropriate to the age, degree of maturity and type of disability by the family and the case manager, including aspects relating to the granting of the disability degree to adults with disabilities; b) support for parents/legal representative for the preparation of the necessary documents for the granting of disability degree for adults with disabilities; c) mediation of the parents`/legal representatives` relationship with the Service for the Complex Evaluation of Adults with Disabilities, hereinafter referred to as SECPAH; d) visits to the residential center or to the home of the professional personal assistant by young people who are about to leave the special child protection system and be transferred to the protection system for adults with disabilities.
Art. 83	(1) The habilitation-rehabilitation plan shall be completed upon expiration of the disability certificate, and the tailored service plan shall be completed upon expiration of the school and professional orientation certificate. (2) Closure of the case shall take place upon expiry of the certificate, but may also take place in the following situations: a) change of residence in another county/sector of Bucharest; b) transition to adult life; c) refusal of the parents/legal representative to collaborate with the competent authorities to classify the child as disabled and/or to implement a habilitation-rehabilitation plan; d) at the request of the parents/legal representative in cases of disability degree classification; e) if the parents/legal representative no longer request the complex reassessment in cases of disability degree classification; f) death of the child.

Note: The first measures—Art. 65, para. (3) and (4)—are taken into account not only in the transition phase to adult life, but also before the other transitional stages in the child's life.

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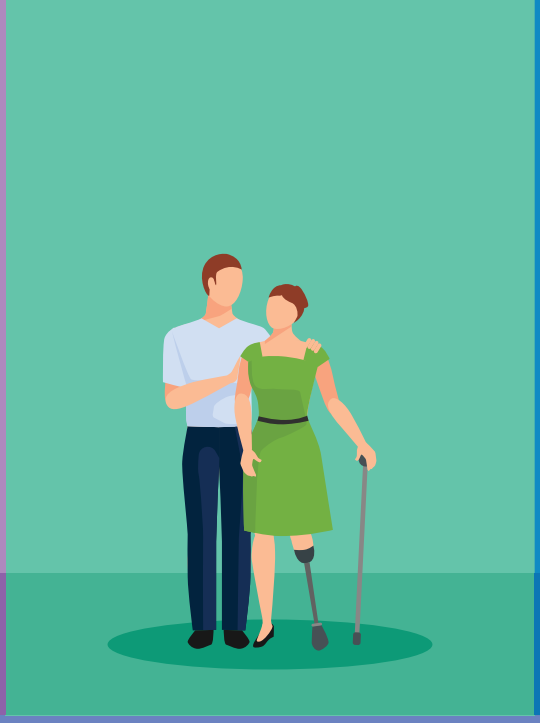


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