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# AN ELUSIVE PARTNERSHIP. THE ORTHODOX CHURCH AND THE SUBSTANCE ABUSE HEALTH CARE SYSTEM IN ROMANIA

Sebastian MOLDOVAN<sup>1</sup>

## Abstract

This article is part of a research dedicated to the participation of religious communities in the advancement of the system of services provided for the persons suffering from substance use disorders in Romania. The first part presents an epidemiologic image of alcohol consumption and the amount of attention paid to it in the national anti-drug strategy. The second part summarizes the problematics of the contributions brought by faith-based organisations to public health, particularly in the field of substance use disorders and addictive behaviours, and describes some of the Romanian Orthodox Church sponsored initiatives in the domain. The promises and uncertainties of an inchoative partnership between the Church and the National Anti-drug Agency are scrutinized through documentary analysis in the final part.

*Keywords:* substance use disorders, alcohol consumption, health care, faith-based organisations, Romanian Orthodox Church

## Introduction

The social, political and cultural transformations of the past century have all been accompanied by an unprecedented increase in addictive behaviours. However, the institutional reaction of the Orthodox Churches to the pastoral challenges of “the globalisation of addictions” (Alexander, 2008) is modest, especially because of the repressions they suffered during the Communist regimes, and due to the ecclesial fragmentation in the Diaspora. In Romania, the passage from Communism to the transitory political regimen towards the EU aggravates not only the addiction phenomenon, but also the need to confront it pastorally. And it is the more so as the Romanian Orthodox Church (ROC) seeks to reaffirm her social

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pre-eminence as historical “mother” of the Romanian people. Coming back on the social forefront, after going through a long historic syncope, the ROC finds herself now in the presence of new actors that are involved in the moulding of people’s well-being, i.e. the secular state, the sanitary system, and the scientific research. As these contributors enjoy major social recognition, they are able to configure, from a political, administrative, medical, and epistemological point of view, the intervention system that is meant to prevent illicit or problematic consumption and treat addictions. What could be the role of the Church in this context? Are her anthropological vision, therapeutic methods and pastoral ministry still relevant today? If so, how could all of these contribute to the holding back of addictions? Are the secular, governmental and non-governmental, ministries interested in a partnership with the Church for the benefit of people suffering with addiction? The present research paper focuses in particular on the issue of alcoholism.

### *The epidemiology of a spiritual failure*

In Romania, the monitoring of alcohol consumption is a problem in and of itself. The different surveys are not always comparable; moreover, the data published by national organizations and that published by the international ones are sometimes different. The National Anti-drug Agency (NAA) registers it every three years, within a general population survey regarding the use of psychoactive substances (2004, 2007, 2010)<sup>2</sup>. The last NAA study confirms that, although slightly decreasing in use, the alcohol consumption is vastly spread in society: over 80% of the people have tried it, around half of them have drunk alcohol in the past month, and almost 10% have been inebriated during this interval (NAA, 2011: 25-26). Yearly adult consumption per capita of pure alcohol is one of the biggest in EU, and so is the prevalence of drinking at a “high” or “very high” risk level (more than 60 grams/day), namely 21% men, and 14.2% women (Rehm, Shield, Rehm, Gmel, Frick, 2012: 20). The heavy episodic drinking (binge drinking - defined as five drinks or more on at least one occasion at least once a week) is 39%, second highest in EU (Anderson, Møller, Galea, 2012: 141). As for the consequences, the alcohol-attributable mortality, i.e. the proportions of alcohol-attributable deaths to all deaths, for people aged 15-64, is 15% in women - the highest value in EU -, and almost 23% in men. Using data from 2007, a study evaluates the prevalence and numbers of women and men aged 18-64 affected with alcohol dependence in Romania thus: 0.7% (50,000) for women, and 2.2 % (155,000) for men, which is less than half the EU average. On the other hand, the disability-adjusted life years (DALYs) - a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death - lost due to alcohol dependence as a disease category, for people aged 15-64, is 455.5 for Romania, comparing to the EU average of 388.5 (Rehm, Shield, Rehm, Gmel, Frick, 2012: 61). As an effect on the social safety, one out of three respondents in the 2010 NAA study, admits to having been verbally abused by inebriated persons, one out of ten declares they were physically abused, and 3.3%

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<sup>2</sup> The results of the surveys are published in the annual National Report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

that they were involved in a traffic accident produced by someone driving under the influence of alcohol (NAA, 2011: 26).

If we take into account that heavy drinking is massively associated with domestic violence, delinquency, rape, suicide, occupational accidents, and traffic accidents, and that, according to the WHO, for each person who abuses alcohol, there are another even persons to suffer the consequences (life partners, close and extended family, friends), then we have the picture of a real endemic situation with syndemic characteristics. Again, if we also consider that, according to the view of the Church, alcoholism is a passion, a spiritual failure<sup>3</sup>, then we have the picture of the challenge that this situation poses for the ministry of the Romanian Orthodox Church. Although there is no evidence in this respect, it is highly probable that most of the problem-consumers are formal members of the ROC. What is her *institutional* reaction against this situation? First of all, though, let us see what the whole situation of the public services in the field indicates.

### *The system of services for SUD – a focus on alcohol*

In Romania, the public services in the fields of health care, SUD and behavioural addictions are generally disconnected and have different histories, although the prevalence of comorbidities, poly-consumption, as well as the medical perspective, which is dominant among the health practitioners and decision-makers, would rather posit a unitary approach under the umbrella of a behavioural health care system. The explanation resides also in the varied degrees of medicalization of these behaviours, in how/if they received institutionalised treatment, and also in their degree of criminalisation and the way they were assigned to various specialised state institutions. The non-pharmacological addictions are barely starting to be acknowledged as relevant for the public health. Also, there is no coherent system of sanitary and social regulations to address the pharmacological addictions, although there are certain law proposals that treat them as a unit. The alcohol consumption is illustrative in this sense (and a detailed account of the situation will be published elsewhere).

For example, the main legislative instrument, the *National Anti-Drug Strategy 2005-2012* states as its general objective regarding drug consumption, “keeping the prevalence of illicit drug use at a low level, as compared to the current one, and reducing in a correlated manner the prevalence of alcohol and tobacco use in the general population by enforcing prevention measures and developing the public and private system of medical, psychological and social care”, as well as “initiating and developing adequate projects and programmes to the benefit of local communities for the enforcement of civic, cultural, and spiritual education as an alternative healthy lifestyle, advocating for drug abstinence, alcohol and tobacco included” (Chapter II, *proemium* and paragraph C)<sup>4</sup>. However, alcohol

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<sup>3</sup> See, for instance, the attitude of the Apostle Paul in Rm 13:13; Gal 5:20; 1 Cor 6:10. On the broader perspective, (Cook, 2006).

<sup>4</sup> The Government Decision No 73 of 27 January 2005 approving the National Anti-drug Strategy 2005-2012 (published in the Official Gazette, Part 1, No 112 of 3 February 2005).

and tobacco are no longer mentioned in the section concerning “the medical, social, psychological assistance and social reinsertion”. These two are also missing from the *Design, Modification and Implementation Methodology of the customised care plan for drug users*, as well as from the *Compulsory Minimum Standards regarding the case management in the field of drug users’ care* (2006).<sup>5</sup> This is true, although a year before, the *Regulations for the implementation of the Law on the prevention and fight against illicit drug trafficking and use* was enlisting, amongst the NAA service types, professed “addiction integrated care centres”, which were destined to render ambulatory medical, psychological, and social assistance services<sup>6</sup>. Besides the classic detox settlements already established in sanitary units, these centres could also include services for alcoholics. During the same year (2005), in a volume that stated from a scientific point of view the services politics of the NAA, the authors admit that the formulated standards target drug consumers specifically, but they suggest that these principles are indirectly relevant for alcohol users, too (Abraham, 2005: 11). The regulatory documents that control the organisation and activity of the services rendered to drug users confirm this situation, and make references to alcohol only in the objectives of the Drug Prevention, Evaluation and Counselling Centres, and solely in the area discussing prevention<sup>7</sup>.

In turn, the *National Program for Medical, Psychological and Social Assistance of Drug Users - 2009-2012* refers explicitly only to the provision of the substitute treatment for alcohol<sup>8</sup>, while the *Nation interest Program for the Prevention of Tobacco, Alcohol and Drug Consumption - 2009-2012* deems alcohol and tobacco as illicit drugs, since its target-group is the school-age population (under-age)<sup>9</sup>. A noticeable change is to be noted in the *Action Plan for the Implementation of the National Anti-Drug Strategy between 2010-2012*, where

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<sup>5</sup> Decision No 17 of 2 October 2006 approving the Methodology for the approval of the design, modification and implementation of the personalised care plan for drug users, issued by the National Anti-drug Agency (O.G. No 899/6.11.2006), and Decision No 16 of 2 October 2006 approving the Minimum compulsory standards of the case management in drug user care area, issued by the National Anti-drug Agency (O.G. No 899/6.11.2006). All the relevant Government and NAA normative documents are available, in Romanian, at [http://www.ana.gov.ro/legislatie\\_interna.php](http://www.ana.gov.ro/legislatie_interna.php).

<sup>6</sup> Decision no. 860/2005 approving the Enforcement regulation of the Law no. 143/2000 on preventing and countering the illicit drug use, further amended and supplemented, (published in the Official Gazette No. 749 / 17.08.2005).

<sup>7</sup> The Order no. 1389 approving the Criteria and methodology used to authorise centres that provide services for drug users and the Compulsory minimum standards of the organisation and operation of the centres that provide services for drug users (O.G. no. 830 of December 10, 2008).

<sup>8</sup> The Government Decision No 1101/2008 approving the National programme of medical, psychological and social care for drug users 2009-2012 (issued by the Government of Romania, published in the Official Gazette No 672, 30.9.2008).

<sup>9</sup> Governmental Decision no. 1101/September 18, 2008 approving the National interest programme to prevent tobacco, alcohol and drug prevention 2009 - 2012 (issued by the Government, published in the Official Gazette no. 672 of September 30, 2008).

the general term “addictions” is used for the first time in regulatory documents, and where alcohol is explicitly mentioned in the chapter on prevention and in the objectives that aim at the services’ increase of availability and adaptability to the type of consumption and the individual needs of the users.<sup>10</sup> The project of the *National Anti-Drug Strategy between 2010-2012*, that is now under debate, means to achieve a “proactive response concerning the phenomenon of drugs, alcohol and tobacco consumption, as well as that of drug trafficking and precursors”. It stipulates an integrated system for the decrease of drug demand, whose measures “will take into consideration all psychological medical and social aspects generated by the use of drugs - alcohol, tobacco and poly drug use included”<sup>11</sup>, but the *Action Plan for the Implementation of the Strategy* on the medium-term (2013-2016) resorts to mentioning alcohol use only in the section dedicated to prevention<sup>12</sup>.

Going back to the service system, officially named “the national system of medical, psychological and social assistance”, we have to say that, in the NAA vision, it has three levels: 1) identification and referrals to specialised services and basic needs assistance (emergency, primary medical care, general social services, harm reduction services); 2) specialised assistance, supervision and coordination between all levels of intervention, and referral to the third level; 3) specific assistance (detoxification, therapeutic communities, day centres, etc.) and social reinsertion (*National Report*, 2011: 49-54). The second level, which is considered central, is serviced by specialised units within the public health system and the NAA. The decisive stage in the path to recovery is the third level. However, this is the weakest developed, especially when it comes to residential services and therapeutic communities, which up until now, have been offered within a few communities that accommodate close to 100 patient, by some of the non-governmental associations belonging to the Romanian Substance Abuse and Addiction Coalition (ROSAAC - most important of which is Blue Cross Romania). As for the social reinsertion services, apart from NAA and ROSAAC, there are several others, such as: the Alliance for the Fight against Alcoholism and Toxicodependence (ALIAT), the Romanian Anti-AIDS Association (ARAS), the 52 AA groups (and other 6 AlAnon), the Association of the Recovery Alcoholics Clubs in Romania, and a few ROC run programs. There is no statistical data on the number of beneficiaries of these services. According to the official data of NAA (2012 National Report, 2012: 161), during 2011 there were 3,622 persons who benefited from reinsertion services, and 3,362 from treatment services, which were provided in 64 centres belonging to the state services system. Assistance for alcohol use was provided for 1,172 persons (35% - the remaining 65% was rendered to illegal drug users and new psychoactive substances consumers), which is less than 1% of the estimated number of addicts (see above). In another assessment, made in accordance with data found in the European Hospital Mor-

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<sup>10</sup> Governmental Decision no. 1369 of 23.12.2010 approving the Action plan for the implementation of the National Anti-drug strategy (issued by Romanian Government, published in the Official Gazette, Part I, no.38 / 17.01.2011).

<sup>11</sup> Available at [http://www.ana.gov.ro/doc\\_strategice/proiecte/SNA\\_2013\\_2020.pdf](http://www.ana.gov.ro/doc_strategice/proiecte/SNA_2013_2020.pdf)

<sup>12</sup> Available at [http://www.ana.gov.ro/doc\\_strategice/proiecte/PNA\\_2013\\_2020.pdf](http://www.ana.gov.ro/doc_strategice/proiecte/PNA_2013_2020.pdf)



bidity Database, 12% of the alcohol addicted persons have had access to treatment in 2004 (4.2% inpatient, 7.8% outpatient) (Rehm, Shield, Rehm, Gmel, Frick, 2012: 125). This data incongruity deserves to be investigated. At any rate, the last estimation seems overrated, if we were to consider that, according to a media report of a recent study done by ALIAT, 90% of the heavy alcohol users have no knowledge about the existence of any addiction treatment centre in their county of residence (Pandelea, 2011).

Besides the highly abridged degree of needs coverage for alcohol abusers, it would be fit to highlight another two aspects of the service system. Firstly, not only is the development of services on those three levels exceedingly uneven, being that important system links are missing - as repeatedly noted in the annual reports of NAA (2011 National Report, 2012: 49) -, but also their functionality is very poorly integrated, and their fragmentation is thus one of the negative traits that is most censured by professionals in the few evaluations done on the quality of services (Oancea, 2007: 66, Lefter, Paiu, 2009: 38)<sup>13</sup> These experts believe that there is no real “therapeutic chain” - along with “case management”, the main theoretic concept of the integrated assistance system envisioned by the legislation -, but that there are only separate institutions which provide services. For a therapeutic chain to exist, it would become necessary not only to fill in the missing local links, but also to create a unique inter-institutional referral system, without which there can be no continuity in the treatment of any patient.

A second critical aspect that is less observed, regards the very nature of the issues this system is intended for to address. An self-evaluation report states that, “in drug addiction, the physical dependence is relatively easily overcome sometime between 7-21 days, while the psychological dependence is the main relapse factor, as it can last for years on end” (Oancea, 2007: 65). Nevertheless, the long-term perspective on addiction, according to which, this is a chronic condition, being either a disease, or a lifestyle or “career”, (White, Kelly, 2011; Hser, Longshore, Anglin, 2007) is the least visible both in theory, and in the practice of the service system. The importance of the time factor derives from the fact that the more the assistance lasts, the more it inevitably permeates the universe of the personal life of the assisted on a personal - mental, affective, and value-related - level, as well as their social environment (family, friends, community). Or, the institutional approach - even the “therapeutic chain” and “case management” type thereof (Abraham, 2005: 97-98) - does not seem to be the most effective one when it comes to going through all the works for an extensive period of time, and that is due to administrative and financial reasons. No matter how comprehensive it becomes, at one point, the chain of services is compelled to hand the assistance over to such a community that is supportive not only of the relinquishment of consumption, but also of the addicted person’s whole life. If this be the case, as

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<sup>13</sup> This is in a surprising contrast with the finds of another NAA self-evaluation report, according to which the professionals of the Drug Prevention, Evaluation and Counselling Centres do not perceived a significant gap between the real and the ideal situations concerning the coordination of services (Lefter, Botescu, 2008: 25). However, the enhancement of the collaboration with local institutions do spark in the final recommendations of the document (Lefter, Botescu, 2008: 71).

stated in the documents of the NAA system, it is to be supposed that the relationship between the services and the said community should get much more interactive than the rhetoric of partnership and participation. Although the principle of subsidiarity, for instance, is enunciated in the normative documents of the social assistance in Romania<sup>14</sup>, it is never mentioned in the documents pertaining to the assistance for SUD. The latter documents rarely attribute any role to the community (the family, in particular), and when they refer to the collaboration with the civil society, they mean strictly non-governmental organisations. The problem here is that these NGOs are not actual communities, but rather another sort of service providers. The only bodies that are organisations and communities at the same time are the religious ones, i.e. the parishes. The philanthropic and the strictly religious “services” are, in principle, the most integrated aids that penetrate into the personal lives of their members. The NAA seems to be aware of this potential therapeutic advantage of the religious groups. But is this advantage completely taken advantage of?

### *The contribution of the faith-based organisations to the SUD health care system*

The religiosity and spirituality are more and more recognised as relevant factors for the clinical practice, health services and sanitary regulations. Despite the controversial relationship between religion and spirituality, and the physical and mental health, findings of past research showed that, when compared to control groups, those who are religious have better physical health, increased psychological well-being, lower depression, substance misuse and suicidal ideation (Koenig, King, Carson, 2012). However, it was not until recently that the academic community and the political decision-makers have started to pay attention to the role the faith-based organisations (FBOs) have in this relationship and to the contribution of the health and social services of the FBOs to the public health (Schumann, Stroppa, Moreira-Almeida, 2011). The concerns in this respect are heightened in the USA - a highly religious country where the religious organisation is at its best -, particularly when it comes to the field of mental health and substance use (MH/SU).

A major reason for this interest in the USA is the emergence and evolution of the Alcoholics Anonymous movement and of its many replicas within all the MH/SU branches. This movement has reoriented this whole system towards the so-called recovery approach, and has imposed the acknowledgement of the decisive role of peer-based recovery support (Slaymaker, Sheehan, 2008, White, 2009). „Self-help groups are responsible for an immense amount of service to the larger MH/SU system”, states a recent review, while noting that this contribution is also due mostly to the 12-Steps groups (Powell, Perron, 2010: 335, 347). There must be stated that, “the term self refers to a group of ourselves who share common experience, challenges, and identities” (Powell, Perron, 2010: 341), so that the

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<sup>14</sup> Law no. 292/2011 of Social Work (published in the Official Gazette, no. 905, of December 20, 2011).



name ‘mutual’ or ‘peer’ help seems more appropriate. No matter how great the diversity of these groups - owing to the diversity of issues approached and methods employed -, three common characteristics may be identified: a) experience perspective – individual experience, i.e. what members share with the group, as a capital of knowledge and recovery; b) referent power - the influence based on sense of identification, in contrast with expert power, i.e., the influence based on professional expertise, and c) the helper-therapy principle – help giving and help receiving acting mutually for the benefit of the members (Powell, Perron, 2010: 341-43).

The main argument that pleads for the collaboration between professional and mutual help services is that a combined system would benefit from the complementary strengths of each approach. For instance, the nature and means of solving a problem change during the transition from the acute situation to the chronic, from treatment to rehabilitation. Therefore, the proper use of mutual help may maintain and amplify the results of the professional treatment, which is temporarily and socially much limited. Also, unlike professional services, mutual-help services are prosumers rather than consumers, due to their multiplier effect: mutual-help use produces more mutual-help resources, since it generates more pairs of givers and receivers, more personal models, recovery stories, and resource networks (Powell, Perron, 2010: 342, 339).

A lot of FBOs support or collaborate with mutual groups, but this is not the only type of service rendered by the FBOs. A study done in an American environment proposes a typology of FBOs services, according to the options these offer (Dekraai, Bulling, Shank, Tomkins, 2011). They order these options in a pyramid of three categories that mark the broad areas of behavioural (MH/SU and other addictions) health care. The top of the pyramid represents the treatment and clinical care, and includes: outpatient services (for mild to moderate conditions), residential treatment (moderate/severe), and inpatient or hospitalization services (severe). All three kinds of conditions qualify for crisis intervention services. The middle of the pyramid encircles the support functions services, like housing, independent living skills, financial, employment, education, transportation, social/recreational, mentoring and respite, care management/wraparound, support groups (like mutual-help). The pyramid base contains information services, which consist of information and referral services, and prevention.

The structure described here corresponds greatly to the three levels of the treatment system promoted by NAA for SUD. As for the ROC, it already provides a number of services at each of these levels, both within the framework of current parochial pastoral and social-philanthropic activities (prevention, primary needs assistance, referrals), and via specialised programs, among which some are accredited. The most important of them - “St. Dimitrios Basarabov” Program for Addiction Education and Counselling in Cluj Napoca, “St. Nicholas” Counselling and Rehabilitation Centre for Persons Suffering from Alcohol and Drug Addictions in Iași, the Counselling Centre “St. Nectarios the Wonderworker” in Bucharest, the Prevention, Evaluation, Counselling and Information Centre for Persons Suffering from Alcohol and Drug Addictions “The Life-giving Spring” in Bacău, the Counselling Centre “Nicholas” in Zalău – carry out educational activities

concerning addiction, cross-addiction, co-dependency, HIV/AIDS, the spiritual aspects of recovery, bio-psycho-social-spiritual evaluations, individual and family counselling, group therapy, assistance with the integration with a peer group, the social and spiritual support, occupational counselling and therapy, art therapy, ludotherapy, socializing and free-time activities, therapy camps, training sessions for volunteers and professionals, campaigns for raising people's awareness regarding the addiction phenomenon. Their therapeutic approach is mainly the Minnesota Model,<sup>15</sup> which they try to mould into the Romanian context, and the collaboration with mutual-help groups, such as AA, AlAnon, and NA. The personnel is made of psychologists, addiction counsellors, spiritual counsellors, social workers, peer counsellors, volunteers undergoing recovery, and trainers, while the proprietary and publicly-owned locations are actual day centres, sanitary units (clinic, psychiatric clinic, TBC sanatorium, psychiatric hospital), and prisons. According to a report for the year 2011, these services were provided to 262 persons on the brink of social exclusion, another 1,593 persons benefited from counselling sessions, support and home health care programs through the parochial activities of 10 dioceses (out of the existing 29) [2012 National Report: 2012: 162]<sup>16</sup>.

As there is no evaluation of the needs for intervention in the parochial communities of the ROC, we can only assume that these services manage to meet those to a low degree. Their collaboration with other services providers in the field, public institutions or NGOs, is appreciated and seems functional, sometimes though, under non-formal circumstances. Still, the attitude of the Church appears to the eyes of the partners as reactive rather than pro-active, and also marked by the lack of decision power within the programs. The over-loading of priests, the fear of competition, the “hyper-performance” (too much to do with too little resources) and the lack of resources are some other obstacles they claim stand on the collaboration path (Niță, 2011: 52-53). Also, the personnel of the services provided by the ROC lament the fact that their programs' capacities are exploited to the maximum, and complain that the local authorities give them only limited help, and that, all in all, their collaboration is inert: “seems as though the relationship is not alive”, as someone describes it (Lefter, Paiu, 2009: 21). When it comes to financing, the prosuming argument that is valid for mutual help groups cannot be extended to all these services. However, insomuch as they rely on the resources of the religious communities, their performance eases the burdens of public finances. On a national level, the ROC runs a set of social-philanthropic activities, whose financing structure in the past years was: 60% owned funds,

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<sup>15</sup> The Minnesota Model is a comprehensive, multi-disciplinary approach to the treatment of addictions which is abstinence oriented and based on the disease model of addiction and the 12-Step method of Alcoholics Anonymous, (Cook, 1988; Tangenberg, 2005). On the issue of compatibility between 12-Step programs and the Orthodox Spirituality, see (Moldovan, 2013).

<sup>16</sup> The Annual Report 2011 of the Filantropia Federation, a private non-profit organisation operating under the blessing of the Holy Synod of the ROC, and currently gathering 18 of the most active ROC-based NGOs in the social field, offers for the same year rather different figures: more than 4000 beneficiaries of “Sf. Nicolae” counseling and rehabilitation center for alcohol and drug addicted people only, but they include therapy and prevention (2011).

sponsorships and donations, 20% external funds, 20% public funds<sup>17</sup>. There is, though, one way that the Church makes her contribution, and the efficiency and efficacy of this method is hardly, if at all measurable. That contribution is the Church's very *raison d'être* and the cause of her popularity, at least for the Romanian people. In lay secular terms, it is called religious assistance.

### *The Romanian Orthodox Church – a strategic partner?*

Statistically speaking, two decades after the fall of the Communist regime, the Romanians are still the most loyal European people when it comes to religious values. Some 0,3% declares themselves as atheists or without religion and most as Orthodox (85.9%), according to the 2011 national census<sup>18</sup>. People's trust in the Church - *recte*, The Romanian Orthodox -, although diminished of late, is also the strongest on the continent (Voicu, 2007). No wonder then, that the ROC plays an important role in the complex relationship between the civil society and the Romanian state. In relation to our field of interest, the social assistance and health care, the ROC finds itself in an ambivalent situation. On the one hand, both the Romanian state and some relevant international organisations which are active in Romania, like the United States Agency for International Development, consider it a major social partner<sup>19</sup>.

After having finalised (in 2006) the legal framework concerning the general regime of religious groups – which are considered “factors of social peace” (Art. 7 of the *Law on Religious Freedom*)<sup>20</sup> - and the national system of social assistance and inclusion, in October 2007, the Romanian Government and Patriarchate signed a 10 year long *Protocol of cooperation in the field of social inclusion*.<sup>21</sup> This convention had among its goals “the strengthening of the national mechanism for the promotion of social inclusion”, “promoting social dialogue towards a better normative and institutional framework in the field of social inclusion”, and “defining the key priorities that will underlie the devising of joint programs and projects in the field of social inclusion”. While the Government took upon itself

<sup>17</sup> \*\*\*, Darea de seamă a sectorului social-filantropic al administrației patriarhale cu privire la activitatea social-filantropică desfășurată în cuprinsul eparhiilor Patriarhiei Române în anul 2011, Consiliul Național Bisericesc, available at [http://www.patriarhia.ro/\\_layouts/images/File/CNB%20SocFil%202012\(1\).pdf](http://www.patriarhia.ro/_layouts/images/File/CNB%20SocFil%202012(1).pdf).

<sup>18</sup> Figures counted by the author from <http://www.recensamantromania.ro/wp-content/uploads/2012/08/TS8.pdf>, 15.12.2012.

<sup>19</sup> As proved, for example, by the three years ROC, USAID, International Orthodox Christian Charities, and the John Snow Institute joint program “Strengthening Community-Based Initiatives in HIV/AIDS and Family Violence in Romania”. In the Final Narrative Reports of the program it is stated “The faith community is a key player in Romanian society. The Romanian Orthodox Church (ROC) [...] is a major driving force for changing perceptions, knowledge, and attitudes towards key social problems.” (Gasco, Iancu, 2007: 1).

<sup>20</sup> Law No. 489/2006 on Religious Freedom and the General Regime of Denominations (published in The Official Gazette, Part I, Issue No. 11 of January 08, 2007).

<sup>21</sup> Accessible at [http://www.patriarhia.ro/ro/opera\\_social\\_filantropica/biroul\\_pentru\\_asistenta\\_social\\_filantropica\\_2.html](http://www.patriarhia.ro/ro/opera_social_filantropica/biroul_pentru_asistenta_social_filantropica_2.html).

to grant the ROC a consultative role in the legislative design of the national social assistance-inclusion system, and to facilitate the valorisation of its philanthropic potential, including via its access to financing opportunities, the Church mainly committed to engaging its available human resources in the formation and evolution of the system, to furnishing the state with a better knowledge of the assistance-inclusion needs of the population, and to facilitating people's access to social programs and services and/or information about the same. The significant fact is that each party explicitly takes on responsibilities in the area that is the staple competence of the Church, i.e. the religious area, as follows: the state "has to offer optimal environments for the activity of spiritual assistance of the beneficiaries, in the centres belonging to the public providers of social services,... on condition that the fundamental human rights, and especially the religious freedom be respected", and the Church "has to offer professional spiritual counselling to the beneficiaries of social services that are rendered by public and private service providers". In a brief allocution after signing the convention, the Patriarch Daniel stated that "the major contribution of the Church must be the very act of highlighting the connection between the spiritual life and the social activity, between prayer, work, and generosity".

The protocol had no provisions as to its implementation mechanisms. In July 2008 however, a new step was taken, by the closing of a *Cooperation protocol with reference to the "Medical and Spiritual Assistance" Partnership, regarding the regulation of the actions enterprised in the health department by the Romanian Patriarchate in collaboration with the Ministry of Health*, whose stated goal was "a physically, psychically, socially and spiritually healthy community, through its increased awareness and involvement in acts of prevention and fight against health-endangering practices."<sup>22</sup> Within the normative framework set by the previous protocol, the current goals aim specifically at the development of a healthy lifestyle and environment, the prioritisation of certain joint programs that target vulnerable social and medical categories of people, and especially the development of an "integrated system of medical, social, and spiritual assistance". The last idea is frequently mentioned, yet never presented as original, for the text gives the impression that we are dealing with a reality that is at least inchoative. It is so daring however, that the official documents of the social-philanthropic service of the ROC (e.g. the annual public reports of this service), and the ensuing legislative initiatives, such as the highly contested and at present, re-evaluated *Law regarding the partnership between the state and the religious groups in the field of social services*, do not mention it anymore. The *Law of social work* also avoids adopting such a perspective in the paragraph that could have included it most naturally. In Art. 5, the *Law* reads that one of the principles the national social assistance system is founded on, is "the complementarity and integrated approach, according to which, the social services must be correlated with all the needs of the beneficiaries and rendered alongside a larger spectrum of measures and services in the economic, educational, health, cultural, etc. fields. In order to do that, the system must ensure that the persons reach their social functioning potential, as full members of a family, community and society."

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<sup>22</sup> The Protocol is available at [www.patriarhia.ro/\\_layouts/images/File/1216886201076490400.pdf](http://www.patriarhia.ro/_layouts/images/File/1216886201076490400.pdf).

In the absence of ulterior evaluations, it is difficult to appreciate whether or not this protocol is translated into practice. The most obvious activity done by the ROC within it, is the constant issuance of reports on sanitary education in the written and audiovisual media sponsored by the Church (the *Lumina* newspaper, *Trinitas* radio and TV station), which gathers professionals, and some members of the Romanian Orthodox Doctors and Pharmacists Association. Furthermore, many sanitary and social units have built-in chapels, and approximately 350 priests provide religious assistance in hospitals, psychiatric included, social institutions, and penitentiaries, yet this activity made its début in the early '90s. Then again, it is difficult to state that the care rendered to beneficiaries is truly integrated, in the sense stipulated in the *Law of social work*, as the services are actually provided independently. The situation in which a pluridisciplinary team - that includes a religious assistant - ensures the integrated approach of all the patient's needs, in the form of case management, belongs to the palliative care realm, whose hospice-like system has recently started to expand in Romania, too.

A second suchlike case that is of interest to us would be that of services rendered to dependent persons. The "*Medical and Spiritual Assistance*" *Partnership* protocol specifies in this sense that "the prevention of health alterations through health and religious education aimed at embracing a healthy lifestyle; the decrease in the consumption of health-endangering products like tobacco, alcohol, drugs, etc.", "the local community representatives' and members' increase in awareness and active involvement in finding solutions to the health problems of the community members, especially of those socially vulnerable, through: ... the conjoint advancement of some integrated care programs (medical, social and religious) within the community, for *the addicted persons* that suffer from chronic or terminal illnesses" (my emphasis). Again, there is but little data available as to whether the partnership has, in this respect, moved further from the stage of good intentions. In the psychiatric clinics and the hospitals that provide services to addicted persons and have a chapel, religious assistance is by all means available to all those patients who are interested. There is a set of social and philanthropic services sponsored by the ROC that have alcoholics and other addicted persons as beneficiaries (see above). At present though, the Church is not involved in any addictions related program done in collaboration with the Ministry of Health or its subunits. Still, the ROC has tighter connections in this area with another state institution, that is, with the National Anti-drug Agency.

An initiative to set up collaboration between the ROC and the NAA seems to have belonged to the latter. In 2004, one year after its inauguration, the NAA sent a proposition to the ROC in order to establish a collaboration protocol between them<sup>23</sup>. Nevertheless, the ROC Synod declined the offer, and recommended instead that each bishopric set up some forms of cooperation with the county branch offices of the NDCA, and that has already happened. The NAA's interest in and offer of cooperation with the religious institutions have been restated for that matter in the *National Anti-drug Strategy for 2005-2012*, enacted in January

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<sup>23</sup> The information comes from an interview with Ciprian Cămpineanu, Bishop-assistant for the Patriarch in charged with the socio-philanthropic activities of the ROC (Aniculoaie, 2010).



2005, where they make the following provisions in the “Community prevention” chapter: “the initiation and implementation of some adequate local community projects and programs, for the consolidation of the civic, cultural and *spiritual* education, which is a *healthy alternative lifestyle; the pursuit of abstinence* in the case of drug consumption, alcohol and tobacco included; the promotion of a *social climate where no drug addict would feel stigmatized or cast out*” (Chapter II.1, paragraph C, my emphasis). The same provision was reiterated in the *Action Plan for the Implementation of the National Anti-drug Strategy for 2010-2012*, according to which, the above quoted objective of the Strategy would be accomplished by December 2012, via “the development of a national network of volunteers concerning the prevention of drug consumption, the consolidation of a civic education and the promotion of a healthy alternative lifestyle”, and by “a general community targeted awareness raising /educational project regarding the alcohol consumption and/or tobacco use at a national/regional/local level”. Although the non-governmental partners that are responsible for this objective are but generically mentioned within another objective, namely “The initiation and implementation by the local public administration, of some public/private, partnership projects that are of local concern, in order to protect their communities, with the aid of the regional centres concerned with the prevention, evaluation and drug-control counselling, and of the National Youth Agency”, there is a reference to “The realization of at least one local/regional project on the general prevention of drug-consumption, in partnership with the Romanian Patriarchate, the Roman-Catholic Church/religious cults/religious organizations” (my emphasis).

It is true that the NAA annual reports of self-evaluation and on the state of the country contain a few references on its collaboration with religious organisations, without having the ROC named directly (except for the last report, in 2012). This is particularly done in the field of prevention - it mentions over 40 partnership projects existent between 2005-2007, that were signed with denominations and NGOs approved by the Church (NAA, 2008: 35) - and in the field of professional competences training, which targets the activities done with consumers and “the provision of integrated services”, as one report writes (NAA, 2007: 37). *Even though a statement, such as “the National Anti-Drug Agency and the Centres for the Anti-Drug Prevention, Evaluation and Counselling have paid specific attention to one of the most important institutions in the local communities, i.e. to the religious denominations”, is time and time again restated in these reports* (NAA, 2008; NAA, 2012: 6, 56), *the latest projects under debate, regarding the National Anti-Drug Strategy 2013-2020 and Action Plan for the Implementation of the National Anti-Drug Strategy between 2013-2016, do not seem to confirm this “distinction”. The Strategy makes only a note of having any denominations (ROC included) as partners in the civil society, and the Plan mentions them twice, in name only, once within the “prevention in schools” objective, and the second time under “the development of interventions for the Romanians who work abroad”.*



## Conclusions

In October 2012, the NAA organised, in collaboration with the Archbishopric of Sibiu, a national anti-drug Symposium under the title “Pro people, closer to God”. Its press release stated that the event was just another in a series of joint efforts, that its target was “to contribute to the optimisation of the cooperation between the main actors involved in the fight against drugs”, and that it “highlighted the need to establish a nationwide anti-drug collaboration protocol between the National Anti-Drug Agency and the Romanian Patriarchate.” <http://www.ana.gov.ro/stire77.phpt> Whether such an event is imminent or not, we cannot say. Neither can we state the contents of the collaboration. Meanwhile, in November 2012, the NAA announced the closing of a collaboration convention with the ROSAAC federation, a coalition of eight Neo-Protestant associations, with a note worth mentioning, that “the specialisations and responsibilities of the two partners [...] are complementary within their joint effort to reduce drug consumption and further the assistance services rendered to drug consumers in Romania”. In that respect, it referred to “the practical experience that the ROSAAC Federation has regarding the prevention of drug consumption and the assistance provided with the purpose of reaching and maintaining complete abstinence, both through outpatient and inpatient treatment services” [[www.ana.gov.ro/stire87.php](http://www.ana.gov.ro/stire87.php)]. For that matter, ROSAAC is managed by a Dutch instructor who comes from the well-known Foundation De Hoop in the Netherlands, which is an Evangelical Christian organisation that has contributed, via a partnership with the NAA, to the training sessions on addictions offered throughout Romania all this time. Or, the De Hoop approach combines the medical approach (somatic-cognitive-affective) with the moral Christian one, which is based on personal responsibility (Abraham, 2004). Here is a proof that the need for spiritual intervention is both acknowledged and unmet within the SUD health care system in Romania.

The image that the above investigation presents to us is one of a relationship that is necessary, possible, desired, initiated, yet elusive. The likely causes of this uncertainty require a special analysis. The NAA has just passed through almost two years of institutional uncertainty, as it has temporarily been under the jurisdiction of the General Inspectorate of Police. At present, the Agency seems preoccupied with re-establishing its position as the central institution in the SUD system, and with designing the national policies for 2013–2020, in accordance with this status. The ROC also appears preoccupied with expanding its organisational potentiality throughout the country, so as to become the most important partner for the state in the field of social inclusion. In this respect, the development of a minimum of viable programs and services may be recognised as a preliminary for any partnership. Considering the way the *Internal regulations of the social-philanthropic assistance in the ROC*<sup>24</sup> is formulated - in a centralised top-down type of view -, wherein the parochial level seems the least important of all (Art. 18: “The social assistance may be stretched at parochial level, *too*”, my emphasis),

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<sup>24</sup> Available at [http://www.patriarhia.ro/ro/opera\\_social\\_filantropica/biroul\\_pentru\\_asistenta\\_social\\_filantropica\\_3.html](http://www.patriarhia.ro/ro/opera_social_filantropica/biroul_pentru_asistenta_social_filantropica_3.html)

the institutional centralism appears to be the ROC's paradigm in the social field. However, the main resource for the recovery of persons suffering from SUD is most probably distributed at local communities' level.

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