WHO Mission to Lithuania:

Assess the challenges
to implement the mental health strategy

15th-18th of May 2007

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WHO mission in Lithuania

1. Overall objectives of the mission

1.1 This mission took place at the request of the Minister of Health of Lithuania following the drafting and adoption of a National Mental Health Strategy. The main objective of the mission was to support the Ministry of Health in its task of preparing an implementation plan for this National Strategy. WHO was asked to assess the current status of the mental health system and to support national experts in identifying priorities for action and mechanisms for their implementation.

1.2 The Terms of Reference of the mission were:

1. Define the most appropriate model of community services in the light of the new mental health strategy.
2. Advise on workforce and resource issues.
3. Identify health finance and other health system obstacles and suggest solutions.
4. Advise on implementation mechanisms.

1.3 The members of the mission comprised of:
Dr Matt Muijen, Regional Adviser, WHO Europe.
Professor Thomas Becker, Professor of Psychiatry, Ulm University, Guenzburg/Ulm, Germany
Mr Stuart Bell, Chief Executive of the South London and Maudsley NHS Foundation Trust,
Ms Ionela Petrea, Technical Officer, WHO Europe

2. Meetings and visits

The members of the mission met the following people during the visit:

- Minister of Health, Rimvydas Turčinskas with participation of the Secretary of MoH Romualdas Sabaliauskas and Robertas Petkevicius from WHO Country Office.
- Heads and specialists of Department of Public Health and divisions of Personal Health and of EU Support incl. Dr Audrius Sceponavicius, Director of the Public Health Department.
- Representatives of the Ministry of Social Security and Labour.
- The chairman of Committee on Health Affairs, Antanas Matulas, and members of the committee of the Seimas.
- Director of the State Mental Health Centre, Dr. Ona Davidonienė.
- Prof. of Vilnius University, Dr Dainius Pūras.
- State Patients' Fund at the Ministry of Health, (Compulsory Health Insurance Fund) Dr Jelena Kutkauskiené, Deputy Director of Medicine.
- Strunos Boarding House in Kaunas region.
- Mental Health Centre of Kaunas Municipality, Vida Matulioniené, Chief of the Kaunas Mental Health Centre.
- Senior staff of The Republican Vilnius Psychiatric Hospital.
- Heads of Hospital of Kaunas University of Medicine (Kaunas University Hospital).
- Department of Psychiatry of Kaunas University of Medicine.
- The President of the GP association, Prof. Leonas Valius.
- The President of Lithuanian Psychological Association, Mr Robertas Povilaitis.

- Institution of the Controller for Protection of the Rights of the Child of the Republic of Lithuania and the meeting with the Controller for Protection of the Rights of the Child of the Republic of Lithuania: Rimantė Šalaševičiūtė.
- Telephone psychological aid service “Vaikų linija” (children’s line).
- Robertas Povilaitis, President of Lithuanian Psychological Association.
- Meeting with the leaders and members of a mental health care users’ NGO.
- Robert van Voren, General Secretary, Global initiative for Psychiatry.

3. National Mental Health Policy

3.1 The national mental health policy is an inclusive and comprehensive document based on the WHO Mental Health Declaration for Europe, which was endorsed by the Ministers of Health of the European Region in Helsinki in 2005. The national policy covers a wide range of principles, priorities and recommendations. The principles of the policy are stated in section 22 of the document, as follows:

22.1. A special focus on human rights of mentally disabled persons;
22.2. Modern services which meet the needs of the patients;
22.3. A balance within a development of a bio-psycho-social model;
22.4. Support of principles of autonomy and participation;
22.5. Cases of common mental health disorders should be managed by primary and other non-specialist care sectors;
22.6. Mental health promotion and prevention of mental disorders should become an integrated part in the implementation of general health, education and social welfare policies;
22.7. Strengthening of the role of patients and non-governmental sector.

3.1.1 The policy recognizes the centrality of mental health for pubic policy and requires that action is taken in education, social security and other health sectors at national level (by the government), at local level (by municipalities) and at EU level.

3.1.2 The document acknowledges that mental health promotion and prevention of mental disorders is an integrated part in the implementation of general health, education and social welfare policies. A set of priority programmes are identified, which include programmes aimed at preventing suicides, alcoholism, drug addiction and smoking; programmes that promote mental health of children and old people and programmes aimed at promotion of mental health in workplaces.

3.1.3 The policy supports provision of services in the least restrictive environment. It promotes modern mental health services with community-based services at their core, focused on meeting the needs of patients. It requires that long term institutional care is only provided to people with severe mental disabilities, whose complex needs cannot be met by the community-based services. Building on the foundation of the existing network of community mental health centres (established in 1997), the document requires that managerial and financial mechanisms are put in place to address the challenges faced by these centres and to increase the range of services provided by them. Additionally, the document recognizes the role of primary care and other non-specialist care sectors in providing treatment and care for people with common mental health disorders that do not require specialist interventions.

3.1.4 The policy emphasizes that equal importance should be given to biological, psychological and social factors in the planning process and that resources are distributed equitably for interventions in each of these areas. Services are given the responsibility to cover all five components of mental health care: pharmacotherapy, psychotherapy, psychosocial rehabilitation, occupational rehabilitation and housing.

3.1.5 In order to implement the proposed model of mental health treatment and care, the policy identifies as one of its main priorities the creation of mechanisms for financing the modern services as outlined in the strategy and requires all sectors involved to contribute to the development of these services. Funding gaps are identified and some possible sources of funding are indicated (e.g. EU structural funds).

3.1.6 The policy also requires that human rights of mentally disabled persons are protected and monitoring is in place. The document acknowledges the need to strengthen the role of patients and the non-governmental sector. In particular, the policy calls for their involvement in the decision making process on issues relevant to their care and for partnerships between service users and health professionals.

3.1.7 While the comprehensiveness of the policy document generated a good national consensus and opened opportunities for action in various areas, there is a need to prioritize actions that are to be implemented within the next 3-5 years. This needs to be incorporated in the national programme for implementation that is currently being developed by the Ministry of Health.

3.1.8 The policy, produced at the request of the Minister of Health, received strong political support, and was adopted by the government and the Seimas.

3.2 The Health Commission of the Parliament

3.2.1 The Health Commission of the Parliament is strongly committed to the mental health policy. They have been actively involved in the development of the mental health strategy, and express strong support for its implementation.

3.2.2 In the view of the Commission for Health of the Parliament, the main priorities of the strategy are:

- The deinstitutionalization of mental health care;
- The integration of the public health (promotion and prevention) and specialist health services (treatment and integration); and
- The involvement of primary care doctors in mental health care.

3.2.3 Their vision for the next 5 years is that there will be not remain any large mental health hospitals; that people with mental health problems are integrated in the community; and that GPs provide care to many patients with common mental health problems such as depression and anxiety.

4. Financing

4.1 Generation and distribution

4.1.1 In Lithuania there are four main sources of funding for mental health: the state budget, the national programmes of the Ministry of Health, the municipalities' budget and the Sickness Fund. Funding for research comes from the Ministry of Health and the Ministry of Education.

4.1.2 During the last year, the state budget and the budget from the municipalities accounted for 25 % of all funds, both tax generated. There are no budgetary links between the Ministry of Health and the municipalities. Some of the funds for the public health bureaux are passed down to the municipalities such as national health programmes incl. environmental programmes. They account only for these projects to the Ministry of Health. There is a wish to establish some element of financing health care at municipality level. If this would happen, they would report to the Ministry of Health based on agreed activities. Municipalities would be able to choose their priorities. It will be their decision to determine the priority and investment of mental health activities.

4.1.3 The Sickness Fund

4.1.3.1 The Sickness Fund guarantees by law the provision of personal health care services, covering prevention, treatment and rehabilitation, but not long term social care. The staff of the Sickness Fund consists of 80 employees at national level and 400 employees at local level.

4.1.3.2 The Sickness Fund mental health budget for 2006 was Lt. 247m, distributes as follows: 39% for hospital care (mental hospitals and psychiatric beds in general hospitals), 19% for community mental health centres, 14% for mental health care in primary care services, 2% for mental health prevention programmes and 36% for psychotropic drugs (representing 17 % of all medicines).

4.1.3.3 In the future, it is expected that salaries in health will increase, and that some structural changes in expenses distribution will take place – more funds will be allocated to salaries. The cost of medicines is also expected to continue to rise both as a result of price inflation and increased uptake of medications.

4.2 Funding of mental health services

4.2.1 In primary health care the payment is per capita from the Compulsory Health Insurance Fund's budget through the territorial patients' funds (for Mental Health Centres 9.4 Litas per capita/per year from the 1st of May 2007).

4.2.2 Consultations with specialists in hospital are free of charge if referred by primary care. Such consultations are covered by the Compulsory Health Insurance according to Ministry of Health certified tariffs. If a person does not have a referral he/she has to pay himself/herself.

4.2.3 Payment for inpatient services is based on the average cost for each diagnosis for the first stay. For readmission within 1 month, the payment is done based on the number of days. Stays of over 52 days are no longer covered by insurance, and hospitals, or individuals, are liable for the costs.

4.2.4 Funds earned by inpatient care can now be used for outpatient care – a system put in place that makes it possible for hospitals to develop alternative services to hospital admission. However, due to limited availability of alternative mental health services outside hospitals (in the

community), this opportunity is rarely used in mental health to date. Currently, it is mainly used by district general hospitals for treatment of somatic disorders. It is not clear how hospitals would be reimbursed if they develop alternative services that do not use beds, such as crisis services or day care preventing admissions. This is a disincentive for the creation of community based services.

4.2.5 Cost of psychotropic medication

Psychotropic medication is 100% free in hospitals. In Outpatient care system, according to a list approved by the Ministry of Health, medications may be reimbursed 100 %, 90 %, 80% or 50 % by the Sickness Fund. For patients with schizophrenia and schizoaffective disorders, all psychotropic drugs (including all new anti psychotics) are covered 100%, for severe depressive or bipolar affective disorder 80%, for organic psychoses 50 %. Difference in price must be covered by the patient. If medication is not on the approved list, the patient has to pay full cost. Expenditure for medicines is increasing, with an average yearly increase of 15-17%.

4.2.6 Psychotherapy

If prescribed by a psychiatrist, the Sickness Fund could cover up to 24 psychotherapy sessions per year per patient according to Ministry of Health certified tariffs.

4.2.7 Cost and Volume

While the cost for services is established by the Ministry of Health, the volume of services is negotiated by the Fund with the provider. The volume of services is relatively stable, but the total expenditure increases constantly due to increase in prices. Both the proportion of readmissions and the length of stay are going down, possibly in response to financial incentives described above.

4.2.8 Priorities in mental health

From the Fund's perspective, there are no major problems in the area of mental health. They believe there is a good availability of mental health services. They perceive a need to improve the quality and skills of staff, to expand the list of services offered and to increase the responsibilities of nurses and the role of social workers.

4.3 EU Structural Funds Support to Health Sector in 2007-2013

4.3.1 The commitment of the Ministry is demonstrated by the allocation of a proportion of the EU structural Fund to mental health care. Investments will be made according to the Operational Programme for Promotion of Cohesion for 2007–2013. The main objective is to provide high quality and accessible health care services.

4.3.2 Investments in health will be concentrated on two main areas:

4.3.2.1. Improving health care activities and reducing morbidity and mortality rates from non-infectious diseases (reduction of morbidity and mortality from cardiovascular diseases; early diagnostics in oncology and completion of treatment; reduction of mortality and disability due to injuries and other external causes of death; optimization of mental health care service infrastructure);

4.3.2.2. Continuity of the health care system reform and optimization of health care infrastructure (reorganization of outpatient care; optimization of inpatient services; development of public health care).

4.3.2.3 Within this overall health agenda, four directions of action have been identified for mental health:

4.3.2.3.1 Establishing mental health outpatient and community centers *(up to 20 such centres)* close to already operating municipal mental health care centres and providing them with appropriate facilities and required equipment. The main aim is to increase the accessibility of such services. Budget is LTL 60m.

4.3.2.3.2 Modernizing of inpatient psychiatric level: equipping premises of acute inpatient psychiatric hospitals with contemporary special care devices and providing them with required medical equipment *(5 hospitals and also 1 forensic psychiatric hospital).* Budget LTL 20m.

4.3.2.3.3. Developing and establishing Crisis Intervention centres *(5 centres in the biggest cities of Lithuania).* The main aim is to ensure as immediate a service as possible to a patient in crisis that may disturb mental health, psychological well-being, social functioning and adaptation. Budget is LTL 15m.

4.3.2.3.4 Development of specialized mental health care services for children and teenagers with mental and behavioural disorders and establish integrated day centres for child and family support *(5 inpatient centres in hospitals).* The main aim is to provide treatment of mental disorders of children and prevent suicide, delinquency and addiction to alcohol and drugs. Budget is LTL 15m.

5. Public Mental health

5.1 The Department of Public Health has 10 staff in the ministry and coordinates the work of 10 specialized institutions, one of which is the State Mental Health Centre.

5.2 Currently, there is one public health specialist per 10,000 heads of the population. Main public health issues related to mental health that were identified by the ministry of health are suicide, bullying, alcohol consumption and drug addiction.

5.3 Municipalities are responsible for education, monitoring, public health programmes, and special events in the area of public health. The main person in charge of the implementation of the mental health strategy at local level is the medical officer who is responsible for health care and public health at municipality level. The level of training of MDs at municipality level varies significantly, with gaps in competence and training needs recognized.

5.4 The specialized institutions advise the public health units at municipality level. Currently, there are 4 such public health units in the country.

5.5 There are about 800 public health specialists who mostly work in schools. They are typically nurses. A small proportion have an MPH; most have either short term (40 hours) or longer term (200 hours) training in public health.

5.6 Role of the State Mental Health Centre

5.6.1 The Centre has been an independent institution since 1999. The Centre reports to the Minister of Health and to the 2 secretaries of state who have responsibilities related to mental

health (the secretary of state for public health and the secretary of state for health care) on their respective areas.

5.6.2 The activities of the State Mental Health Centre cover mental health, alcohol, drugs, and tobacco control. In the Centre, there are no assigned specialists for suicide prevention and the number of staff committed to mental health service delivery is low.

6. Mental Heath Services

Mental health services are delivered by a mix of providers, still heavily dominated by large mental health hospitals.

6.1 Primary Care

6.1.1 The role of GPs is crucial, since it can be estimated based on international epidemiological research that 25% of people attending primary care will be suffering from a mental health problem, mostly depression and/or anxiety.

6.1.2 General Practice is a relatively new speciality in Lithuania since the reform of the old Soviet District Doctor Model in 1997. Between 1997 and 2003 intensive retraining took place, lasting 18 months. Recently developed primary care residency training lasts 3 years of which about 6 weeks is committed to mental health. At present the new model covers about 70% of the primary health care. The Ministry of Health plans to increase the coverage by GPs to 100% by the end of 2008.

6.1.3 Primary health care in Lithuania is organized mostly in large municipality-owned outpatient clinics called polyclinics. Even though the number of private primary health care providers in the period of 2002-2004 increased 4 times, they still form a minority of provision.

6.1.4 A primary health team consists of GPs and nurses attached to their offices. Consultations are free for all insured patients registered with a GP from their catchment area, since GPs receive capitation funding.

6.1.5 According to secondary legislation adopted by the ministry of health, GPs have the right to diagnose and treat (including the prescription of anti-depressant medication for a period of 6 months) people with mental health problems. However, if GPs prescribe antidepressants, patients apparently are not compensated. They can refer patients to specialist mental health services either in primary care (Mental Health Centres) or secondary care (district general hospitals or mental hospitals).

6.1.6 In spite of the legislative framework allowing GPs to diagnose and treat people with mental health problems, GPs are reluctant to become involved in mental health care. One reason is the fact that older GPs (who currently constitute the majority of the GPs in the country) did not receive adequate training in mental health and have little or no interest in dealing with it. Another reason is the many other responsibilities of GPs, including the heavy burden of administration they reported to us. The consequence is that in reality GPs do not act as gatekeepers for specialized mental health services, and many patients are directed or self-refer to the specialist services even before the consultation with the GP. This is enhanced by the stigma of mental illness and the low confidence of many people in primary care.

6.2 Community mental health services based in primary health care

6.2.1 Specialist community mental health services are typically placed within polyclinics and are part of their administrative structure. Most patients have their first contact with services at this level through self-referral, although some patients are referred by GPs.

6.2.2 Larger primary care units contain mental health centres under the same roof, separated but working together. Smaller primary care units experience greater difficulties, since mental health centres will be based in separate units, without any direct connection.

6.2.3 The services provided and the staff mix varies significantly across centres. Most centres act as small psychiatric offices, with one psychiatrist providing consultation, and a nurse who serves mainly as a receptionist with little or no involvement in direct provision of care. Some centres manage to develop excellent services in these settings (e.g. the mental health centre in central Kaunas, see box below). They employ a mix of mental health staff (psychiatrist, nurses, occupational therapists, social workers, psychologists) and provide a broader range of services (including day care and exceptionally some form of crisis intervention).

6.2.4 All primary care centres in the country receive the capitation funding, and the minimum of 7% of primary care funding committed to the mental health centres is compulsory. Centres can apply for additional funds from the national programmes of the Ministry of Health. If they succeed, they can further develop the services provided.

6.2.5 A challenge for the mental health centre is that they do not hold their own budget, but the director of the primary care centre is the budget holder. This leads to great variety across centres, and depending on the relationship between the mental health centre and the director of the polyclinic, it has implications in terms of the services provided by the centre, the mix of staff and connection with secondary care services.

6.3 Hospital Services

6.3.1 Mental hospitals remain the main provider of mental health services in the country. Reportedly 45% of the total mental health budget is spend on inpatient care. General district hospitals provide both outpatient services and inpatient services (22% of all inpatient services). The length of stay has decreased significantly in the last years Average stay was 64 days in 1991 and 32 days in 2001.

6.3.2 The number of beds is 2637 (dropped from 5380 beds in 1991). Hospitals have been built from the beginning of 20th century until 2005 (there has been some new building of mental hospitals) and almost all have seen some renovation.

6.3.3 Conditions in facilities visited varied. Some recently renovated rooms for acute patients were modern and attractive. Rooms were very basic and in a poor condition in wards for severely ill patients. The number of patients per room varied between 2 and 6. Wash sinks and toilets are constantly available; showers and baths are available at regular intervals. All are reasonably clean. Patients admitted to hospitals are provided with personal lockers (though visit to facilities showed that in many wards, particularly in those with severely ill patients, the lockers did not work), gowns, coats and slippers or they can wear their own clothes. A concern is that conditions are poorest for those with the highest level of dependence.

6.3.4 Services provided

6.3.4.1 Mental hospitals admit people referred by GPs, the primary care mental health centres and the district general hospitals. Additionally, the hospitals accept emergencies and self-referred patients or patients referred by family members, who can access the hospital directly.

6.3.4.2 In the last years the trends show a decrease in the length of stay in mental hospitals, with very few cases staying over the total period covered by the Sickness Fund for each disease.

6.3.4.3 Mental hospitals offer a wide range of services, from sophisticated emergency care for people with alcohol disorders, to psychiatric care, counselling and psychotherapy and occupational therapy. Hospitals are only very exceptionally involved in providing specialized services in the community (e.g. crisis intervention), and we detected very little interest in developing in this direction. We only heard of such a centre in Vasaros and Kaunas.

6.3.4.4 Patients are discharged and receive a prescription for medication for 30 days. After this period they are expected to attend the psychiatrist in the primary care setting. There are no community services that facilitate early discharge and prevent readmission of vulnerable patients.

6.3.5 Staffing

The staff working in mental hospitals include a high number of psychiatrists (8.5 per 100 patients), a relatively low number of nurses (30 per 100 patients) and some psychologists (2.5 per 100 patients).

6.3.6 Financing

Hospitals are funded on a tariff based on an admission of 52 days, beyond which the hospital carries the risk. Savings can be reinvested. Readmissions within 1 month are paid per hospital day up to a maximum of 52 days. Current legislation allows hospitals to use their funds for services in the community, which gives the opportunity for hospital managers to develop or contract services such as day care, crisis intervention and home treatment. However, reimbursement of patients treated in crisis services with the aim to prevent admissions is not currently agreed, which is a disincentive. There are also no financial incentives for the hospital system to provide long term community support for people with long term mental health problems at high risk of relapse.

6.4 Social Care Homes

6.4.1 The responsibility for providing services for people with disabilities is shared between the Ministry of Social Affairs and the municipalities. The former is responsible for the provision of services for people with high level of disability, while the latter is responsible for providing services for people with medium/low level of disability and for older people.

6.4.2 Since January 2007 funding has shifted from the State to the municipal budget. All services are in principle contracted on the basis of tendering, creating incentives for municipalities to establish a mix of providers based on the needs and the preferences of the clients. Transferred money to the municipalities is not ring fenced. Spending of municipalities varies between 1-7% of their budget.

6.4.3 Most long term care is still provided in large social care institutions. Many of their facilities, county owned, have been recently renovated, with decent living conditions and good hygiene and central heating. In the visited institution rooms had 2-4 beds, with one leisure room assigned to a unit of 20 people. Residents had their own lockers and a wardrobe for clothes.

6.4.4 Most patients admitted to these facilities have severe and persistent mental disorders (mainly psychosis), learning disabilities or neurological disorders. Most of them have a history of repeated previous admissions to hospitals. They are referred to these facilities by social care departments at the level of municipalities, on the basis of assessment of their disability. Institutions have long waiting lists (people typically wait in the hospital or at home). For example, the home we visited had a capacity of 225 beds and a waiting list of over 100 beds. This raises questions about competition and supply.

6.4.5 The majority of the staff are care staff. Institutions employ a small number of physicians, psychiatrists and dentists, typically on part-time basis.

6.4.6 Care is very institutionalised, as can be expected in places of this nature and of this scale, with a low level of activity, since employment opportunities are no longer available.

6.4.7 Patients referred to social care institutions do presently not have alternatives to choose from in the communities where they live. Most patients remain in these institutions for the rest of their lives.

6.4.8 The large institutions are placed in small communities (typically rural areas) where most people living in that community are employed by these institutions – closing down such an institution would have a significant impact on the economy of the local population, and there are therefore strong reasons to preserve the status quo.

7. Strengths and Challenges

7.1 The mental health care system and public health activities have developed impressively over the last 15 years. There are many aspects of the system Lithuania can take pride in. Inevitably, the development of the components of the system has created demands which require some adjustment. In addition, mental health care internationally has continued to evolve towards decentralization and care in community settings, with a greater emphasis on prevention and greater flexibility of roles. This is recognized well in the new Policy, and this implies some reconsideration of the status of the present system and direction of travel.

7.2 Policy

The Seimas has approved a very comprehensive and forward looking document that should move Lithuanian psychiatry in the direction of an evidence-based and modern model of community based mental health care in line with other countries the European Union. The Policy is a bold and comprehensive high level document, setting out ambitious aims across the range of prevention, treatment, care and public policy. It does not however set out the detail of how it might be implemented. There are plans which have been developed to support implementation of the strategy, notably the investment of infrastructure funds identified by the Ministry of Health. The picture of implementation is not however complete, and we see significant risks to the strategy which need careful mitigation plans to be developed. The creation of a clear performance framework identifying the tasks and responsibilities for implementation at every level of the system, and the allocation of leadership roles (together with support and

development arrangements for those leaders) should improve the chances of successful implementation and enable much better tracking of how it is going.

7.3 Addressing primary care challenges

Lithuania has been active in reforming the roles and training of its primary care staff, moving decisively from the old specialist model to a generic model with the aim to complete this transformation by the end of 2008. This generic model requires education and (re)training that incorporates many different areas of expertise, including the identification, assessment and treatment of mental health problems. Particularly identifying and treating depression is crucial, which can be expected to be present in about 25% of attendees. The success of any mental health plan will depend on the role of primary care staff to function as gatekeepers, only referring people with severe mental health problems to specialist staff.

7.4 Community services

The existence of community mental health services is an asset. In Lithuania, unusually, they are a component of primary care based in polyclinics. In reality their scale and functions are often limited to diagnosis and prescribing, comprising a psychiatrist and a nurse only, without any capacity to offer outreach or coordinate social care. There are nevertheless significant opportunities for the development of community based services inherent in this structure. The service in Kaunas described above illustrates what good leadership and financial support can achieve.

There are distinct advantages in the location of community based mental healthcare facilities in generic settings such as polyclinics, both in terms of ensuring adequate physical healthcare for mental health service users and also in reducing stigma. The principal disadvantage of this arrangement is not so much to do with the location of services, but rather the way in which funding for mental healthcare is constrained within an envelope which must provide for all the needs of the population covered by the polyclinic (typically around 40,000) but which has no relationship with the funding for secondary, hospital based mental health services. Thus increasing the extent or the scope of mental healthcare in a polyclinic must be at the expense of the other services provided there, with no compensating income from the hospital sector, even though better polyclinic services might result in reduced need for hospitalization or shorter length of stay and savings therefore reduced hospital costs. This fundamental disincentive to change must be tackled.

7.5 Hospital modernization

Inpatient care is provided in psychiatric wards of general hospitals and in a number of large specialist psychiatric hospitals. The average length of stay has decreased significantly during the last years. The facilities we visited were mostly of a reasonable standard, at best spacious, well maintained and with significant medical staff cover. However, the variation of quality was of concern, some wards being in poor condition, particularly those housing the most dependent and vulnerable. While there was scope for the hospital sector to offer alternatives to hospital admission, there were few incentives – they would not be rewarded for it even though the overall costs to the healthcare system might be reduced – and while they were performing well at reducing length of stay for the majority of patients, for some the fixed cut off point for funding created a situation where it became impossible to ensure continuity of care (particularly in relation to continuation of medication) again with risk of relapse and consequent readmission increasing overall costs. It was also noticeable that there was a greater interest in investment in individually attractive therapeutic projects, even in the absence of evidence, than whole system change.

7.6 Social care

Long term care is provided by institutions funded by the Social Security and Labour Ministry, which care for those with mental, physical and learning disabilities in the same place. We support the efforts of those institutions to increase the levels of privacy in living space and to create more homely conditions for their residents. The overall standards of the home we visited compared well with those of other former Soviet-bloc countries, although life styles were of a very institutionalised nature, well behind the expectations of social inclusion expected in EU countries. The large institutions are placed in small communities (typically rural areas) where most people living in that community are employed by these institutions. Breaking down of these institutions into smaller long-term care units remains a challenge, with a significant impact on the local population, and there are strong incentives to prevent it. A significant change has been the transfer of responsibility for the funding of these institutions to local municipalities. This offers the scope for greater local ownership of long term care, and the prospect of more focus of supporting people in community rather than institutional settings, but it will depend on local willingness to accord priority to this task, and so is at risk in the absence of strong national standard setting, regulation and performance management.

7.7 Public Health System

The training of 550 public health specialists with the aid of EU structural funds creates an opportunity to boost the capacity to raise levels of mental health promotion, but it is important to ensure that the resources available are carefully targeted and work with the grain of existing provision and priorities. Given the focus on young peoples' mental health for example there is scope to use these specialists in schools to pick up on some of the problems identified by the Children's Commissioner and the young people's telephone helpline, which though admirable in its approach, clearly lacked the resources to tackle the scale of the problem.

7.8 Structural Funds

The allocation of Structural Funds is an unique investment opportunity, and mostly their allocation is wisely chosen. Our only major reservation about the use of the infrastructure funds relates to the investment in CAMHS inpatient services. While it is clearly right that children should be a priority, nevertheless the investment in extensive CAMHS inpatient facilities seems disproportionate to the need to develop community based facilities and services for this group. Children are 25% of population, and so any inpatient response is bound to be at the end of a pathway of care that needs strong community response and capability. It is a good strategy to focus on supporting mental health in schools considering the high prevalence of bullying and substance abuse, and that is where we would have placed more priority.

8. Way Forward and Recommendations

8.1 Structure primary care-community services-hospital care

8.1.1 At present the mental health services comprise 4 semi-independent clusters of care: family doctors, community services in polyclinics, hospitals and social care homes. The first 2 services are capitation based (community services ring-fenced from the primary care budget), hospital care reimbursed on the basis of activity and social care homes now funded by municipalities.

8.1.2 Key are the roles of primary care and community services, now both directly accessible to the general public (as is to a lesser extent the hospital service, but since formal referral is required we ignore this pathway at this point). A decision will have to be made about what the core responsibility of community services should be: open access to anyone with any mental

health problem; or focus on people with severe mental illness requiring intense and often continuing care. If they are intended as the first point of open access to mental health care, they can expect to be overwhelmed by large numbers of people with depression and anxiety, requiring routine treatment, as is occurring now. Many people with more demanding conditions will be referred on to specialist services in hospital settings, without any early intervention and lack of continuity of care. In combination this is likely to result in unnecessary suffering, social exclusion and cost to individuals, their families, the health system and the national economy. If on the other hand, these services and their budgets were to be integrated with the hospital services, greater reliance will be placed on the ability of family doctors to identify and provide routine treatment for common mental disorders, referring people with severe an/or complex disorders to specialist services. In this scenario, family doctors, or family care, become the lynchpin of the system.

8.1.3 In the short term, the capacity, competence and inclination of family doctors are unlikely to be sufficiently comprehensively developed to entrust to them the role of gatekeeper and primary treatment point for mental disorders. However, the status quo, as described above, has created disincentives for hospitals to offer care alternatives to bed based services such as crisis care and home based services. The new National Mental Health Strategy promises a different approach.

8.1.4 It is therefore suggested that community psychiatrists should remain based in community settings, working closely with family doctors. However, we propose, initially as a pilot-programme in a few settings, the transfer of the management of community mental health services to specialist mental health services, accompanied by the transfer of funding. A suggested proportion is the equivalent of about 75% of the capitation funding for mental health care to the hospital budget. This money needs to be ring-fenced, and hospitals will be expected to develop community services to incorporate primary care support services, crisis care and home treatment services. This should gradually include the development of day services. To ensure that this produces the desired results clear targets for the change should be set, and performance management systems set in place to account for progress.

8.1.5 Essential is that access to community services is only by referral from a family doctor. Family doctors could invest the other suggested 25% of the present capitation funding to purchase support to deal with common mental health problems, either by employing support staff, or by commissioning support from specialist services.

8.1.6 This transfer of community based services to specialist services needs to be complemented by incentives in the hospital system to expand beyond providing beds and develop their community approach in order to avoid isolation of the community services in polyclinics. Some funding incentives are already implemented, such as the DRG system which permits hospitals to retain funding even after an early discharge. This will incentivize home treatment.

8.1.7 However, there are presently no measures to create crisis teams, since hospitals would have to fund them from their savings, as against other priorities, and do not make any financial gains as described above. In fact, under the existing financing scenario, they would incur a loss from developing crisis services, since such a service would be skimming off patients who presently are the main earners of hospitals, i.e. those only requiring brief admissions (but will instead be treated outside hospital by such crisis teams, not creating any income). Crisis services in Lithuania seem to be the realm of NGOs. We therefore support specific funding from the EC Structural Fund guaranteed by the Health Insurance Fund, earmarked to set up crisis teams.

Initially we advise such funding to be additional to the hospital budget, functioning as temporary bridging money and in order to guarantee the stability of the hospital during a transitional period of 3 years. Gradually costs can be incorporated by either adjusting DRG rates upwards but for a lower number of beds, since effective crisis teams will reduce the number of beds required but the lower number of beds will serve severely ill patients only (since less severely ill patients who are now admitted will be cared for by the crisis team outside hospital). Alternatively crisis services could be reimbursed for number of patients treated.

8.1.8 Specialist services should also be responsible for the continuity of care. We recommend that this will be the responsibility of the outpatient and community centres that are planned to be funded by EC Structural Funds. It is essential that these community centres prioritize people with severe and enduring mental disorders who are at high risk of regular breakdowns and hospital admissions, resulting in high suffering and cost to individuals, families and communities. Since such centres care for patient populations that require specialist services, funding should be part of the hospital system budget, possibly by earmarking special funding following the evaluation of benefit during the funding period by the EC Structural Funds.

8.1.9 There would also be added value by close links between crisis teams and community centres. Their functions are complementary, and indeed many of their patients will be the same. We recommend positioning these services in the same location wherever possible, under combined management.

8.2 Hospitals

8.2.1 We support the proposal to renovate some hospital infrastructure. We also hope that this will incorporate prison services for the mentally ill. On a previous WHO visit, the unacceptable and inhumane condition of prison care was observed, although we noted with appreciation plans to replace these cells. We hope that investment in hospitals will benefit the most dependent and vulnerable as a priority.

8.2.2 We are concerned about the role of hospitals as specialist but isolated treatment centres, accepting referrals and discharging patients at the end of their stay. Instead we hope that hospitals can become the hub of a seamless and integrated mental health system, at its core offering a service that combines crisis services, hospital care and outpatient and community centres based on the needs of the individual, as envisaged in the Strategy.

8.2.3 There appears to be no policy to strengthen general hospital psychiatry. They are involved in pathways to inpatient care and are involved in psychosomatic care, but we had little sense about their role. They would have potential as small scale hospital units serving the same catchment area as community teams, lowering stigma and strengthening the community-hospital interface. As such they should be expected and equipped to cope with a similar range of inpatient care as the psychiatric hospitals.

8.3 Child psychiatric care

As mentioned above, we support the investment in child psychiatry, well covered in the strategy. However, we were surprised by the emphasis on beds for children, already well provided in Lithuania, and hope this can be replaced by investment in community services for families.

8.4 Social Care

The shift of funding towards municipalities for the purchasing of accommodation for persons with long term mental health problems is an excellent initiative. We hope that a market of providers will develop. We are concerned that the social care homes will remain as a monopoly

provider, magnificent in their isolation and history, and providing an exclusive and secure livelong livelihood to residents and staff alike. These are perfect conditions for complacency and institutional practices. We hope therefore that social care homes will gradually shrink, admissions limited and if possible stopped and that providers can be encouraged to invest in small scale facilities in towns and villages.

8.5 Municipalities

Additionally, the Municipality has been given important new roles in the delivery of healthcare in Lithuania, both in relation to long term social care and to improving public health. Municipalities will therefore be key to delivering important aspects of the mental health strategy, and so it is essential that they are clear about the expectations and responsibilities placed upon them for the strategy to succeed. This requires the development of an appropriate performance management framework at national level which commands a national consensus and which distinguishes the respective roles of the Ministries of Health and Social Security, national health insurance organizations, Municipalities and local healthcare providers. The publication of comparative data on the relative success of individual municipalities in improving mental healthcare against an agreed baseline position would be a good way for the Ministry of Health to create incentives for them to afford the strategy priority and to ensure consistent implementation across the country by local government.

8.6 Workforce

A key area to be worked through in more detail for implementation of the strategy is a workforce and leadership plan. In part this is because of the major risk that the workforce issues pose, from wage inflation to skill shortages, to international competition. These must be described and plans made to mitigate them. Another aspect is the change in working practices and the increased flexibility and new skills required from psychiatrists, nurses, psychologists and other staff groups, working in a system that spans from home care to intensive hospital treatment. There are also major opportunities here, for example to train the workers who emerge from the investment programme with skills in modern and effective interventions appropriate to their roles, and to consider new types of jobs which help offset some of the pressures for increased costs.

8.7 Leadership, implementation and evaluation

8.7.1 Although everyone we talked to shared in the recognition of the problems, few were signed up to solutions. Part of the problem is the overwhelming comprehensiveness of the strategy, which can be de-motivating in the absence of a clear implementation plan. The other reason for the complacency is that many seemed relatively content with the status quo of the parts they are operating in, ignoring the problems of the system experienced by service users and carers. Finally, we noted the absence of leadership in mental health reform. Many agencies and individuals have a role in some part of the reform, but we found it hard to identify who 'owned and championed' the strategy. We are therefore concerned about the lack of clear responsibility for implementation**.**

8.7.2 Leadership is important – who will lead the impetus for change, and will they have the authority in the face of the inevitable resistance which for a variety of reasons (not all bad) all major change on this scale encounters? The implementation plan needs to specify who is responsible for that leadership, not just at national level, but in localities and municipalities, in polyclinics and in the hospital and academic sectors. Those leaders need to be supported and developed, and the opportunity to learn from each others experiences as the change progresses. In some respects this is the hardest aspect of strategic implementation to describe, but that is all the more reason why it is important to understand how it will work in practice.

8.7.3 We recommend the appointment of a national mental health director, responsible for the drafting of a national mental health action plan with the aim to implement the Strategy. This plan will include priorities including suicide prevention, need for new legislation, a workforce strategy, costing and a timetable. In order to be effective, the national director will be appointed by the Minister of Health, and given the task to lead on strategy development and implementation. The mental health lead will therefore be given the authority to plan and coordinate activities that relate to the national mental health policy, involving funders, psychiatrists, hospitals, family doctors, municipalities etc. He/she will be most effective working in an environment with resources that enables action. We therefore imagine that the national mental health director would be based in the State Mental Health Centre, but reporting directly to a person with senior responsibility at the Ministry.

8.7.4 We are aware that each country is unique, and although our assessment of the national policy and our recommendations are based on best evidence and experience, this does not guarantee successful implementation of all aspects of the policy in Lithuania. Some adaptations might benefit the services, and some national or local experiences might prove to be particularly effective or different in its impact from what was expected. It is therefore crucial that developments and outcomes are monitored, evaluated and disseminated, and that conclusions are drawn from these on a regular basis. Some resources should be made available for evaluation, and this process should fall under the competence of the national mental health director.

9. Conclusion

9.1 We believe that Lithuania has shown impressive progress in developing a mental health strategy, and is already initiating a number of exciting initiatives. Lithuania has the potential to become the model country in its part of the Region. We have therefore resisted from writing a report offering many dozens of recommendations, since they are already all described in the Strategy and are therefore endorsed. We have also refrained from detailed recommendations related to every aspect of implementation. These will need to be addressed at a later stage and will require national expertise and commitment, such as workforce planning and investment. Instead we have concentrated on the key messages that we believe address the major obstacles to deliver the National Mental Health Strategy.