The Deinstitutionalization of Lithuanian Mental Health Services in Light of the Evidence-based Practice and Principles of Global Mental Health

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Abstract. *During this time, in which Lithuania is going through the deinstitutionalization of its mental health services, the principles of Global Mental Health are especially relevant. This global field for study, research and practice places a priority on improving mental health outcomes as well as reducing respective inequities for all people worldwide. Scaling-up support services for persons who have mental health problems based on both scientific evidence and human rights has become one of the main focuses for action globally, and the key principles of Global Mental Health apply to the situation in Lithuania as much as they do in a number of other countries. This article explores the critical need to effectively reform the existing mental health care system in the country, which in its current form often results in human rights violations. It points to the idea, based on the global evidence base, that different Lithuanian authorities and other key stakeholders could start working together in an intersectoral way in order to reorganize mental health services from institutional to community-based models of care. It is suggested by this article that a sensible, local application of the broad key principles of Global Mental Health could be a mature and rational step taken by Lithuania. This has the potential to be a major step toward the improvement of human rights and mental health outcomes in the country.*
Keywords: *Mental health, human rights, deinstitutionalization.*

Introduction

The World Health Organization's (WHO) World Mental Health Survey has demonstrated that even though less prevalent than physical disorders, mental health problems and related conditions lead to higher rates of disability (Caldas de Almeida et al. 2013). Additionally, the "days out of role" due to mental health problems are a major source of lost human capital (Alonso et al. 2011). Hence, the effects of mental health problems and related disability result in having an impact not only on the quality of life of individuals themselves, their families and communities, but also extend to affect the economics of countries and employment rates, which further impact other related policies (Wang et al. 2011).

However, the prevalence of mental health problems, as proven by multiple epidemiological studies, far surpasses the availability of *specialist treatment* services, even despite the detrimental

manifold effect this has on a population. Moreover, there are studies consistently showing better outcomes worldwide in *community-based* services for individuals who have mental health problems or psychosocial disability. These studies show greater accessibility to care, protection of human rights, prevention of stigma (Thornicroft and Tansella 2003) and greater user satisfaction (Thornicroft and Tansella 2003; Killaspy 2007) when compared with other models of support, e.g., institutional care. According to Patel and Prince (2010), as an area for study, research and practice, Global Mental Health places a priority on improving mental health, related care and support availability and outcomes as well as on reducing respective inequities for all people worldwide. Generally, the Movement for Global Mental Health is described as a network of persons and institutions committed to close the significant treatment gap (Patel and Prince 2010).

The outdated and human rights violating mental health care system, rooted in institutional culture, one that perpetuates stigma, social exclusion, isolation, segregation and discrimination still exists in Lithuania, as it does in many other countries across the globe. The actual *implementation* of the country's modern Mental Health Strategy (2007), the action plan and its related programs are currently ineffective (Puras et al. 2013). Major efforts are required in order to generate political commitment and support for this matter. Currently expressed political, institutional and budgetary commitment, as per concepts described by Caldas de Almeida et al. (2013), is lacking in Lithuania and "most of the measures [in the action plan] are not carried out or their implementation is constantly being postponed" (Puras et al. 2013).

Continuous research and evaluation are essential in order to ensure not only the most effective development, which would be based on human rights, too, but also the improvement of mental health care, treatment, support and respective services (Hanlon et al. 2010). Thus, the aim of this article is to identify how the key principles and approaches of Global Mental Health could be applied to the local context, aiming to pursue the urgently needed effective reform and reorganization of the Lithuanian mental health care system and services. The objectives of this article are as follows: to present the background of Global Mental Health and its related worldwide movement; to identify the relevance that Global Mental Health bears on the local context in Lithuania and how the ongoing deinstitutionalization in Lithuania actually relates to the identified global principles; to discuss the experience of the development of community-based services worldwide and what could be learnt from this experience; to analyze the existing evidence base for the globally identified common barriers and strategies for overcoming those in relation to the deinstitutionalization of mental health services; to draw recommendations for further academic research, as well as to the decision-makers on the more practical level, for the potential ways forward in developing more effective mental health services and achieving better outcomes of mental health and human rights in Lithuania.

Methodology of the Analysis

The author of this article has reviewed, analyzed and related to the current local context of Lithuania a number of existing international scientific publications and best practice examples in the field of Global Mental Health. This has been completed in conjunction with the author's personal and professional experience obtained through her day-to-day practice in the non-governmental sector as well as over ten years of international working experience in the field of mental health in

general. The knowledge and evidence base provided by the analysis of scientific publications and best practice examples from across the globe has enabled the author to discuss the relevance of the aims, principles and outcomes of Global Mental Health to the current local context in Lithuania. It has allowed for the analysis of the ongoing deinstitutionalization and its effectiveness, from the perspective of these principles, and for drawing of specific recommendations for the potential ways forward in order to achieve better human rights and mental health outcomes in Lithuania. This is especially relevant in the light of the existing and presently stagnant post-Soviet mental health care system and the ongoing reform of the often-human-rights-violating mental health services in the country.

The Concept of Global Mental Health

Global Mental Health may be described as an area for study, research and practice that places a priority on improving mental health, related care and support outcomes as well as reducing respective inequities for all people worldwide (Patel and Prince 2010). The main principles of it address are such global inequities in the mental health field as gaps in care, treatment and support provision as well as prevalent human rights violations of persons who have mental health problems and who often suffer from poor quality of life, stigma and discrimination. The ultimate goal of Global Mental Health is to improve the quality of lives of individuals, through looking for a better understanding of the origins and causes of mental health problems and conditions, as well as to search for effective and affordable treatments, care and support. Patel and Prince (2010) argue that scaling-up services for persons, who have mental health problems or psychosocial disability, on the twin-principle of scientific evidence and human rights has become one of the main focuses for action within Global Mental Health.

In addition to the above, Patel and Prince (2010) describe the movement for Global Mental Health as a "coalition of individuals and institutions committed to close the treatment gap." According to Kohn et al. (2004), the treatment gap in mental health provides that even though mental health problems are highly prevalent worldwide, there is a significantly large number of persons who have those remain untreated even though effective treatments and other types of support do exist. According to WHO, the treatment gap for severe mental health conditions has been between 35–50% in developed countries and between 76–85% in low- and middle-income countries (WHO World Mental Health Consortium 2004). Patel (2016) argues: "Given the limited knowledge that we currently possess about the nature of mental disorders or their effective prevention and treatment, this may well be the most important ultimate contribution of global mental health, i.e. generating knowledge which not only reduces the treatment gap, but the actual global burden of mental disorders, and will finally do justice to the 'global' of this discipline." Becker and Kleinman (2013) identify a number of major initiatives in Global Mental Health, which include the following:

- Mental Health and Poverty Project and the Programme for Improving Mental Health Care, both supported by the Department for International Development in the UK;
- The Grand Challenges Canada program;
- Grand Challenges in Global Mental Health, led by the National Institute of Mental Health and the Global Alliance for Chronic Disease, in partnership with others.

Additionally, several "milestones" are described by Becker and Kleinman (2013) that mark significant advances in the integration of mental health care into primary health care in settings with constrained resources worldwide:

- World Health Report devoted to mental health in 2001, preceded by World Mental Health, Harvard (1995) and WHO Nations for Mental Health (1996);
- Mental Health Global Action Programme (mhGAP) in 2002;
- Series of reviews published in 2009, providing recommendations on a model of collaborative care (Patel and Thornicroft 2009; Patel et al. 2009);
- WHO mhGAP and Global Movement for Mental Health (2009); mhGAP Intervention Guide (2010); WHO training package (2012).

The more country-specific initiatives noteworthy for their measure of early success identified by Becker and Kleinman (2013) are as follows: an integrated approach to scaling-up equitable care for poor populations in Kenya (Kiima and Jenkins 2010) and integrating mental health into health sector reforms in Egypt (Jenkins et al. 2010). Additionally, due to various policy and legislative efforts and initiatives, "successful and innovative reform processes have taken place in most Latin American and Caribbean countries" (Caldas de Almeida and Horvitz-Lennon 2010).

Finally, the shift in Global Mental Health to a collaborative model of care delivery is also significant. The '*task-shifting*' model focuses on the mental health specialist as having a reconfigured role, emphasizing training, supervision and tertiary care, "while transferring the bulk of direct service delivery to community health workers or primary care professionals, who would receive specific training and supervision in mental health" (Patel 2009). A human resources gap could potentially be reduced through "task-shifting" (Petersen et al. 2011), which is an "evidence-based approach to addressing the human resources challenges to scaling-up effective treatments" for mental health problems (Patel 2009).

The following analysis employs the main messages and principles of Global Mental Health as a prism through which the author looks at how the ongoing mental health services' reform in Lithuania meets global standards; how effective or ineffective its deinstitutionalization of mental health services has been so far; finally, how could one of the main pillars of successful deinstitutionalization – the development of community-based services – be improved, based on the global evidence base and best practice examples.

Analysis

Applying Global Mental Health Principles and Approaches to the Lithuanian Context

The main principles of Global Mental Health that may be described as specifically relevant to the current Lithuanian context are as follows: 1) The acknowledgement of gaps in mental health care, treatment and support provision; 2) The search for and promotion of effective and affordable treatments, care and support, and scaling-up of community-based services; 3) Respect for fundamental human rights of all persons; 4) The fostering of the best possible quality of life for individuals through looking for a better understanding of the origins and causes of mental health problems and psychosocial disability; 5) The reduction of stigma and discrimination against persons who have mental health problems or psychosocial disability.

According to Puras et al. (2013), the situation in Lithuania is very complicated when it comes to an official acknowledgement of the system as being ineffective and as having serious gaps. It is evident that instead of accepting this fact and solving the existing problems in a mature way, currently, the stagnant system is being strengthened even further. This, in its turn, only deepens segregation, stigma, social isolation and exclusion. Up until this day, human rights monitoring in healthcare facilities is very rarely applied; there is not one independent monitoring body in the country, which would be responsible for the rights of patients, related control, addressing of complaints, independent analysis of the broader situation, monitoring of legislation review and human rights in this specific field in general (Puras et al. 2013). Such key issues as policy development versus services organization and policy implementation could be seen as central to the current situation of mental health care and services in Lithuania. However, it appears that any processes of change in the existing post-Soviet mental health care system are often hindered by the lack of top-down *and* bottom-up initiatives working *together*. Additionally, such key messages of Global Mental Health as the resources to treat and prevent mental health problems remaining insufficient, inequitably distributed and inefficiently utilized may be seen to apply to the situation in Lithuania, as much as they do in many other countries.

Even though compelling arguments have been made globally to advocate for the investment in mental health services as being "a matter of cost-effectiveness, social justice, and even a smart development strategy" (WHO 2010: 2; Lund et al. 2011), the political commitment to mental health care in Lithuania has not been reported to strengthen much thus far. The tangible and effective implementation of the National Mental Health Strategy (2007), action plan and related programs is almost non-existent (Puras et al. 2013); this indicates that both expressed political, institutional and budgetary commitment, as well as intersectoral collaboration, are majorly lacking. Hence, the strong prioritizing of better mental health outcomes and scaling-up of effective services on the principles of scientific evidence and human rights (Lancet Global Mental Health Group 2007) have thus far been significantly delayed in the Lithuanian context.

The outline of the present local situation and arguments, summarized in the two paragraphs above, illustrate the clear divergence from the first two principles of Global Mental Health. It points to the abstention from acknowledging the gaps in provision of mental health care in the first place and then points to this being complemented by the lack of active search for and promotion of effective and affordable treatments, care and support, as well as of scaling-up of services, based on scientific evidence and human rights.

Nevertheless, a *partial* scaling-up of mental health services may be observed to have in fact taken two distinct paths in Lithuania. According to WHO and Wonca (2008), it is important to integrate mental health into primary health care in order to achieve truly holistic care for all people, additionally integrating mental health care into other existing health programs. This type of *integration* has indeed started in Lithuania: Puras et al. (2013) describes clear developments in the field from as early as 1999, when the State Mental Health Centre was established. This landmark had a strategic meaning and was at the time surrounded by such other developments as the Government adopting the Program for the Maintenance of Mental Disorders (1999–2009). This Program described the plans for improving the accessibility of mental health services in primary, secondary and tertiary levels of healthcare. Additionally, the National Mental Health Committee was established in 2000, which was assigned the responsibility for ensuring

intersectoral collaboration in the field of mental health policy. However, according to Povilaitis et al. (2015), in practice, all outpatient mental health services in Lithuania are currently provided either by the General Practitioners, or at Mental Health Centers, which are mostly a part of the primary healthcare level. It is argued by Povilaitis et al. (2015) that, in following a thorough analysis of the services provided at Mental Health Centers, it is clear that it is dominated by the biomedical model and treatments are based on providing medications: this type of treatment is currently reported to be the most accessible to all. Additionally, Murauskienė et al. (2013) argues: "Because of the large flow of patients with mild disorders to the mental health centres and lack of resources (including the staff numbers and skill mix), interventions are commonly limited to a short consultation with a psychiatrist and administration of medicines." Meanwhile, psychologist consultations or psychotherapy are only accessible to around 4.33% of all persons who are registered as having mental health problems (Povilaitis et al. 2015).

All of the above indicates that the secondary mental health care level is practically non-existent and there are currently next to none effectively working community-based services, such as mobile outreach teams or psychosocial rehabilitation for people who have the more severe mental health problems or psychosocial disabilities. This points to serious gaps in the mental health services provision and a lack of effectiveness in the processes of the related national reform and deinstitutionalization of services, which again may be described as not compliant with the key principles of Global Mental Health.

According to Puras et al. (2013), even though the National Mental Health Strategy was adopted by the government of Lithuania in 2007, most of its measures have not been implemented. This may still be observed as being the case now in the year 2017, ten years after the adoption of the Strategy. Once again, this indicates the significant lack of political will, among other factors. Additionally, the Lithuanian Action Plan (2014–2020) for the Transition from Institutional to Community-Based Care was approved by the Minister of Social Security and Labor on 14th February 2014. However, there are still no practically visible improvements within the existing post-Soviet style mental health care and support system in the country. Moreover, this Action Plan focuses only on the social care institutions, completely leaving out of the planned reform the psychiatric hospitals and any other medical facilities or systems. This is due to the medical facilities being a responsibility of the Ministry of Health, unlike the social care institutions that fall under the programs by the Ministry of Social Security and Labor. It appears to be inevitable that due to the lack of inter-ectoral collaboration, no synergies are currently being drawn between potentially reforming both systems in parallel with each other. This essentially may be described as going against the global principle that to be effective mental health services and systems have to be planned and managed in an intersectoral way (Petersen et al. 2011).

According to the Ministry of Social Security and Labor, there are regular queues of up to 200 people who wait to be admitted to social care institutions. This indicates that *non*-institutionalization and adequate provision of acute, as well as continuing, mental health care and services closer to or in the communities where those affected live (Patel and Prince 2010) are still lacking in Lithuania, and people are forced to wait in queues in order to be admitted to institutional care instead. The existing permanent queues of people waiting to be placed into institutional care suggest that alternative forms of support have not been offered to them. This digression from effective implementation of the foreseen reforms clearly results in non-compliance with yet

another fundamental principle of Global Mental Health – respect for human rights of all persons. The lack of and/or unavailability of community-based services inevitably determines subsequent human rights violations, especially those under Article 19 of UN Convention on the Rights of Persons with Disabilities, as well as restriction of choice and loss of dignity and autonomy. This permanent flow into institutional care may be assessed as contributing significantly to keeping the existing mental health care system stagnant and resistant to change, whilst programing itself for subsequent human rights violations, poor quality of life of service users, and restrictions of their participation and inclusion in society, which does not comply with most of the key principles of Global Mental Health.

Moreover, it is relevant to the Lithuanian situation, that, as stated by Becker and Kleinman (2013), "[…] the most basic cultural and moral barrier to the amelioration of global mental health problems continues to be the enormously negative, destructive, and almost universal stigma that is attached to mental illnesses, to patients with a mental illness and their families, and to mental health caregivers."

People with mental health problems do not tend to seek help, they struggle with their recovery and are often socially isolated in Lithuania, all due to high levels of stigma and discrimination linked to mental health and related disabilities (Murauskienė et al. 2013). Currently even in media there are plenty of publications that are discriminatory and which reinforce the stigma in the attitudes toward people who have mental health problems (Mataitytė-Diržienė 2011). From all of the above, it is clear that integration of such aspects as, for example, the modern "recovery approach" into the new models of mental health services in Lithuania are currently rare. Potentially, such practices would mean finally moving closer to accepting that people who have mental health conditions "are central to their own recovery and can manage their mental health problems themselves, supported by family, friends and community" (Saraceno et al. 2015). The promotion of the recovery approach in Lithuania could potentially contribute to the improvement of care, support and quality of life of people who have mental health problems, and move Lithuania closer to complying with the principles of Global Mental Health, reducing stigma and discrimination, too. In its turn, this could also tap into achieving the collective goals and principles of Global Mental Health, aiming to improve the lives of individuals living with mental health problems all around the world (Patel and Prince 2010).

Development of Community-Based Services Across the World

The complex process of developing mental health services has been observed in three periods across the world: "the rise of the asylum, the decline of the asylum and the reform of mental health services" (Wing and Brown 1970; Grob 1991; Desjarlais et al. 1995; Thornicroft and Tansella 1999; Thornicroft and Tansella 2004). According to Thornicroft and Tansella (2004), currently there is no global consensus on which of the mental health service models are most appropriate in low, medium or high-income countries. Naturally, different mental health care models work in different areas of the world, depending on the level of available resources and other factors. For example, the provision of certain follow-up community services is more prevalent in upper-middle-income countries than in low-income countries (WHO-AIMS 2009). Nevertheless, nowadays there is an international consensus on the need "to shift from the model of care based on the traditional large psychiatric institutions to modern comprehensive community-

based models of care, including acute patient units at general hospitals" (Caldas de Almeida and Killaspy 2011). Hence, there is a clear global call for deinstitutionalization of mental health services in all countries.

The common experience of barriers to mental health services' reforms and shifting toward community-based care and support primarily in low- and middle-income countries presents a significant body of evidence and factors to consider for other countries, such as Lithuania, that are currently undergoing the deinstitutionalization. Saraceno et al. (2007) identifies that, first, the lack of political will evidently poses a great hindrance to any effective reform of mental health services in most countries. Secondly, the related advocacy is often not defined clearly enough, it is not targeted enough, nor empowering enough of the people who have mental health problems and their families themselves. Thirdly, the development of secondary care-level community-based services is often not prioritized. Finally, formal and informal resources, which are already available in the community, are often not used in effective and efficient ways by those developing and delivering community-based services. All the above describes several very clear and commonplace barriers, which are of relevance and are to be carefully considered by any country undergoing the deinstitutionalization and developing new community-based services that eventually are to replace all institutional care.

The development of community-based services globally has so far presented that any comprehensive changes in mental health services require provision, and that lasting improvements take time to achieve and cannot be rushed (Thornicroft et al. 2008). This is due to various factors, such as the adjusting of the mental health staff to new ways of thinking and working, acceptance of change and them actually starting to believe that such changes can be positive and are likely to bring positive outcomes for the service users. According to Killaspy (2006), longer-term studies (Leff 1997; Leff and Trieman 2000; Trieman and Leff 2002; Thornicroft et al. 2005) of the outcomes that followed service users, who had spent a number of years living in asylums, and eventually moved to live in the community with appropriate support, have demonstrated that "[…] the majority of people, even those with the most complex problems, have increased their social networks, gained independent living skills, improved their quality of life and have not required re-admission."

Additionally, support of not only staff but also of various organizations and agencies, including international actors, is important and also takes time to be ensured. It is to be identified and established gradually in order to succeed in achieving sustainable mental health services change. Moreover, as stated by Thornicroft et al. (2008), it is often necessary to build a wide political consensus on the national mental health strategy, so that when the government changes, it does not affect the consistency of striving for improvement of services. Finally, "time is also needed to progress from the initiation stage of a change to the consolidation phase" (Thornicroft et al. 2008). This is deemed important in order to ensure sustainability and long-term maintenance of any newly established systems and services.

With regards to the Lithuanian situation, in relation to the global evidence base described above, Puras et al. (2013) states that political will in the mental health policy field was demonstrated by the Minister of Health Ž. Padaiga back in 2005–2007; however, that did not grow into a wider political consensus and, up until now, the long-term strategic and coherent implementation of deinstitutionalization is missing in the country. This, in its turn, indicates that the possibility for

Lithuania to use the best global practice examples and evidence with regards to development and implementing of new community-based services for people who have mental health problems or psychosocial disability is still hindered and restricted.

Moreover, hearing the voices and valuing the expertise of service users and their families is seen as being vital across the world. This is a unique expertise, gained through direct experience and perspectives of people. Since the ultimate aim of services' improvement is to improve the quality of life of the service users and their families/carers, so it is important that their voices, choices and advice are sought, taken into account and valued immensely. This is still observed as lacking in Lithuania, where the "expert" label is often given to the medical professionals and personnel of service providers instead of the service users. Ruškus and Mažeikis (2007) argue that especially within the "clinical vision," more emphasis is put on the person's problems and inabilities, rather than on the valuing of his/her potential and expertise. It is then inevitable that whilst being surrounded by such negative predominant approaches, the voices of service users and their families can hardly be truly heard and valued.

Another aspect of development of community-based services worldwide has been related to economics, finance and budget-planning. It refers to the fact that the team managing the process of change in service provision is deemed to need "clear expertise to manage the whole budget and that the risks are high that services changes will be used as an occasion for budget cuts" (Thornicroft et al. 2008). Commonly, additional funding is required during the transitional period, which naturally poses a significant challenge, especially in low- and middle-income countries (Saraceno et al. 2007). Due to various reasons, including the lack of political will, such an additional funding has not been identified thus far in Lithuania, and one of the main arguments for the slow deinstitutionalization by the government officials is often based on the perceived myth of there being not enough money within the system required for financing the related processes.

Over the years it has also been assessed globally that there is no scientific evidence to say that either hospital services *alone* or community services *alone* can ensure most effective, satisfactory and comprehensive mental health care. Instead a "balanced approach," with elements of both hospital and community care, has been supported by both the evidence and practical experience (Thornicroft and Tansella 2002). As described by Thornicroft and Tansella (2004), the balanced approach framework can be applied differently in settings with different levels of resources, through the "stepped care model." For example, the balanced approach in countries with low levels of resources may include improving primary mental health care, with only a specialist back-up, whereas countries with medium resources may additionally aim to provide "out-patient clinics, community mental health teams, acute in-patient care, community residential care and forms of employment and occupation" (Thornicroft and Tansella, 2004). However, according to Thornicroft and Tansella (2004), the stepped care model does raise a couple of significant challenges and implications, as follows. First, to work most effectively, the model requires a well-coordinated system with an adequate and often multidisciplinary management of the provision of primary and specialist care. Second, the model implies that the level or resources and training of mental health professionals needs to be adequate to the service stage that has been reached. Realistically, this points to the risk that it may cause gaps in practice, which in turn might seriously affect local planning and development of quality services; hence, it requires an in-depth prior analysis, consideration and strategic approach.

In general, development of community-based services in most countries is a lengthy and complex process (Thornicroft et al. 2008) that faces several challenges and barriers, and Lithuania is no exception here. These barriers include some that exist at the policy level, and others at the level of the existing health care system (WHO World Health Report 2001). For example, these could include competing priorities, lack of intersectoral collaboration, underfunding, negative attitudes toward mental health and concerns about skills of staff and quality of care (Hanlon et al. 2010). Moreover, during the deinstitutionalization and development of community-based services, all of the main areas of people's lives need to be effectively addressed, as described by Rossler (2006). For example, for the *housing* part of individuals, who will eventually be leaving psychiatric hospitals and social care institutions during deinstitutionalization, the flexible and individualized *supported housing* option has been proven to be mostly effective worldwide. Rehabilitation research shows that "once in supported housing, the majority stay in housing and are less likely to become hospitalised" (Rossler, 2006). With regards to *education and employment*, it is now common knowledge, backed up by science, that engaging in work has positive effects on mental health. It has been proven to have the potential for people to achieve improved cognition, quality of life and better symptom control through engaging in meaningful work activities. Additionally, the most promising vocational rehabilitation model today is believed to be *supported employment*. In addition to the above, the *social skills* training also has an important role to play in psychosocial rehabilitation and deinstitutionalization: "social and community functioning improve when the trained skills are relevant for the patient's daily life and the environment perceives and reinforces the changed behavior" (Rossler 2006). Finally, Rossler (2006) states that the role of a psychiatrist, integrated in a community team, is also important as an integral part of the multidisciplinary support to the individuals, especially those with persistent, long-term mental health problems and conditions. All the above demonstrates how complex and intersectoral the processes of deinstitutionalization are and how much systemic planning and collaboration between different key stakeholders it requires.

Since differences in mental health services between low-, middle- and high-resource countries are vast (Thornicroft and Tansella 2004), the *strategies* that could be adopted to address the related challenges also vary from country to country**.** The resources (un)available in a country will severely constrain how the "balanced approach" and "stepped care model" are applied in practice (Thornicroft and Tansella 2004), and this is relevant in the Lithuanian context, too. However, regardless of the area, the planning and decision making are always to be informed by such elements as ethics, evidence and experience (Thornicroft et al. 2008), and include both community and hospital services (Thornicroft and Tansella 2004). Also, the planning and investment of funds in mental health care worldwide have included a wide range of stakeholders, amongst them service users and family members/carers, participating in related decision making. Building coalitions of stakeholders to oversee the scaling-up of balanced care, as well as including advocacy for sustainable resources, engaging with other relevant health and non-health programs to truly integrate mental health in their activities and raising awareness about mental health, as well as human rights, are all likely to prove as effective strategies in the strive for change in any country.

Mostly low-income countries have been found to be likely to more effectively provide mental health services in the primary healthcare level with specialist supervision, training and backup

(Mubbashar 1999; Saxena and Maulik 2003). Redefining the role of specialists, in general, "is essential to reforming mental health services in low-income and middle-income countries, and will require specialists to be trained in adult-learning methods to train and supervise others" (Saraceno et al. 2007). This is especially relevant in the Lithuanian context, even though it is deemed to be a high-income country, nevertheless, the specialist psychiatric community play a significant role in the mental health services planning and provision. Additionally, according to the global evidence base, the development of robust mechanisms to ensure reliable supplies and availability of essential psychotropic medications is also needed, which would be in balance with basic and "feasible psychosocial interventions to augment medication approaches in the time-pressed primary care setting" (Hanlon et al. 2010).

Deinstitutionalisation: Common Barriers and Strategies for Overcoming Those

As per the contextual analysis presented in the chapters above, the gaps in the mental health care system in Lithuania include the following: inaccessibility, inadequately used resources, a lack of new investments, an old post-Soviet infrastructure of services, a lack of preventative measures, prevailing stigma and discrimination as well as the bio-medical approach, a lack of individualized support, little acknowledgement of social determinants of mental health, often low quality of care and violations of human rights (Puras et al. 2013). At least three main specific barriers to effective progress in improvement of mental health services that are relevant in the current context of the country, may be defined. Based on the globally established evidence base, these barriers to improvement of mental health services in Lithuania and the potential comprehensive strategies for overcoming them are described and looked at below.

Centralised Mental Health Resources, Mostly in Large State Residential Social Care Institutions and Psychiatric Hospitals

A smooth transition to decentralized, community-based services in Lithuania could be aided by a reallocation of existing funds as well as some additional funding during the transitional period: both of which are currently lacking. Such means would be required from both the Ministry of Social Security and Labor, responsible for social care institutions, and the Ministry of Health, overseeing psychiatric hospitals. Additionally, municipalities also play an important role here in Lithuania, especially when it comes to development and funding of community-based services. Unfortunately, as it is common globally, so too in Lithuania the main decision makers have "the incorrect perception that mental health care is not cost-effective" (Saraceno et al. 2007), thus investment in this area is scarce. In many countries, including Lithuania, "scarce mental health funds are spent on long-term institutional care […] and on […] pharmaceuticals which, in general, are much less cost-effective than community-based care and generic essential medicines" (Saraceno et al. 2007; WHO 2006; Hyman et al. 2006). Not only does institutional care generally consume most of mental health resources, it also contributes to the social isolation of individuals from their natural support systems and creates opportunities for human rights violations and societal stigma (Saraceno et al. 2007), which in itself is a major public health concern (Saraceno et al. 2009). Reforms of institutional care-based mental health care systems commonly tend to be hindered by a lack of development of community-based services (Saraceno et al. 2007), and this too may currently be observed to be the case in Lithuania.

As it also has been observed by Saraceno et al. (2007) in other countries, one of the key barriers to progress in the decentralization of mental health services in Lithuania has been the resistance by mental health workers, whose interests are served directly by the existence of large social care homes and psychiatric hospitals. Feelings of insecurity are reported to be prevalent among them, they are anxious about losing their jobs and do not have adequate information about the reform; hence, they are reluctant to contribute to it and avoid accelerating the "undesirable changes" in any way (Sumskiene et al. 2015).

Generally, the psychiatric community and management of social care institutions tend to have the power over most of the mental health system-related decisions in Lithuania. For example, the heads of social care institutions are the main invited members of interministerial working groups for deinstitutionalization; the Regional Development Councils are responsible for overseeing related processes in the regions. Hence, the main responsibility for planning and implementing the reform lies with the persons who have an obvious conflict of interests, a desire to sustain their own social care institutions, and, at the same time, often lack the knowledge of human rights-based approaches and competences for the development of community-based, individualized and person-centered services (Sumskiene et al. 2015).

Difficulties in Integrating Mental Health Care in Primary Health Care Services

A recent analysis of mental health services at the primary health care level shows that currently, the primary-care Mental Health Centers in Lithuania predominately provide pharmaceutical treatment, mostly due to its accessibility and the predominant biomedical approach. Meanwhile, counselling, psychologist consultations and/or psychotherapy are only accessible to about 4.33% of people who have mental health conditions (Povilaitis et al. 2015). The assigned functions of Mental Health Centers are seen by experts in the field as needing a review in order to ensure real opportunities for the provision of preventative as well as clinical services, especially if having in mind the Mental Health Centers' extremely limited amounts of human resources (Povilaitis et al. 2015). For example, re-arranging the profile and structure of the existing Mental Health Centers across Lithuania to turn them into comprehensive and truly community-based and person-centered units, from which new *outreach services* and *home-visiting mobile teams* would operate, whilst redirecting mental health *prevention and promotion* functions to Public Health Centers, could potentially be a starting point. Then, at the same time, a network of psychiatric units available inside of the general hospitals could be established (Caldas de Almeida and Killaspy 2011).

Moreover, effective psychosocial rehabilitation programs are reported to be lacking both inside and outside of the psychiatric, as well as general hospitals, which could otherwise help to prepare people for living in the community (Caldas de Almeida and Killaspy 2011). According to Rossler (2006), all people who have severe mental health conditions require "psychiatric rehabilitation"; however, in practice, the Ministry of Health of Lithuania currently does not appear to follow the global advice to take a "balanced approach" or to focus on the two intervention strategies described below while addressing the needs of individuals during the future deinstitutionalization of psychiatric hospitals in Lithuania.

Rossler (2006) describes that most individuals would benefit from the empowerment to live in a community through the combination of the following two strategies: 1) An individual-centered strategy that aims at developing the person's skills in interacting with a stressful environment;

2) An ecological strategy directed toward developing the environmental resources to reduce the potential stressors. In "psychiatric rehabilitation" the real-life situations and conditions are to be taken into consideration whilst preparing individuals for leaving long-term psychiatric hospitals and prepare for the daily living situations that they are likely to encounter when living in the community (Rossler 2006). Additionally, time and attention needs to be devoted to ascertaining personal goals, focusing on the person's strengths, with associated costs and benefits to those goals. In order to effectively coordinate and integrate all the different required services and professionals involved concentrating on different aspects of the same person, *case management* could be introduced and act as the key coordinating and integrating mechanism: "The core elements of case management are the assessment of patient needs, the development of comprehensive service plans for the patients and the arrangement of service delivery" (Rossler 2006).

The above described approaches are relevant to the Lithuanian context; nevertheless, currently, the deinstitutionalization of psychiatric hospitals and integration of mental health care into general hospitals or generic primary healthcare in Lithuania is reported not only to be slow but mostly not adequately happening in practice at all (Puras et al. 2013).

A Lack of Political Will and Thus Funding for the More Effective Mental Health Care and Support

This issue may be seen in some countries as partially affected by inconsistent mental health advocacy; the concepts used by advocates are often unclear to the policy/decision-makers. In Lithuania, this is especially relevant ever since the mass emigration started, following the country joining the European Union in 2004. Several years later, people started bringing back to Lithuania more and more new modern and global ideas, based on foreign experiences and concepts. Moreover, the confusion in understanding and advocating for the modern mental health principles has been even more pronounced ever since the ratification of the UN Convention on the Rights of Persons with Disabilities and its Optional Protocol on 27th May 2010, the vision and direction of which differs from previously long-established national laws and predominantly post-Soviet and biomedical approaches. Such lack of clarity may also partially be due to there being "many types of mental health problems, advocates for mental health often lobby against one another to draw attention to different mental health problems, […] each of which might need different *public mental health* solutions" (Saraceno et al. 2007). In Lithuania, this may be observed to extend to an additional element of strong competition among the leading mental health experts and non-governmental organizations (NGOs): due to scarce resources and small size of the country, they tend to compete for limited funding, human and other resources; hence, unfortunately, certain related disagreements may often literally be down to a "fight for survival."

In addition to the above, generally, it is relevant that people who have mental health problems and their families "in […] middle-income countries are only rarely mobilised to form powerful constituencies, and to press for the availability of effective and humane mental health care" (Saraceno et al. 2007). In Lithuania, too, even though it is now classed by The World Bank as a high-income country, people who have mental health problems, their families and/or carers are often invisible, "voiceless", experiencing shame, discrimination and stigma. It is even challenging to engage service users and families in interviews for research purposes: people do not feel comfortable or willing to share their stories, even anonymously and with all the

appropriate confidentiality measures in place (Grigaite 2014). Moreover, residents of social care institutions are rarely adequately informed about the potential changes in the mental health care and support system; hence, they end up isolated and denied the opportunity to take an active part in the reforms. In fact, most often they are misinformed, for example, "residents of one [visited] social care institution have been informed that following the reform they will be accommodated in a new building, or vice versa, that they all will be released from the institution" (Sumskiene et al. 2015). This naturally leads to heightened anxiety among service users, consistent lack of self-advocacy and resistance to changes, which they just literally do not understand.

Potential Strategies for Overcoming the Barriers

There is more and more compelling evidence globally for prioritizing mental health (Saraceno et al. 2009). Saraceno et al. (2007) argues that it is important to generate political will in order to overcome the barriers to progress in improvement of mental health services. In order to generate political will for prioritizing mental health specifically in Lithuania, first of all, a consensus may be assessed to be needed between mental health and human rights advocates; the objectives and terminology of mental health advocacy to be more clearly defined, making it more focused and informative; also, more service users and their families/carers could be empowered to self-advocate.

Mental health advocates in Lithuania mostly work with the Ministry of Health, Ministry of Social Security and Labor, Ministry of Education and Science and the municipalities. However, intersectoral communication and collaboration between these various central and local authorities is still reported to be lacking and is consistently advocated for by local NGOs. Critical areas in service-planning that are deemed to need addressing by the Lithuanian policy/decision-makers in the light of best practices known in Global Mental Health are as follows: the downsizing of psychiatric hospitals and development of primary and secondary level mental health care; the integration of mental health into general hospitals; the development and provision of community-based services; the development and promotion of psychosocial rehabilitation. Trying to achieve this could potentially take a major shift in the prevailing paradigms, especially the one from the biomedical to biopsychosocial approach, with a focus on the social determinants of mental health, social and psychological dimensions of care and support. This would naturally require an intersectoral collaboration between all the respective authorities and other key stakeholders.

With regards to the primary mental health care level, the document governing the assigned functions of primary-care Mental Health Centers in Lithuania defines such services as prevention, treatment and rehabilitation. However, the volume and type of most such interventions are not reflected in the national statistics related to persons who have mental health problems or psychosocial disability (Povilaitis et al. 2015). Certain functions of the Mental Health Centers could potentially be delegated to other bodies; for example, activities related to mental health promotion and prevention could be transferred to Public Health Centers, since a key aim of any public health body is to "prevent disease/disorder wherever possible and to promote good health" (Saraceno et al. 2009). Also, the availability of and accessibility to quality counselling, psychological consultations and psychotherapy are continuously advocated for local use (Povilaitis et al. 2015) and could be scaled up as per principles of Global Mental Health.

Additionally, the development of secondary care-level community mental health services has not yet become a priority on Lithuania's political agenda. "Decentralisation of services and integration of mental health into general health care are critical to improve mental health status in populations" (Saraceno et al. 2009). Downsizing both of social care institutions and of psychiatric hospitals would require availability of a wide spectrum of community-based services. Moreover, formal and informal resources that already exist within the community could be used more effectively: "[…] more action is needed to ensure that non-professional community members take part in mental health programming" (Saraceno et al. 2007). At the same time, it is argued globally that nonetheless, investment in primary care or existing tertiary care is vital, but *only* as long as it is "preceded by, or […] at least in tandem with, development of community mental health services" (Saraceno et al. 2007).

In the case of Lithuania, evidently most of the European Union structural funding in 2007–2013 was used for the improvement of living conditions in social care institutions but without the tangible parallel development of alternative community-based services. In the next programing period of the European Union structural funds, an investment into development of community-based services in Lithuania is expected by local NGOs and activists, in order to overcome the barriers to improvement of the mental health care system, and specifically to decentralise mental health services.

Finally, "a set of simple, consensus-based indicators [need to] be monitored to track the progress of countries towards attainment of specific targets" (Lancet Global Mental Health Group 2007). However, the monitoring of the reform and development of new community-based services, and related indicators are currently reported to be insufficient in Lithuania: according to experts in the field, various indicators are currently missing, especially for monitoring of the progress of integration of mental health into primary health care services and the decentralization of mental health services (Puras et al. 2013). It was suggested by Sumskiene et al. (2015) that an accurate tracking of real changes in the number of beds in social care institutions and psychiatric hospitals could be an important indicator to be observed: "Along with other indicators of development of community-based services, it is important to assess this number every year to monitor the pace of the transitional processes."

Conclusion and Recommendations

Based on the key messages and principles of Global Mental Health, existing evidence base and best practices, the author of this article has determined that it is clear that the mental health care system and the mostly institutional-type services in Lithuania could be more effectively reformed and reorganized. As per the main principles of Global Mental Health, it would be important that different Lithuanian Central and Local Authorities start working together with other key stakeholders in an intersectoral and multidisciplinary way in order to most effectively achieve the needed change. They would all be invited to first of all acknowledge the gaps in mental health care, treatment and support provision; then, to search for and promote the more effective and affordable treatments, care and support, as well as to scale up new community-based services. Long-term political commitment would be important here; so, would be the building of respective networks and ensuring of collaboration between all the key stakeholders. As the central aspect, the respect

for fundamental human rights of all persons and fostering of the best possible quality of life for individuals, through looking for a better understanding of the origins and causes of mental health problems and psychosocial disability, is emphasized in and invited by the principles of Global Mental Health. Additionally, the reduction of stigma and discrimination against persons who have mental health problems could be addressed as a part of comprehensive systemic change.

In order to generate political will for prioritizing mental health in Lithuania, first of all, a consensus could be reached between mental health and human rights advocates; the objectives and terminology of mental health advocacy could become more clearly defined, making advocacy efforts more focused and informative; and more service users and their families/carers could be empowered to self-advocate. More active advocacy for prioritizing mental health and scaling up of effective services on the principles of scientific evidence and human rights for people who have mental health problems or psychosocial disability are important in the current Lithuanian context. A reallocation of financial and other resources, the development of community-based services, as well as introduction of programs of psychosocial rehabilitation, could all be potentially addressed in parallel with each other. In addition to the above, all of the related planning and decision making could be informed by such key elements as evidence, ethics, and experience; they may also include both community-based and hospital services. Moreover, it is important that the relevant legislation is adequately reviewed: the main piece of legislation currently being the Law on Mental Health Care, which has not been reviewed ever since 1995.

Moreover, the further academic as well as more practical exploration of the possibility to adapt the "task-shifting" model in Lithuania could potentially propose a rational redistribution of tasks and responsibilities among various health teams and providers of medical as well as social services. In order to make more efficient and rational use of the available human resources for mental health, very specific tasks could be appropriately moved, from highly qualified health professionals to community health workers with fewer qualifications, but instead with specialized training and ongoing supervision, as described by Petersen et al. (2011). Additionally, it is important that the decentralization of services and development of secondary care-level, community-based ones becomes a priority on the political agenda, since downsizing the existing mental health institutions would require availability of a wide spectrum of community-based services. The parallel investment in existing care services is also important here, but only if it is in parallel with the development of community-based services. Moreover, there is a significant role for the integration of evaluation and monitoring of the processes, as well as of the new solutions found. Such interventions could focus on using low-cost case management and multidisciplinary approaches, as described by Von Korff and Goldberg (2001). Clear, realistic and measurable indicators could be introduced on the policy and systemic level and attentively, continuously, consistently and independently monitored, evaluated and regularly reviewed from the very beginning of the deinstitutionalization processes; they could also be complemented with further academic research and expansion of the local evidence base in this field.

In conclusion, whichever more specific path for a more effective systemic reform was to be chosen in Lithuania, the resources for mental health care and support could primarily be decentralized and made more available and accessible in the community; it would be important to include human rights as the central pillar of the newly developed system and services; awareness raising and time would be needed to progress; a mobilization of informal resources in the

community could be stepped up; grassroots stakeholders could unitedly advocate for change and take part in the community mental health services development and delivery. Finally, continuous research and evaluation would be important, too, in order to ensure the most effective and human rights based development, improvement of mental health care, treatment, and support services' provision, as well as better health outcomes, as a result of the deinstitutionalization of mental health services in the country.

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