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The provision of community-based mental health care in Lithuania

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Abstract and key points

1. Lithuania needs to strengthen community-based mental health care services to meet current and future needs. The burden of mental ill-health in Lithuania is significant. More than one in six Lithuanians experienced a mental health problem in 2016, and the prevalence of diagnosed mental health disorders has increased significantly over the past two decades. It is likely that increased diagnostic rates will continue to put upward pressure on the mental health system. Lithuania's suicide rate has been declining, but remains the highest in the European Union. The suicide rate is particularly high amongst groups with comparatively low rates of diagnosis: men and people living in rural areas. Comparatively low rates of diagnoses and high rates of suicide may indicate a diagnosis and treatment gap which is larger for these groups.

2. Significant stigma around mental illness persists in Lithuania. Despite legislative reform in recent years, there remains legislation prohibiting those with a diagnosed mental health disorder from taking up specified professions, and performing certain activities. Formal and informal modes of stigmatisation continue to act as a barrier to help-seeking and treatment.

3. Lithuania spends less on mental health care as a proportion of total government health spending than the OECD average, and spending on mental health care as a proportion of total health expenditure has been declining. Additionally, funding is geared towards hospital care. While the share of funding devoted to inpatient services has been declining, inpatient services continue to absorb almost 60% of the mental health budget in the health care sector.

4. There is a risk that the payment system for mental health care constrains care coordination. Inpatient and outpatient providers are paid in accordance with different payment methods, which give rise to conflicting incentive structures; outpatient providers are incentivised to avoid hospitalisations for patients with schizophrenia, while inpatient providers are paid according to hospitalisations (by bed day or in accordance with diagnosis-related groups). Volume caps aim to reduce incentives for hospitalisation, but there remains a risk that incentive structures conflict if caps are not designed and monitored carefully. This could affect the continuity of care for people in the critical period following discharge from hospital, which is a period of peak suicide risk.

5. Existing payment methods may also discourage the treatment of severe mental health conditions. Because primary mental health care providers derive most of their revenue from capitation, it may be advantageous for providers to over-select patients with mild and moderate mental health conditions where the cost and complexity of treatment is lower. In practice, public primary mental health care centres record a greater share of contacts with those diagnosed with 'severe' mental health disorders than private centres.

6. The mental health workforce is inequitably distributed, both in terms of the composition of the workforce and its distribution across the country. Lithuania has one of the highest rates of doctors per 1 000 population in the OECD and also employs more psychiatrists than the OECD average, but has one of the lowest rates of psychologists in the OECD. There are particular shortages of psychologists in the public system, and of child and adolescent psychiatrists. Geographical imbalances in the distribution of the primary mental health workforce pose a considerable challenge, particularly in rural areas.

7. Funding, resource and skills constraints affect the delivery of mental health care. Lithuania's Mental Health Strategy sets an ambition for General Practitioners (GPs) to treat a majority of mental health conditions, but in practice there is a high rate of onward referral by GPs to specialised mental health care providers.

8. The bulk of 'primary' mental health care is delivered in 116 primary mental health care centres across Lithuania, which – together with GPs - are the first point of contact for most people with a mental health condition. While the network of mental health care centres is a strength of the system, overcrowding, funding and resource constraints affect the type of treatment these centres are able to provide. These constraints mean that mental health care centres can be geared towards treatment of mental health disorders with a lower level of complexity. Lack of capacity to treat moderate/severe mental health disorders can lead to the referral of patients to inpatient care which could potentially be treated in community-based care settings if they were sufficiently funded and resourced to do so.

9. There is a lack of systems capacity for the provision of psychotherapeutic care in community-based (outpatient) settings. In 2019, psychotherapies represented less than 3% of all services delivered in primary mental health care centres, and almost a third of primary mental health care centres did not provide any psychotherapeutic services at all. Service users report challenges accessing publicly-funded psychotherapies in outpatient settings, and report having to seek such treatments privately where users pay out-of-pocket. This makes such services inaccessible for many Lithuanians, raising equity concerns.

10. The insufficient availability and use of psychotherapeutic services translates to an over-reliance on medication-based treatment. While pharmaceutical consumption in Lithuania is below the EU average, Lithuanian mental health experts and service users consistently note a heavy reliance on medication-based treatment, with little recourse to alternative treatments.

11. Lithuania needs to continue efforts to rebalance service delivery toward care in the community. The mental health system remains geared towards hospital care. Lithuania still has one of the highest ratios of hospital beds per 1 000 population in the European Union, and one of the highest rates of admissions to inpatient care amongst OECD countries for which data is available. Coordination amongst providers is also recognised as a major challenge, particularly in the transition from inpatient to outpatient care.

12. Based on a limited number of quality and outcome indicators available in Lithuania, and compared to other countries able to report similar indicators, Lithuania's mental health system performance appears to be middling. Particular attention needs to be paid to coordination of care, and in particular post-discharge care and follow-up. Additionally, while Lithuania provides access to mental health services which are free at the point of use, unmet needs are substantial: 30% of Lithuanians report unmet needs for mental health care due to financial reasons, waiting times or transport.

13. Greater efforts are required to monitor and ensure the quality of mental health care. Lithuania currently employs a narrow payment-based indicator on the quality of mental health care in primary care settings. While implementation of the measure has been followed by some improvement in the rate of avoidable hospitalisations for those with schizophrenia, consideration should be given to the expansion of quality and outcome improvement mechanisms. Routine collection and reporting of key indicators to track quality and outcomes across regions and over time would also be beneficial.

14. Greater efforts are also required to ensure that people with a mental health condition are able to access respectful and inclusive mental health care which enables them to feel ownership over their care. Interviews with service users highlight challenges around the coordination of care, and also suggest shortcomings in terms of care delivery in inpatient settings, and limits to how 'person-centred' the system currently is. Additionally, there are currently limited mechanisms in place for users to co-design and evaluate services. Strengthening mechanisms to elevate service user voice may help to improve care quality.

Résumé et points saillants

1. La Lituanie doit renforcer les services de soins de santé mentale de proximité pour répondre aux besoins actuels et futurs. Le fardeau des problèmes de santé mentale en Lituanie est important. Plus d'un Lituanien sur six a connu un problème de santé mentale en 2016, et la prévalence des troubles de santé mentale diagnostiqués a considérablement augmenté au cours des deux dernières décennies. Il est probable que l'augmentation des taux de diagnostic continuera à exercer une pression à la hausse sur le système de santé mentale. Le taux de suicide de la Lituanie est en baisse, mais reste le plus élevé de l'Union européenne. Le taux de suicide est particulièrement élevé parmi les groupes dont les taux de diagnostic sont comparativement faibles : les hommes et les personnes vivant dans les zones rurales. Des taux de diagnostic comparativement faibles et des taux de suicide élevés peuvent indiquer un écart de diagnostic et de traitement plus important pour ces groupes.

2. Une stigmatisation importante de la maladie mentale persiste en Lituanie. Malgré la réforme législative de ces dernières années, il existe toujours une législation interdisant aux personnes atteintes d'un trouble de la santé mentale diagnostiqué d'exercer certaines professions et de réaliser certaines activités. Les modes formels et informels de stigmatisation continuent de faire obstacle à la recherche d'aide et au traitement.

3. La Lituanie consacre aux soins de santé mentale une part des dépenses publiques totales de santé inférieure à la moyenne de l'OCDE, et la part des dépenses de santé mentale dans les dépenses totales de santé est en baisse. En outre, le financement est orienté vers les soins hospitaliers. Bien que la part du financement consacrée aux services hospitaliers ait diminué, les services hospitaliers continuent d'absorber près de 60 % du budget de la santé mentale dans le secteur des soins de santé.

4. Le système de paiement des soins de santé mentale risque de limiter la coordination des soins. Les prestataires de soins hospitaliers et ambulatoires sont payés selon des méthodes différentes, ce qui donne lieu à des structures d'incitation contradictoires ; les prestataires de soins ambulatoires sont incités à éviter les hospitalisations de patients atteints de schizophrénie, tandis que les prestataires de soins hospitaliers sont payés en fonction des hospitalisations (par jour-lit ou en fonction des groupes de diagnostic correspondants). Les plafonds de volume visent à réduire les incitations à l'hospitalisation, mais il subsiste un risque de conflit entre les structures d'incitation si elles ne sont pas conçues et contrôlées avec soin. Cela pourrait affecter la continuité des soins pour les personnes dans la période critique suivant la sortie de l'hôpital, qui est une période où le risque de suicide est au plus haut.

5. Les méthodes de paiement actuelles peuvent également décourager le traitement des troubles mentaux graves. Étant donné que les prestataires de soins de santé mentale primaires tirent la majeure partie de leurs revenus de la capitation, il peut être avantageux pour eux de sur-sélectionner les patients souffrant de troubles mentaux légers et modérés, pour lesquels le coût et la complexité du traitement sont moindres. Dans la pratique, les centres publics de soins de santé mentale primaires enregistrent une plus grande proportion de contacts avec les personnes diagnostiquées comme souffrant de troubles mentaux "graves" que les centres privés.

6. Le personnel de santé mentale est inégalement réparti, tant en termes de composition du personnel que de sa répartition dans le pays. La Lituanie a l'un des taux les plus élevés de médecins pour 1 000 habitants de l'OCDE et emploie également plus de psychiatres que la moyenne de l'OCDE, mais elle a l'un des taux les plus faibles de psychologues de l'OCDE. Il existe des pénuries particulières de psychologues dans le système public et de psychiatres pour enfants et adolescents. Les déséquilibres géographiques dans la répartition du personnel de santé mentale primaire constituent un défi considérable, notamment dans les zones rurales.

7. Les contraintes en matière de financement, de ressources et de compétences affectent la prestation des soins de santé mentale. La stratégie lituanienne en matière de santé mentale vise à ce que les médecins généralistes (GP) traitent la majorité des troubles mentaux, mais dans la pratique, le taux d'orientation des GP vers des prestataires spécialisés en santé mentale est élevé.

8. La majeure partie des soins de santé mentale "primaires" est dispensée dans 116 centres de soins de santé mentale primaires en Lituanie, qui - avec les médecins généralistes - constituent le premier point de contact pour la plupart des personnes souffrant de troubles mentaux. Si le réseau de centres de soins de santé mentale est un point fort du système, la surpopulation, les contraintes de financement et de ressources affectent le type de traitement que ces centres sont en mesure de fournir. Ces contraintes font que les centres de soins de santé mentale peuvent être orientés vers le traitement de troubles de santé mentale d'un niveau de complexité moindre. Le manque de capacité à traiter les troubles de santé mentale modérés / graves peut conduire à l'orientation vers des soins hospitaliers de patients qui pourraient potentiellement être traités dans des centres de soins communautaires s'ils étaient suffisamment financés et dotés de ressources pour le faire.

9. Il existe un manque de capacité des systèmes pour la prestation de soins psychothérapeutiques dans les milieux communautaires (ambulatoires). En 2019, les psychothérapies représentaient moins de 3 % de tous les services fournis dans les centres de soins de santé mentale primaires, et près d'un tiers des centres de soins de santé mentale primaires ne fournissaient aucun service psychothérapeutique. Les utilisateurs de services signalent des difficultés d'accès aux psychothérapies financées par l'État en milieu ambulatoire, et déclarent devoir chercher ces traitements dans le privé, où les utilisateurs paient de leur poche. Cela rend ces services inaccessibles pour de nombreux Lituaniens, ce qui soulève des problèmes d'équité.

10. La disponibilité et l'utilisation insuffisantes des services psychothérapeutiques se traduisent par une dépendance excessive à l'égard des traitements médicamenteux. Alors que la consommation de produits pharmaceutiques en Lituanie est inférieure à la moyenne de l'UE, les experts lituaniens en santé mentale et les usagers des services notent systématiquement une forte dépendance à l'égard des traitements médicamenteux, avec un faible recours aux traitements alternatifs.

11. La Lituanie doit poursuivre ses efforts pour rééquilibrer la prestation de services en faveur des soins de proximité. Le système de santé mentale reste orienté vers les soins hospitaliers. La Lituanie a toujours l'un des ratios les plus élevés de lits d'hôpitaux pour 1 000 habitants dans l'Union européenne, et l'un des taux les plus élevés d'admissions en soins hospitaliers parmi les pays de l'OCDE pour lesquels des données sont disponibles. La coordination entre les prestataires est également reconnue comme un défi majeur, notamment lors de la transition entre les soins hospitaliers et les soins ambulatoires.

12. Sur la base d'un nombre limité d'indicateurs de qualité et de résultats disponibles en Lituanie, et par rapport à d'autres pays en mesure de communiquer des indicateurs similaires, les performances du système de santé mentale lituanien semblent moyennes. Une attention particulière doit être accordée à la coordination des soins, et notamment aux soins et au suivi après la sortie de l'hôpital. En outre, bien que la Lituanie offre un accès aux services de santé mentale qui sont gratuits au point d'utilisation, les besoins non satisfaits sont importants : 30 % des Lituaniens déclarent avoir des besoins non satisfaits en matière de soins de santé mentale pour des raisons financières, de temps d'attente ou de transport.

13. Des efforts plus importants sont nécessaires pour surveiller et garantir la qualité des soins de santé mentale. La Lituanie utilise actuellement un indicateur étroit, basé sur le paiement, de la qualité des soins de santé mentale dans les établissements de soins primaires. Si la mise en œuvre de cette mesure a été suivie d'une certaine amélioration du taux d'hospitalisations évitables pour les personnes atteintes de schizophrénie, il convient d'envisager l'extension des mécanismes d'amélioration de la qualité et des résultats. La collecte et la communication systématiques d'indicateurs clés permettant de suivre la qualité et les résultats dans les régions et dans le temps seraient également bénéfiques.

14. Des efforts plus importants sont également nécessaires pour s'assurer que les personnes atteintes d'un trouble de la santé mentale sont en mesure d'accéder à des soins de santé mentale respectueux et inclusifs qui leur permettent de se sentir propriétaires de leurs soins. Les entretiens avec les usagers mettent en évidence les défis liés à la coordination des soins, et suggèrent également des lacunes en termes de prestation de soins en milieu hospitalier, ainsi que des limites quant au degré de " centrage sur la personne " du système actuel. En outre, il existe actuellement peu de mécanismes permettant aux utilisateurs de co-concevoir et d'évaluer les services. Le renforcement des mécanismes permettant aux utilisateurs de s'exprimer pourrait contribuer à améliorer la qualité des soins.

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1 Setting the Scene: the Burden of Mental Ill-health in Lithuania

Introduction

15. This report sets out strengths and challenges of the mental health care system in Lithuania. The analysis presented in this report has been informed by interviews with Lithuanian mental health experts, service providers and service users, and by input from the Lithuanian Ministry of Health, the National Health Insurance Fund, the Institute of Hygiene, and Statistics Lithuania. Additional data on mental health indicators has been sourced from the European Commission, the World Health Organisation (WHO), and OECD databases.

16. The primary focus of this report is on the provision of community-based mental health care services for adults, in line with the Government of Lithuania's ambition to strengthen community-based care. Mental health is an extensive field that encompasses situational ill-health, chronic disorders and substance abuse issues for children, adolescents and adults. In some countries, the mental health field also encompasses developmental disorders such as ADHD, autism and intellectual or learning disabilities. The focus of this report is on the provision of community-based mental health care for adults with chronic or situational mental ill-health. The provision of care for those with dementia and developmental disorders is out of scope for the purposes of this analysis. Substance abuse services and services for children and adolescents are discussed briefly, but are not the primary focus of this report. Prevention and promotion services have also been excluded.

17. This chapter provides an overview of the burden of mental ill-health in Lithuania, emphasising the critical importance of a strong mental health care system. It begins with a brief contextual overview of key demographic, socioeconomic and health care statistics in Lithuania, before turning to an analysis of the burden of mental ill-health. It sets out the working definitions of 'mental health' used by the OECD and the Government of Lithuania for the purposes of this work, and provides an overview of mental-health related morbidity and mortality rates in Lithuania.

Health and health care in Lithuania

Table 1.1. Demographic and socioeconomic context in Lithuania, 2017

Demographic factors

Demographic factors	Lithuania	EU
Population size (mid-year estimates)	2 828 000	511 876 000
Share of population over age 65 (%)	19.3	19.4
Fertility rate[1]	1.6	1.6

Socioeconomic factors

Socioeconomic factors	Lithuania	EU
GDP per capita (EUR PPP[2])	23 500	30 000
Relative poverty rate[3] (%)	22.9	16.9
Unemployment rate (%)	7.1	7.6

Notes: [1]Number of children born per woman aged 15-49. [2] Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. [3] Percentage of persons living with less than 60% of median equivalised disposable income.
Source: (OECD/European Observatory on Health Systems and Policies, 2019[1])

18. Lithuania has among the lowest health outcomes in the EU. Despite increases in life expectancy in recent years, life expectancy in Lithuania remains low: in 2017, life expectancy at birth was 75.8 years, compared to the EU average of 80.9 years (OECD/European Observatory on Health Systems and Policies, 2019[1]).

19. Lithuania's health care expenditure is significantly below the EU average, both in absolute terms and as a proportion of GDP (OECD/European Observatory on Health Systems and Policies, 2019[1]). Health expenditure accounted for 6.5% of GDP in 2017, compared to the EU average of 9.8% (OECD/European Observatory on Health Systems and Policies, 2019[1]).

20. Both health care expenditure and health service delivery are geared towards inpatient care. Inpatient care absorbed 30% of the total health care budget in 2017, and Lithuania has one of the highest ratios of hospital beds per population in the EU (OECD/European Observatory on Health Systems and Policies, 2019[1]). Across the Baltic States, the structure of expenditure in Lithuania is similar to that of Latvia, though differs from Estonia where relatively more resources are devoted to outpatient care (OECD/European Observatory on Health Systems and Policies, 2019[1]).

21. Lithuania also faces challenges with respect to population mental health (OECD/European Observatory on Health Systems and Policies, 2019[1]). The burden of mental ill-health is significant. In Lithuania, as in other EU countries, more than one in six people experienced a mental health problem in 2016 (OECD/European Union, 2018[2]). The rate of people diagnosed with a mental health disorder has increased significantly over the past two decades. Lithuania has both the highest rate of suicide and one of the highest rate of hospitalisations due to mental disorders in the EU (Eurostat, 2021[3]). A strong mental health care system is critically important to ensuring that those experiencing mental ill-health are able to access high-quality mental health care.

Defining Mental Health

OECD Terminology

The language used in this paper aligns with ongoing efforts to address the stigma surrounding mental ill-health and is, where possible, person-centred, strengths-based and recovery-focused (OECD, 2021[4]). The definitions and terminology used in this paper have been adopted from the OECD's report *'A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health' (2021)'.*

"The OECD adopts the World Health Organization's widely-accepted definition of **mental health**, referring to a state of well-being in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (OECD, 2021[4]).

"The broad term "**mental ill-health**" is used to describe mental and behavioural disorders but also includes psychological or mental distress, i.e. symptoms or conditions that do not reach the clinical threshold of a diagnosis within the classification systems but which can account for significant suffering and hardship, and can be enduring and disabling" (OECD, 2021[4]).

"The terms '**disorders**' or '**conditions**' are used to apply to symptoms reaching the clinical threshold of a diagnosis according to psychiatric classification systems including disorders such as depression, anxiety, bipolar disorder and schizophrenia amongst many others" (OECD, 2021[4]).

The use of this language reflects "that the experience of mental health conditions can be highly fluid – an individual experiencing a moderate depressive episode can worsen and become "severe", just as a severe episode can be stabilised with symptoms lessened or alleviated" (OECD, 2021[4]).

Lithuanian Terminology

The Lithuanian definition of mental health is in line with the definition adopted by the OECD.

The Republic of Lithuania defines "**mental health**" (**Psichikos sveikata**) as a person's well-being, when he or she can realise his or her abilities, overcome normal life difficulties, and work and participate in the life of society.

"**Mental and behavioural disorders"** (**Psichikos ir elgesio sutrikimas**) are defined as "disorders of a person's thoughts, behaviour, and/or feelings caused by biological, psychological, or social factors, or the use of psychoactive substances specified in the current classification of diseases and health disorders" (Law of the Republic of Lithuania on Mental Health Care (1995), as amended).

A full list of relevant terminology is contained in Chapter Annex 1.A.

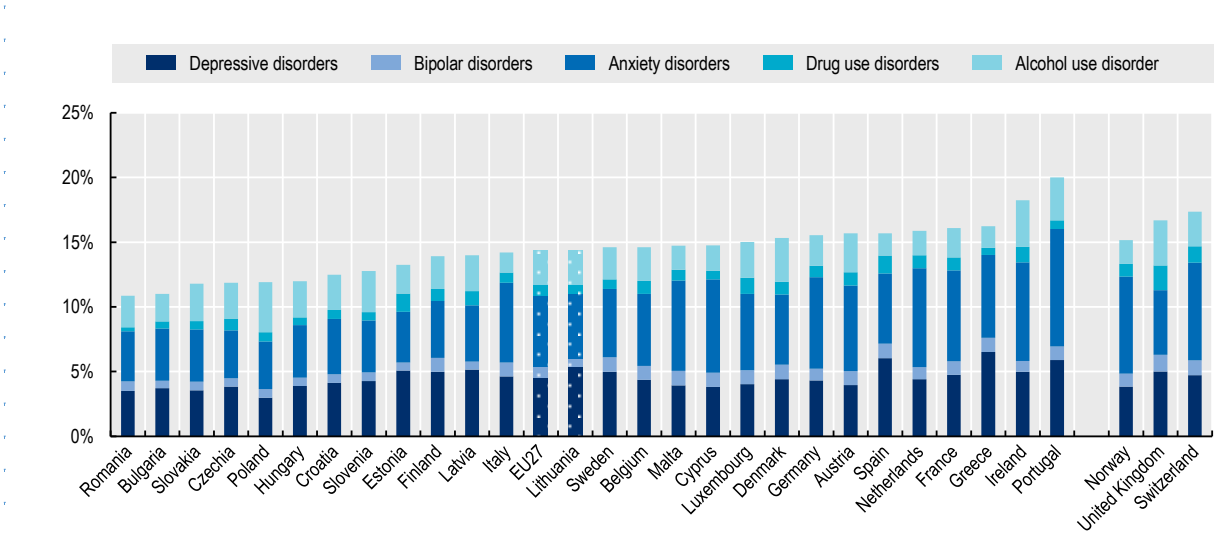
The Burden of Mental Ill-Health

22. The prevalence of mental health conditions in EU countries is difficult to estimate, as data obtained via population surveys often focuses on a few specific mental health conditions, or on the prevalence of conditions amongst specific age groups. Estimates of the prevalence of mental health conditions are also affected by self-reporting rates within populations, which can be influenced by different levels of mental health literacy or stigma within countries.

23. Nevertheless, the existing evidence shows that mental ill-health affects tens of millions of Europeans every year. The latest estimates from the Institute for Health Metrics and Evaluation (IHME) show that more than 14% of people in EU countries had a mental health condition in 2019, excluding those with developmental and conduct disorders (IHME, 2019[5]). The burden of mental health conditions in Lithuania is in line with the EU27 average (Figure 1.1). Portugal, Ireland and Greece register the highest estimated prevalence of mental health conditions, while Romania, Bulgaria and Slovakia register the lowest.

Figure 1.1. More than 14% of Lithuanians experienced a mental health problem in 2019

Estimates of the percentage of people experiencing mental health problems in European countries in 2019



Note: Attention deficit, autism spectrum disorders, conduct disorders, eating disorders, idiopathic developmental intellectual disability and other mental and behavioural disorders are not included in this graph
Source: (IHME, 2019[5])

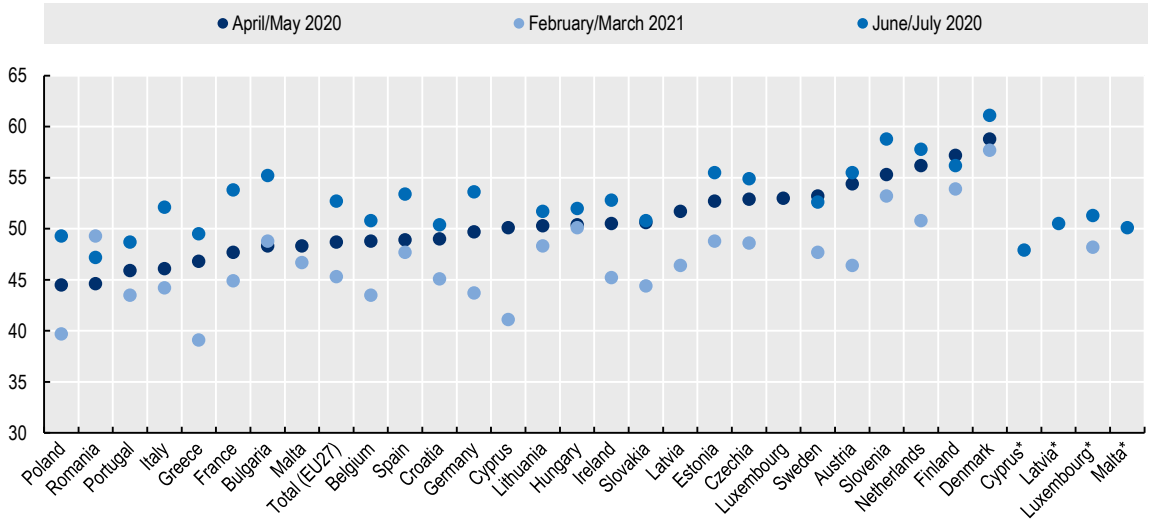
24. IHME estimates suggest that the burden of mental health disorders is slightly differently distributed in Lithuania compared to other EU countries. IHME estimates include data on anxiety disorders, depressive disorders, alcohol and drug use disorders, and bipolar disorder. Across EU countries, anxiety disorders represent the most common mental health problem (affecting around 30 million people in 2019, according to the IHME estimates), followed by depressive disorders and alcohol use disorders. Bipolar disorders and drug use disorders affect a lower share of the population across the EU, both at 0.9%. According to IHME estimates, in Lithuania depressive disorders represent the most common mental health disorders, followed by anxiety and alcohol use, drug use and bipolar disorders.

25. Population mental health may have worsened over the course of the COVID-19 pandemic. The pandemic and associated containment measures had a significant impact on population mental health across OECD countries. In the early stages of the pandemic in 2020, the prevalence of symptoms of anxiety and depression as much as doubled in some countries (OECD, 2021[6]). The pandemic appears to have had a significant impact on Lithuanians' mental wellbeing as well: survey data from Eurofound's *Living, Working and COVID-19* e-survey shows that, in the spring of 2021 when various lockdown and confinement measures were in place, on average Lithuanians could be considered to be at risk of depression (Figure 1.2). The low levels of self-reported mental wellbeing seen in Lithuania during this stage of the pandemic are in line with those seen in many European countries at that time, with the average level of wellbeing in Lithuania in February/March 2021 (48.3) slightly higher than the EU27 average (45.3) (Figure 1.2).

26. The long-term impact of the pandemic on population mental health in Lithuania remains to be seen. Across a number of OECD countries, stringent containment measures and high COVID-19 infection and death rates appear to have been associated with poorer mental health over the course of the pandemic (OECD, 2021[7]); (Aknin et al., 2022[8]); (Vos et al., 2020[9]), suggesting that population mental health could recover to some extent as COVID-19 deaths fall, and restrictions continue to be eased. Indeed, the Eurofound survey data shows that mental wellbeing in Lithuania (as in other EU27 countries) recovered somewhat in the period between April/May 2020 and June/July 2020 as restrictions were being eased across Europe, and then fell again in February/March 2021 when European countries were once more in various stages of lockdown (Figure 1.2). However, it is too early to say whether population mental health in Lithuania – and many other European countries – has returned or will return to pre-pandemic levels. The long-term impact of the pandemic on population mental health in Lithuania remains to be seen, and the implications could be significant. Indeed, in the early stages of the pandemic the Lithuanian Government developed a COVID-19 Action Plan to tackle the potential long-term consequences of the pandemic on population mental health (set out in further detail in Section 2 below) (Ministry of Health of the Republic of Lithuania, 2020[10]).

Figure 1.2. Mental wellbeing declined during the COVID-19 pandemic

Average (mean) self-reported mental wellbeing (WHO-5) score in EU27 countries (out of 100), 2020 and 2021



Note: The WHO-5 Well-Being Index (WHO-5) is a self-reported measure of well-being, measured using a five-item questionnaire. Lower scores represent lower mental wellbeing, and a score of 50 or lower is sometimes considered to indicate a risk of depression. The data shown here is the mean score for respondents in the EU27 on the WHO-5 Index. *Data with low reliability
Source: (Eurofound, 2021[11])

The prevalence of diagnosed mental and behavioural disorders in Lithuania has increased significantly over the past two decades[1]

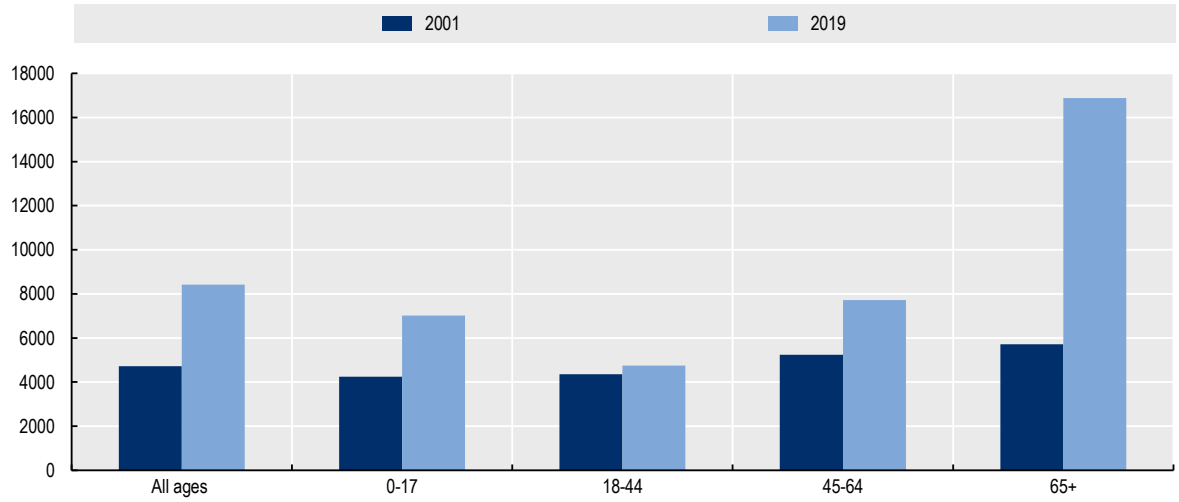
27. The prevalence of diagnosed mental and behavioural disorders per 100 000 people increased significantly in Lithuania in the period between 2001 and 2019, from 4 723 disorders per 100 000 people in 2001, to 8 418 disorders per 100 000 people in 2019 (Figure 1.3). The increase appears to be highest for older people (ages 65+). However, the rate of diagnosed mental health and behavioural disorders reported in Figure 1.3 includes dementia, and must therefore be interpreted with caution. Among other age groups, diagnosed mental and behavioural disorders increased most amongst younger people (ages 0-17) and adults aged 45-64.

28. Increased rates of diagnosis do not necessarily reflect increases in the prevalence of mental health conditions. Rates of diagnosis can be influenced by a range of factors. Increased rates of diagnosis could reflect increases in the underlying prevalence of mental health conditions, or could alternatively reflect increases in the accessibility of mental health care, greater diagnostic capacity, or a greater willingness to seek help and/or take up treatment for mental health conditions. Given the prevalence of diagnosed mental and behavioural disorders has increased by approximately 80% over the past two decades, it seems highly unlikely that increased rates of diagnosis have been driven purely by an increase in the underlying prevalence of mental health conditions. Irrespective of the driver, however, there is no indication that the upward trend in diagnostic rates is set to decline, and increased rates of diagnosis will likely continue to put upward pressure on the mental health care system. The health, social and economic impact of the COVID-19 pandemic and associated containment measures could serve to exacerbate these pressures in coming years, particularly if the medium to long-term impacts of the pandemic on population mental health prove significant, and translate to increased demand for mental health care services.

[1] This section discusses trends in diagnostic rates for mental and behavioural disorders in the period between 2001 and 2019. These referent years have been selected due to data availability.

Figure 1.3. Prevalence of all diagnosed mental and behavioural disorders including dementia, 2001-2019

Prevalence of diagnosed mental and behavioural disorders per 100 000 population, by age

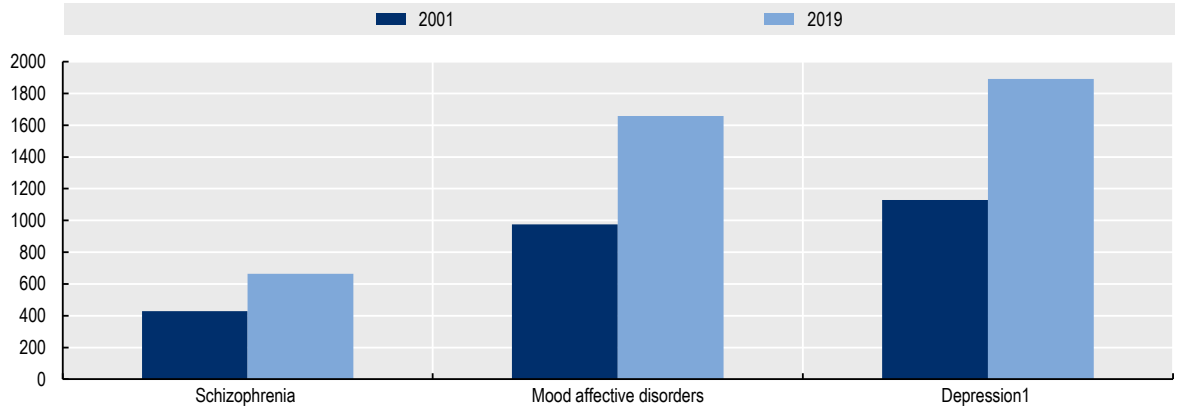


Note: The Lithuanian Institute of Hygiene records the prevalence of mental and behavioural disorders in accordance with the number of people with a diagnosed mental health condition (whether newly or previously diagnosed) who have at least one recorded contact with health services during the course of a calendar year. Data reported above refers to all diagnosed mental and behavioural disorders classified according to ICD-10 codes F00 – F99. Data includes dementia and developmental disorders
Source: (Lithuanian Institute of Hygiene, 2021[12])

29. Increased diagnostic rates are evident across a range of mental health disorders. As outlined above, the rates of diagnosed mental health and behavioural disorders reported in Figure 1.3 include dementia, and must therefore be interpreted with caution. However, the upward trend in rates of diagnosis is also evident when considering specific mental health disorders. The rates of people diagnosed with schizophrenic, mood affective and depressive disorders per 100 000 population all increased significantly in the period between 2001 and 2019, for instance (Figure 1.4).

Figure 1.4. Prevalence of diagnosed schizophrenic, mood affective and depressive disorders, 2001-2019

Prevalence of schizophrenia, mood affective disorders and depression per 100 000 population in 2001 and 2019

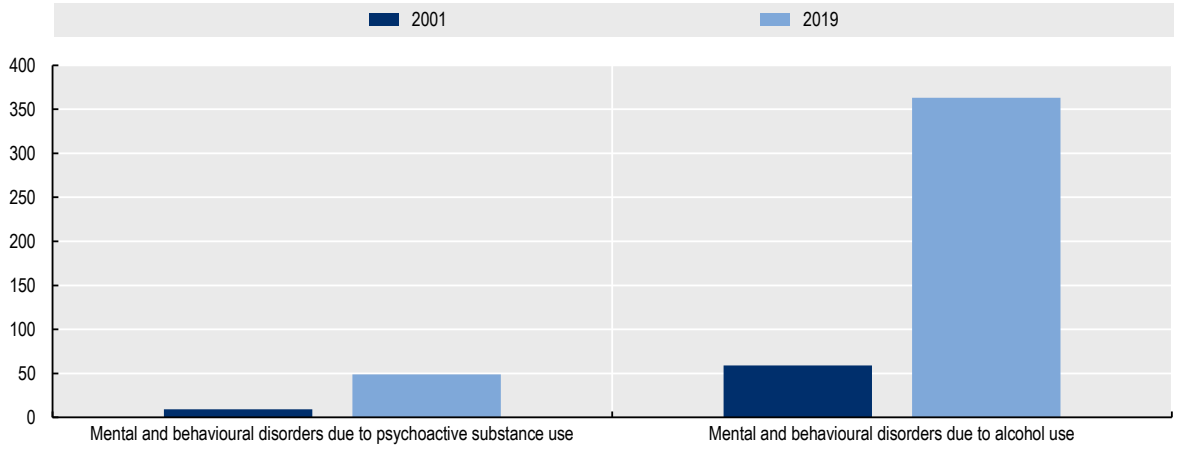


Note: [1]Data for depression for persons aged 15+
Source: (Lithuanian Institute of Hygiene, 2021[12])

30. Rates of diagnosed alcohol-related and psychoactive substance-related mental disorders have also increased significantly over the past two decades (Figure 1.5). In Lithuania, alcohol-related and psychoactive substance-related mental disorders in the population are measured by their incidence, defined as the number of people with whom the disease was newly diagnosed over the course of a calendar year (Lithuanian Institute of Hygiene, 2021[12]). The incidence of diagnosed alcohol-related disorders has increased at a particularly high rate, with a sixfold increase in the period between 2001 and 2019, from 59 per 100 000 in 2001 to 363 per 100 000 in 2019 (Figure 1.5). The incidence of alcohol-related disorders is particularly high amongst the 18-44 and 45-64 age groups, and amongst men. In 2019, the incidence of alcohol-related disorders was 504 per 100 000 people amongst those aged 18-44, and 547 per 100 000 people amongst those aged 45 - 64. In the same year, the incidence of alcohol-related disorders was 591 per 100 000 for men, compared to 164 per 100 000 for women (Lithuanian Institute of Hygiene, 2021[12]).

Figure 1.5. The incidence of diagnosed mental and behavioural disorders due to alcohol and substance use has increased substantially

Incidence of mental and behavioural disorders due to alcohol and psychoactive substance use per 100 000 population, 2001 and 2019



Note: The Lithuanian Institute of Hygiene records the incidence of alcohol-related mental and behavioural disorders and the incidence of mental and behavioural disorders due to psychoactive substance use in accordance with the number of people with whom the disorder was newly diagnosed during the course of a calendar year
Source: (Lithuanian Institute of Hygiene, 2021[12])

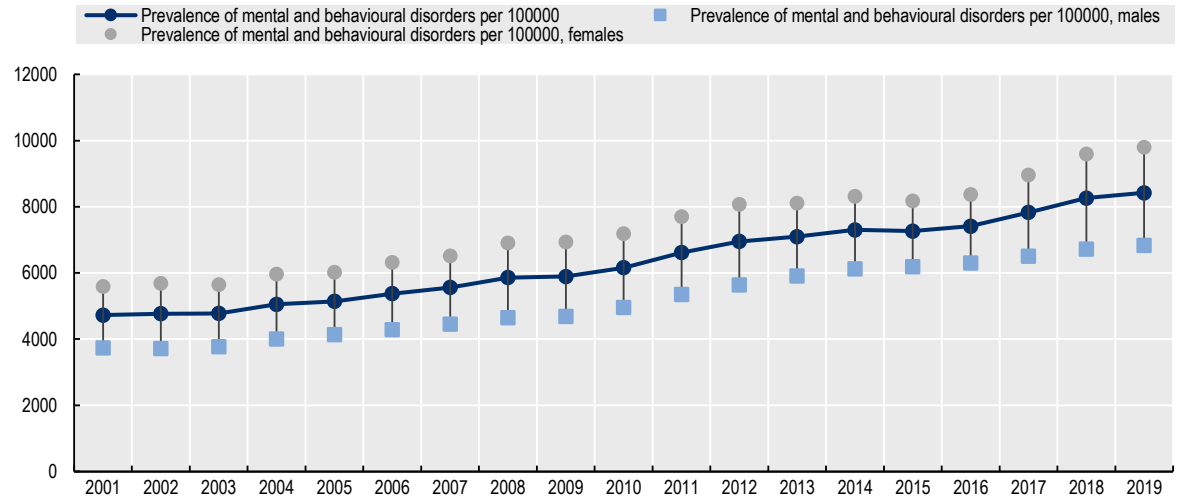
The burden of mental ill-health and the prevalence of diagnosed mental and behavioural disorders are higher amongst women

31. The number of diagnosed mental and behavioural disorders is significantly higher amongst women than men (Figure 1.6). In 2019, the prevalence of all diagnosed mental and behavioural disorders was over 30% higher for women than men: 9 797 disorders per 100 000 were recorded for women, compared to 6 833 per 100 000 for men.

32. While the number of diagnosed mental and behavioural disorders has increased amongst both men and women over the past two decades, the gender gap in rates of diagnosis has widened slightly over time (Figure 1.6). The number of diagnosed mental and behavioural disorders amongst women increased from 5 590 per 100 000 population in 2001 to 9 797 per 100 000 population in 2019, remaining consistently higher than the number of diagnosed mental and behavioural disorders amongst men. The prevalence of diagnosed mental and behavioural disorders for men increased from 3735 per 100 000 population in 2001 to 6833 per 100 000 population in 2019. However, the rates of diagnosed mental health and behavioural disorders reported in Figure 1.6 include dementia, and must therefore be interpreted with caution.

Figure 1.6. The prevalence of diagnosed mental and behavioural disorders is significantly higher amongst women, and the gender gap has widened over time

Prevalence of all diagnosed mental and behavioural disorders per 100 000 population by sex, 2001 - 2019



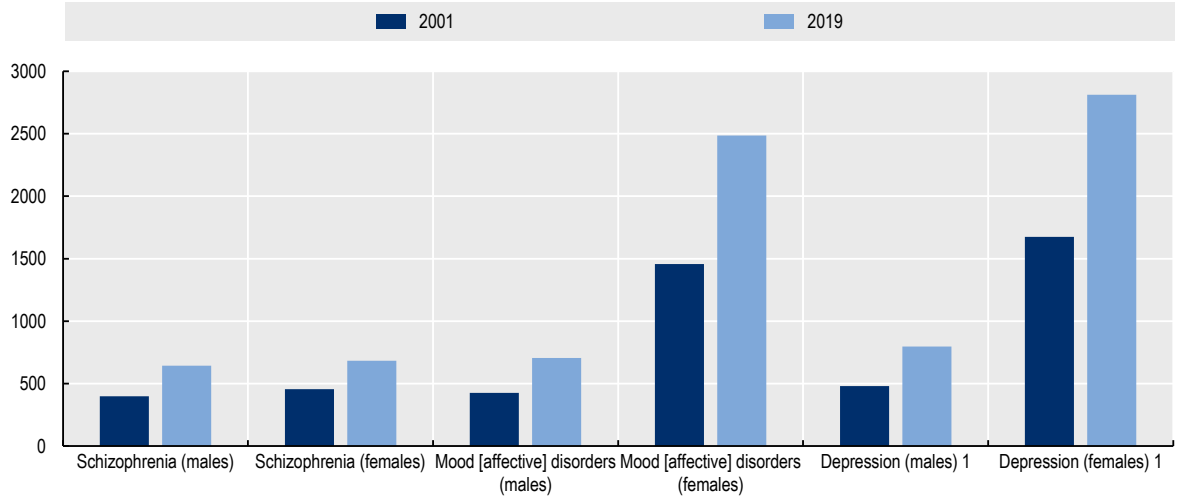
Note: The Lithuanian Institute of Hygiene records the prevalence of mental and behavioural disorders in accordance with the number of people with a diagnosed mental health condition who have at least one recorded contact with health services during the course of a calendar year. Data reported above refers to all diagnosed mental and behavioural disorders classified according to ICD-10 codes F00 – F99. Data includes dementia and developmental disorders

Source: (Lithuanian Institute of Hygiene, 2021[12])

33. The gender gap in diagnostic rates is evident across a range of mental health disorders, though the difference is more marked for certain disorders. The prevalence of diagnosed mood affective and depressive disorders is significantly higher amongst women than men, for instance, while the prevalence of diagnosed schizophrenic disorders is only slightly higher for women than men (Figure 1.7). In 2019, the prevalence of diagnosed depressive disorders amongst women aged 15 and over was over three times higher than that of men: 2811 per 100 000 population for women, compared to 796 per 100 000 population for men aged 15 and over. The prevalence of diagnosed mood affective disorders amongst women was 2486 per 100 000 of the population in the same year, compared to 706 per 100 000 population for men (Lithuanian Institute of Hygiene, 2021[12]).The prevalence of diagnosed schizophrenic disorders was 682 per 100 000 population for women in 2019, compared to 644 per 100 000 population for men.

Figure 1.7. The prevalence of diagnosed mood affective and depressive disorders is significantly higher amongst women than men, though rates of schizophrenia are relatively comparable

Rate of prevalence of diagnosed mental and behavioural disorders per 100 000 population by sex, 2001 and 2019



Note: [1]Depression refers to age 15+
Source: (Lithuanian Institute of Hygiene, 2021[12])

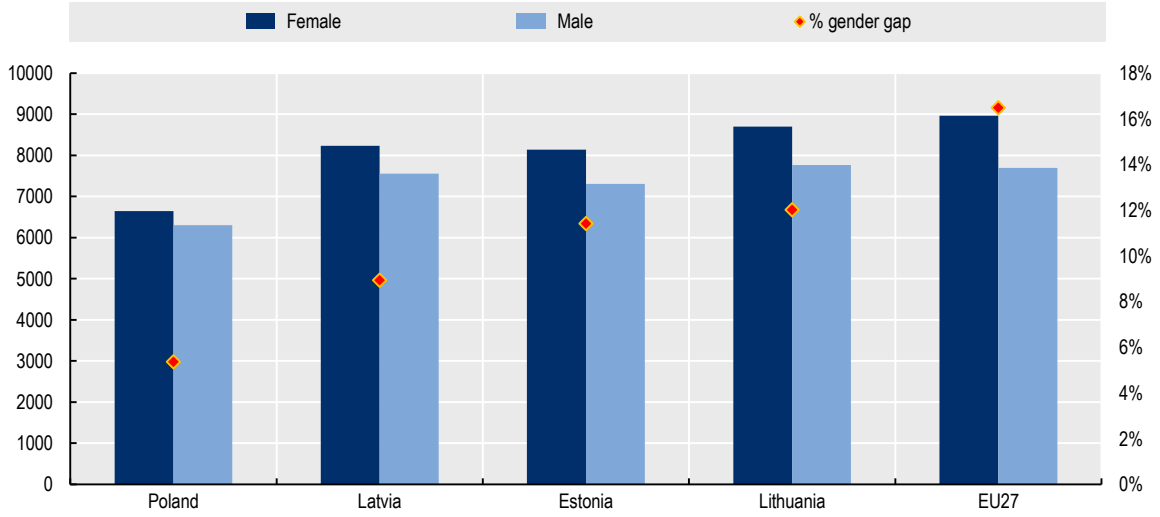
34. Gender gaps in rates of diagnoses could be interpreted in a number of ways. They may reflect differences in the underlying prevalence of mental health conditions, differences in coping strategies, differences in the propensity to seek help for mental health conditions, differences in help-seeking methods, or differences in the diagnosis of mental health disorders due to gender stereotyping by physicians, for instance. In and of itself, the gender gap in rates of diagnosis should therefore not necessarily be taken as an indication of a greater prevalence or severity of mental health conditions among either gender. However, IHME estimates suggest that the underlying prevalence of mental health conditions in Lithuania may indeed be higher amongst women than men.

35. While it is difficult to ascertain the underlying prevalence of mental health conditions in any country, IHME estimates suggest that that the prevalence of mental health disorders in Lithuania is higher amongst women than men, with an estimated gender gap of 12% in 2019 (Figure 1.8).

36. According to the IHME estimates, the gender gap in the prevalence of mental health disorders is higher in Lithuania than in neighbouring countries Estonia, Latvia and Poland. In 2019, the gender gap in the prevalence of mental disorders was estimated to be 11% in Estonia, 9% in Latvia and 5% in Poland (Figure 1.8). It is important to note, however, that the estimated gender gap in the prevalence of mental health disorders in Lithuania, Estonia, Latvia and Poland are all below the EU average (16%).

Figure 1.8. The gender gap in the prevalence of mental health disorders is higher in Lithuania than in neighbouring countries, but below the EU27 average

Prevalence of mental health disorders per 100 000 population by sex, 2019



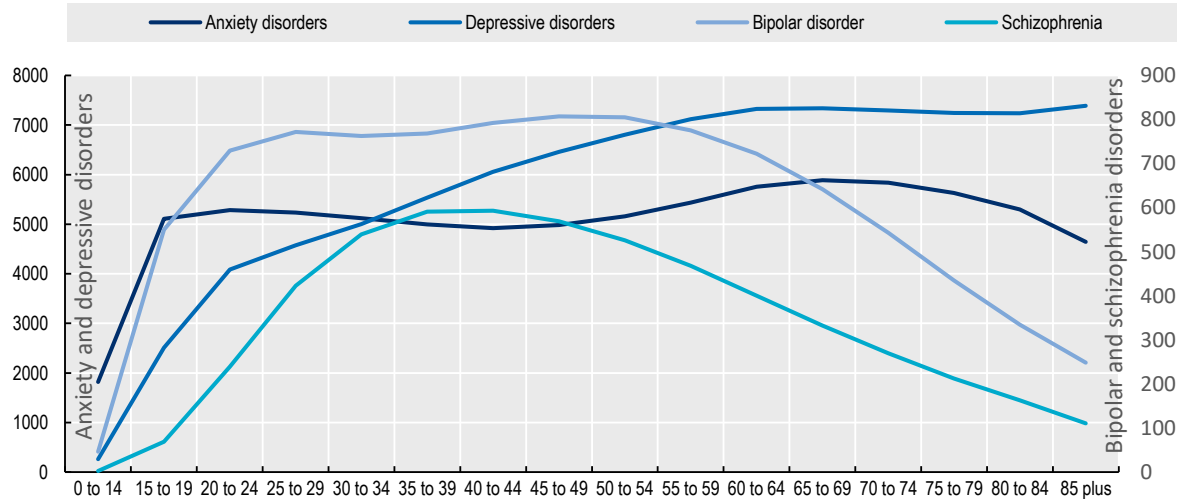
Note: Data excludes dementia but includes developmental disorders
Source: (IHME, 2021[13])

The burden of mental ill-health varies with age

37. In Lithuania, as in other OECD countries, the prevalence of mental health conditions differs across age groups. According to 2019 estimates from the IHME, the prevalence of anxiety, depressive and bipolar disorders in Lithuania increase sharply between the age groups 0-14 and 15-19, while schizophrenia experiences a greater increase from the ages of 15-19 until the age of 35-39. The sharp increase in the prevalence of mental health conditions in younger age groups is not unique to Lithuania, as globally many mental health conditions onset at a young age (Kessler et al., 2007[14]). The IHME estimates for Lithuania indicate that anxiety, bipolar disorders and schizophrenia all experience the highest prevalence rate in adult age, followed by a decrease in older age. Conversely, the prevalence of depressive disorders increases across almost all age groups (Figure 1.9). This gradual increase in the prevalence of depressive disorders is largely consistent with European trends. Data from the 2014 European Health Interview Survey indicates that, across EU countries, rates of self-reported chronic depression generally increase with age, though dip somewhat in the years 65-74 before increasing again amongst people aged 75+ (OECD/European Union, 2018[2]).

Figure 1.9. The prevalence of mental disorders differs across age groups

Estimated prevalence of mental disorders per 100 000 population in 2019, by age group



Note: Anxiety and depressive disorders are reported on the primary (left-hand) axis. Bipolar and schizophrenic disorders are reported on the secondary (right-hand) axis.
Source: (IHME, 2021[13])

The prevalence of diagnosed mental and behavioural disorders is generally higher in urban areas, though the gap is narrowing

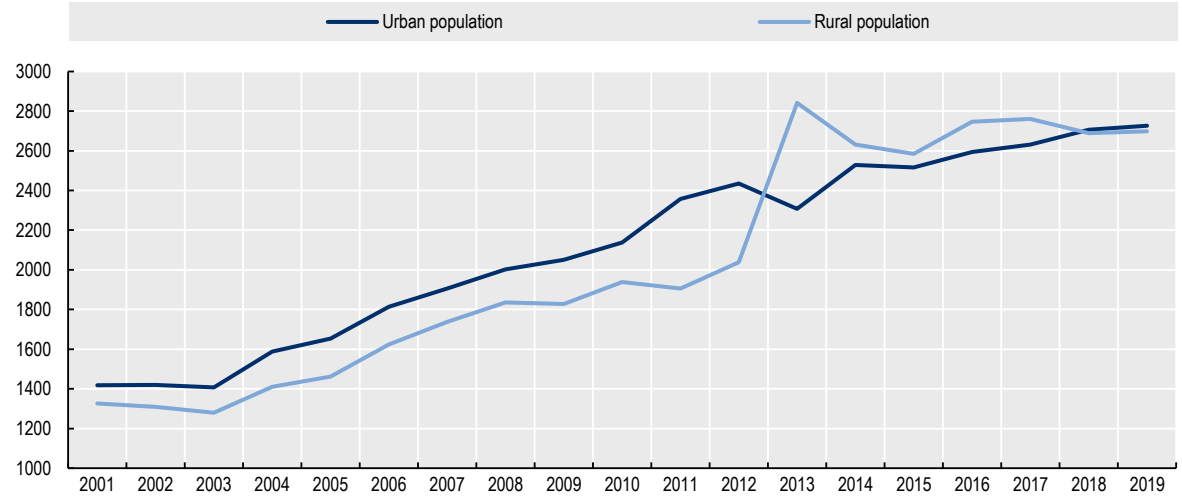
38. The prevalence of diagnosed mental health disorders has historically been higher in urban than rural areas, though the urban-rural gap has shrunk significantly.[2] The prevalence of diagnosed schizophrenic, mood affective, alcohol-related and psychoactive substance-use related mental disorders combined was considerably higher in urban areas in the period between 2001 and 2011, but increased in both rural and urban areas at a similar rate. In the period since 2012, the rate of diagnosed mental disorders in rural areas has increased considerably, significantly reducing the geographical gap (Figure 1.10). In the period between 2013 and 2017 the prevalence of diagnosed mental disorders was actually higher in rural areas, though the reverse has again been true since 2018 (Figure 1.10).

[2] In Lithuania, "urban" and "rural" residential areas within municipalities are classified primarily according to the number of residents, and their occupation. 'Urban' areas are primarily cities and towns with over 3 000 residents, where two-thirds of residents are employed in business, industrial or social industries (Lithuanian Institute of Hygiene, 2021[12]). 'Rural' areas are other residential areas which do not share these features (Statistics Lithuania). In the following discussion, references to 'urban' and 'rural' areas refer to urban and rural residential areas within municipalities, in accordance with Lithuanian classifications.

In accordance with the Law on the Territorial Administrative Units of the Republic of Lithuania and their Boundaries (1994), towns with a population below 3 000 residents which had already been legally designated as a 'town' prior to the enactment of the Law retained their township status. Therefore, there are a number of towns with populations below 3 000 residents which are classified as 'urban' in national statistics.

Figure 1.10. The urban-rural gap in diagnostic rates for mental disorders is shrinking in Lithuania

Prevalence of specific diagnosed mental health disorders in Lithuania per 100 000 population, 2001 - 2019

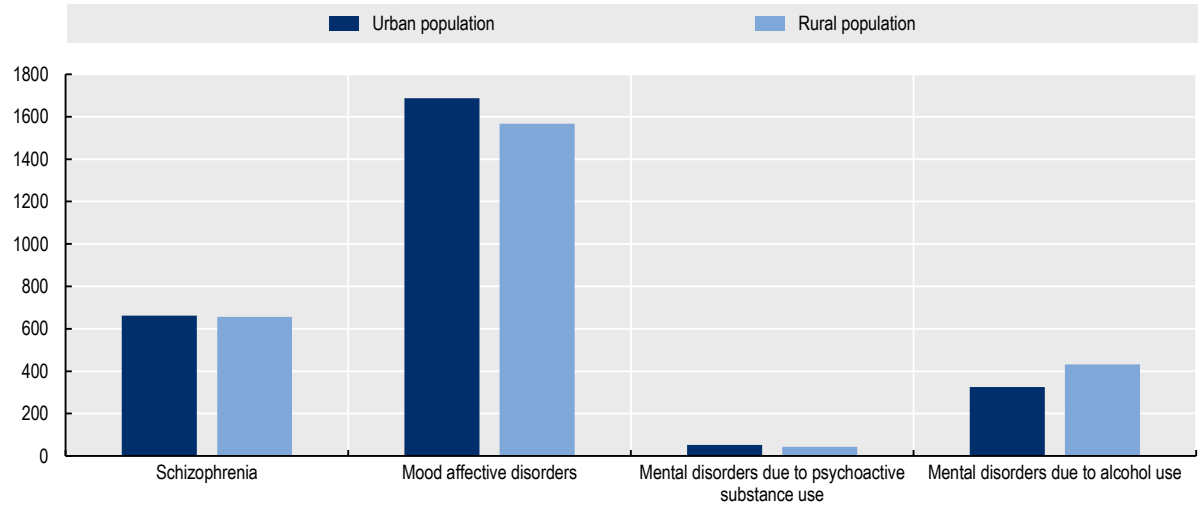


Note: Data refers to the prevalence of diagnosed schizophrenic, mood affective, alcohol and psychoactive substance-use related mental disorders
Source: (Lithuanian Institute of Hygiene, 2021[12])

39. As of 2019, the prevalence of diagnosed schizophrenic, mood affective and psychoactive substance-use related mental disorders was still slightly higher among the urban population, while the opposite holds for mental disorders due to alcohol use. Moreover, differences in diagnostic rates between urban and rural populations are more marked for mood affective disorders and alcohol-related disorders, but negligible for schizophrenic disorders and mental disorders due to psychoactive substance use (Figure 1.11).

Figure 1.11. The prevalence of most diagnosed mental disorders is still slightly higher in urban areas

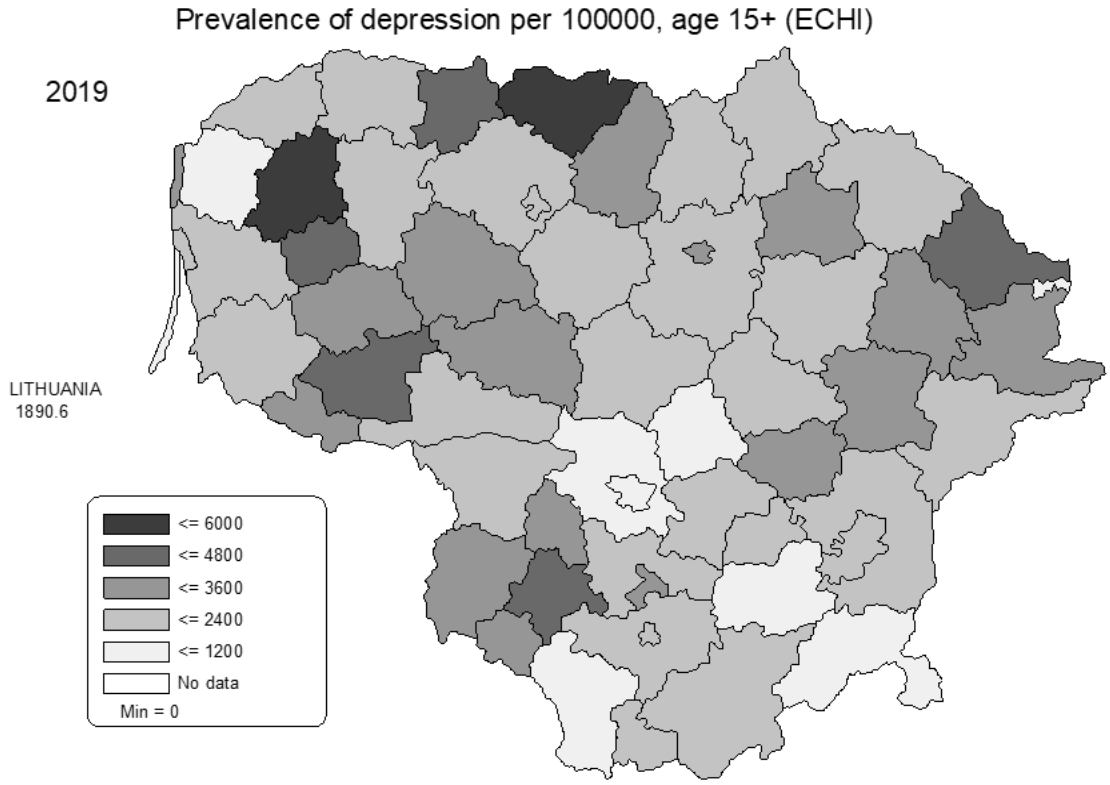
Number of diagnosed mental disorders in Lithuania per 100 000 population in 2019



Source: (Lithuanian Institute of Hygiene, 2021[12])

40. The prevalence of diagnosed depressive disorders varies considerably across municipalities. Figure 1.12 shows the geographical distribution of diagnosed depressive disorders amongst people aged 15 and over in greater detail. The prevalence of diagnosed depressive disorders varies across municipalities, with the southern areas of the country showing a lower level of diagnosis than the north. A variety of causes could explain these differences, such as regional variation in health care availability, socio-economic differences, and differences in mental health literacy and health care utilisation.

Figure 1.12. The prevalence of diagnosed depressive disorders varies across municipalities



Source: (Lithuanian Institute of Hygiene, 2021[12])

Box 1.1. Comparator Countries

This report refers to the mental health care systems and outcomes of France, Latvia, Norway and Scotland as comparator countries for the quality of Lithuania's mental health care system.

France

France has a centralised social insurance system, and regional health agencies play an increasing role in managing the provision of health services at the local level. In France, outpatient mental health care services are provided by General Practitioners, private practitioners (such as psychiatrists or psychologists), and regional medical-psychological centres (Centre Médico Psychologiques, or 'CMPs') which are located in most major townships (The Commonwealth Fund, 2020[15]); (UK Foreign & Commonwealth Office, 2020[16]). CMPs are linked to hospitals, and have multi-disciplinary teams of psychiatrists, psychologists, social workers and nurses (UK Foreign & Commonwealth Office, 2020[16]).

Latvia

As Lithuania's Baltic neighbour, Latvia shares similar challenges in the provision of mental health care. Like Lithuania, Latvia has one of the highest rates of suicide in the EU. Additionally, Latvia has high rates of hospitalisation for mental health conditions. The governance of mental health care is also similar to Lithuania, with Latvia's National Health Service responsible for the implementation of policies developed by the Ministry of Health, while municipalities are responsible for mental health promotion. In Latvia, outpatient mental health care services are provided by 22 municipal medical outpatient centres with specific mental health care consulting rooms, private practitioners (such as psychiatrists' practices), and outpatient departments in four mental health hospitals (Latvian Centre for Human Rights, 2016[16]).

Norway

In Norway, municipalities coordinate and provide primary mental health care (including general practices), while the national government provides specialist secondary services via four regional health authorities which own 19 health trusts that operate hospitals and specialised mental health services (Ruud and Friis, 2021[17]). In Norway, municipalities operate primary mental health care, which includes team-based primary mental health care and mental health care related to substance abuse (Ruud and Friis, 2021[17]). Secondary specialised mental health care is delivered in 66 local community mental health centres (CMHCs, which are referred to as 'District Psychiatric Centres' in Norway) which collaborate with GPs and primary mental health care practitioners in municipalities. CMHCs have mobile teams, outpatient clinics and inpatient wards. Specialised health services also include services for children and adolescents (Ruud and Friis, 2021[17]).

Scotland

The mental health system in Scotland is strongly oriented towards care in the community. General Practitioners (GPs) play a key role in managing manage mild and moderate disorders, and referral from a GP is typically needed to access specialist mental health services. Mental health care is also delivered by community mental health care teams, consisting of psychiatrists, and a range of other specialists such as psychologists and social workers.

Note: These countries were selected as comparator countries by the Lithuanian Ministry of Health
Source: (OECD, 2019[18]), (OECD, 2019[19]) (OECD, 2019[20]), (OECD, 2014[21]); (Forti, 2014[23])

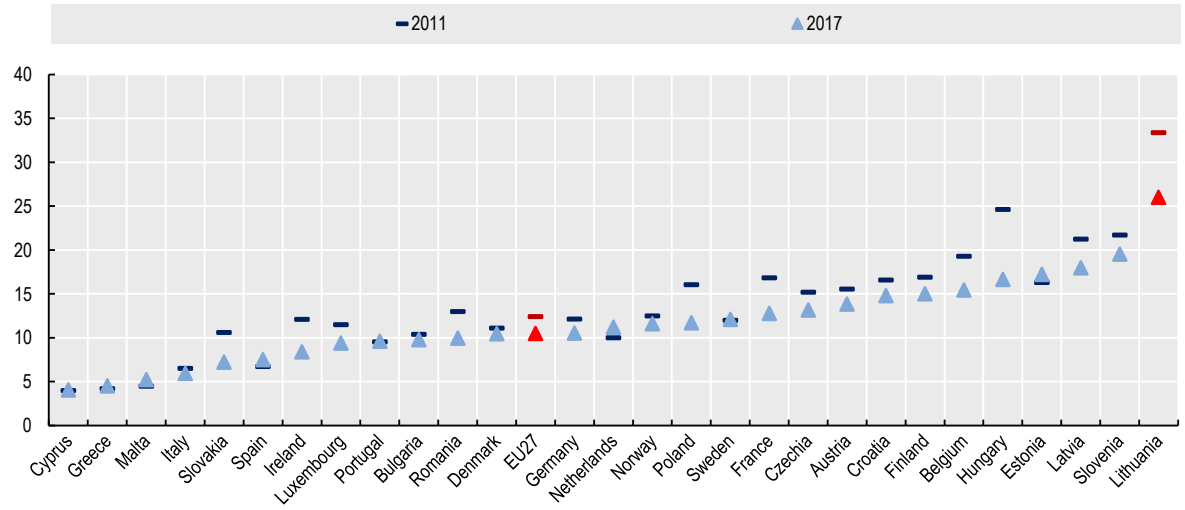
Rates of Death from Suicide

Lithuania has the highest suicide rate in the EU, though the rate has decreased significantly in recent years

41. Lithuania's suicide rate has decreased significantly in recent years (by approximately 22%) from 33 per 100 000 population in 2011, to 26 per 100 000 population in 2017 (Eurostat, 2021[3]). Additionally, Lithuania's suicide rate has fallen at a greater rate than the EU average: the EU27 average decreased by 15% between 2011 and 2017. However, Lithuania still has the highest suicide rate in the European Union, at times double that of France and Norway, and almost 10 percentage points higher than the rate in Latvia (Figure 1.13) (Eurostat, 2021[3]). The combined rate of suicide, alcohol and drug-related deaths in Lithuania (44 per 100 000 population in 2017) is also amongst the highest in Europe (OECD.Stat, 2022[22]). In 2017, it was almost double the average of European countries for which data is available (24 per 100 000 population based on 14 European countries), and second only to Slovenia (48 per 100 000 population) (OECD.Stat, 2022[22]).

Figure 1.13. Lithuania has the highest suicide rate in the EU

Standardised death rate per 100 000 population in 2011 and in 2017



Source: (Eurostat, 2021[23])

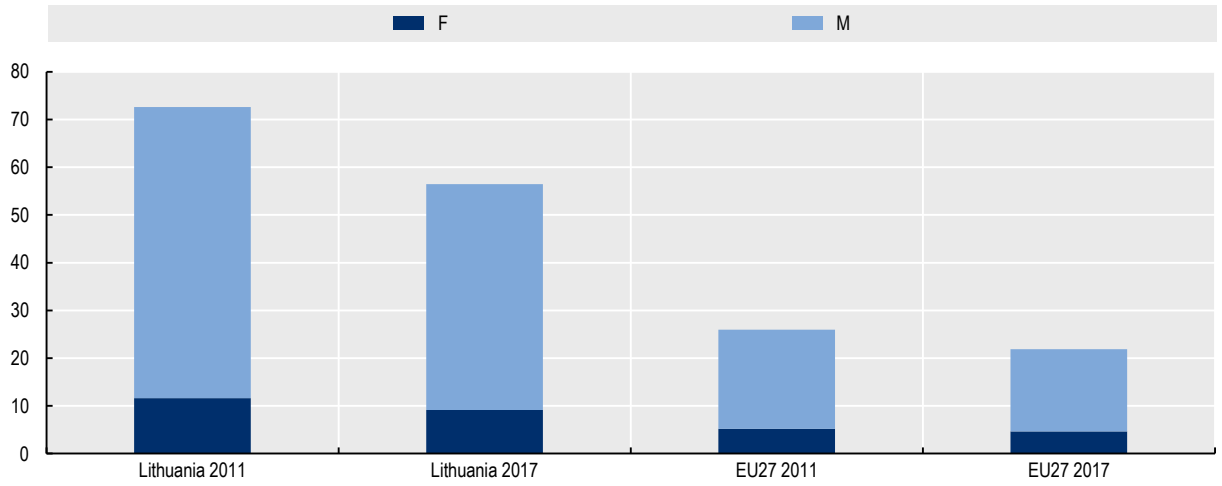
42. In Lithuania, suicide rates differ according to age, sex and location. Older populations aged 50+ have higher mortality rates from suicide. The 85+ age group experienced a decrease in suicide rates between 2013 and 2016, followed by an uptick in the most recent years (Eurostat, 2021[24]). While the suicide rate is highest amongst older populations, it is nevertheless noteworthy that suicide is among the leading causes of death among younger populations (ages 15-29) globally (WHO, 2014[25]). Lithuania is no exception in this regard. Over the past decade, self-harm and violence have been the leading cause of death for those in the age group 10-24, and the 5th cause of death for those in the age group 5-14 (GDB, 2021[26]).

43. Suicide rates are substantially higher amongst men than women across EU countries, and Lithuania is no exception. While the gender gap has slightly reduced over time, rates of death by suicide are still over 5 times higher for Lithuanian men than women (Figure 1.14). It is important to note that this trend runs counter to the differentiated rates of diagnosed mental health disorders outlined above, given

the rates of diagnosed depressive and mood affective disorders are significantly higher for women than men (Figure 1.7). The gap between the high suicide rate amongst men on the one hand and relatively low rate of diagnosed depressive and mood affective disorders on the other may be indicative of a diagnosis and treatment gap that could be more significant amongst Lithuanian men (Doblytė, 2021[27]).

Figure 1.14. The rate of death from suicide is over five times higher for men than women

Standardised death rate per 100 000 population in 2011 and in 2017



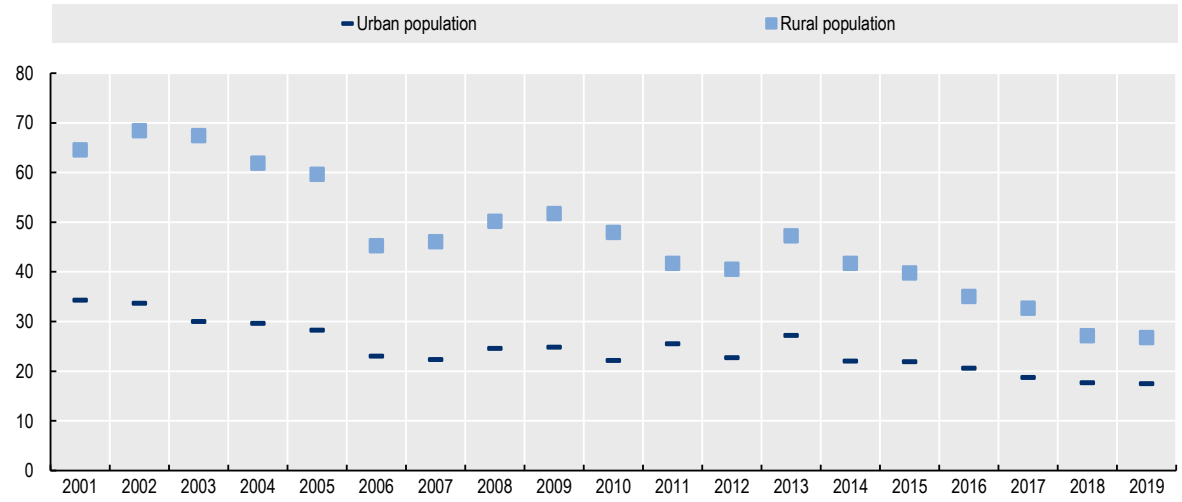
Source: (Eurostat, 2021[23])

44. It is important to note that women in Lithuania attempt suicide at a higher rate than men. In 2019, the number of suicide attempts in Lithuania was higher amongst women than men (National Suicide Prevention Action Plan 2020-2024, Order No. V-2008). The gender gap in suicide rates should therefore not necessarily be taken as an indication of greater mental distress amongst men than women.

45. The suicide rate in Lithuania has historically been substantially higher in rural areas than in urban areas, though the urban-rural gap has been shrinking. The urban-rural gap shrunk from a 30 point difference in 2001 to a 9 point difference in 2019 (Figure 1.15). While the gap is shrinking, urban-rural differences in suicide rates remain particularly striking when compared to the geographical distribution of diagnosed mental disorders. As outlined earlier in this Chapter, the rate of diagnosed mental and behavioural disorders has historically been far higher in urban areas. The gap between the suicide rate – higher in rural areas – and the diagnoses of mental disorders – lower in rural areas – may indicate a diagnosis and treatment gap which is greater in rural areas. This is in line with reports from Lithuanian mental health experts, who have indicated that the stigma surrounding mental ill-health is particularly persistent in rural areas and may pose a greater challenge to help-seeking as users do not want to be seen accessing mental health services (OECD interviews, 2021).

Figure 1.15. The suicide rate is much higher in rural areas, though the gap is shrinking

Standardised death rate for suicide and intentional self-harm, per 100 000 population, 2001-2019



Source: (Lithuanian Institute of Hygiene, 2021[12])

Conclusion

46. A strong mental health care system is critically important to meet current and future needs. Around one in six Lithuanians experienced a mental health problem in 2016, and the prevalence of diagnosed mental health disorders has increased significantly in the past two decades. Relatively low rates of diagnosis and high rates of suicide amongst men and those living in rural areas may indicate a diagnosis and treatment gap which is higher for these groups, though it is important to note that these differences should not necessarily be read as differences in the underlying prevalence of mental health conditions.

Annex 1.A. Mental Health Terminology

Mental Health Terminology Codified in Lithuanian Legislation

Case management (Atvejo vadyba)

- The process (or method) of services, efficient and effective planning and coordination to ensure that the necessary services are provided individually to the mental health care recipient.

Compulsory hospitalisation (Priverstinis hospitalizavimas):

- Hospitalisation without the consent of the hospitalised patient.

Family counselling (Šeimos konsultavimas)

- The work of a psychiatrist, adolescent psychiatrist, medical psychologist, social worker and (or) a mental health nurse working with the patient's family, informing the patient about the health of the patient, the characteristics of the disease, the cure tactics, the need for palliative/counter-treatment, and the characteristics of communication with the patient.

Hospitalisation (Hospitalizavimas):

- Placing a patient for examination and (or) treatment in a mental health care institution providing inpatient mental health care services.

Intensive psychiatric care (Intensyvi psichiatrinė slauga)

- Continuous individual monitoring and nursing of the patient by a mental health nurse.

Involuntary treatment (Priverstinis gydymas):

- Treatment without the patient's consent.

Mental and behavioural disorder (Psichikos ir elgesio sutrikimas):

- Disorders of a person's thoughts, behaviour, and (or) feelings caused by biological, psychological, or social factors, or the use of psychoactive substances.

*Mental health (*Psichikos sveikata)*:*

- A person's well-being, when he or she can realise his or her abilities, overcome normal life difficulties, and work and participate in the life of society.

Mental health care institution (Psichikos sveikatos priežiūros įstaiga):

- A personal health care institution with a license granting the right to provide personal mental health care services.

Mental health center (psichikos sveikatos centras)

- A personal health care institution (or its subdivision) holding a personal health care license of the institution, which gives the right to provide primary mental health care services.

Primary psychotherapeutic intervention (Pirminio lygio psichologinė-psichoterapinė intervencija):

- Services provided by a psychiatrist, child and adolescent psychiatrist or medical psychologist to a person, group or family which, through psychotherapeutic techniques, change an individual's pattern of problematic behaviour and/or attitudes, enhance the emotional maturity of an individual and improve mental health.

Primary outpatient mental health care (Pirminė ambulatorinė psichikos sveikatos priežiūra):

- A complex of qualified primary outpatient mental health care services provided in mental health centres.

Psychosocial rehabilitation (Psichosocialinė reabilitacija)

- An inpatient or outpatient process that includes assessment, counselling, training, support and general health services to enable people with mental and behavioural disorders to achieve an optimal level of self-functioning in the community.

Psychotherapeutic technique (psichoterapinė technika)

- Short-term specialized method used in primary-level psychotherapeutic intervention by a psychiatrist, a psychiatrist for children and adolescents, or a medical psychologist who has completed training in psychotherapeutic techniques and holds a certificate of completion.

Public mental health care (Visuomenės psichikos sveikatos priežiūra):

- A field of care designed to implement the prevention of mental and behavioural disorders to preserve and strengthen public mental health.

Remote primary outpatient mental health care service (Nuotolinė pirminė ambulatorinė psichikos sveikatos priežiūros paslauga) ('NSP service'):

- The provision of services by a psychiatrist, adolescent psychiatrist and (or) adolescent doctors of a mental health centre, and (or) a medical psychologist, to a patient without going to a primary outpatient mental health care facility by means of information and electronic communications technology that makes it possible to identify a person.

Source: Chapter 1, Article 2 of the Law of the Republic of Lithuania on Mental Health Care (1995, as amended); Chapter 1, section 3 of the Procedure for the Provision of Primary Outpatient Mental Health Care Services (2012, as amended); to Chapter 1, section 3 of the Description of the Procedure for Providing Psychosocial Rehabilitation Services to Persons with Mental Disorders (2012, as amended)

2 Structure of the Lithuanian Mental Health Care System

Introduction

47. This chapter provides an overview of the structure of the Lithuanian mental health care system, with a specific focus on governance and leadership, funding and expenditure, provider payment structures, and the mental health workforce. It sets out the accountabilities of public actors in the provision of mental health care, outlines the legislative basis for the provision of mental health care, sets out funding mechanisms for mental health care, and discusses workforce, payment and incentive structures, with comparative reference to other OECD countries.

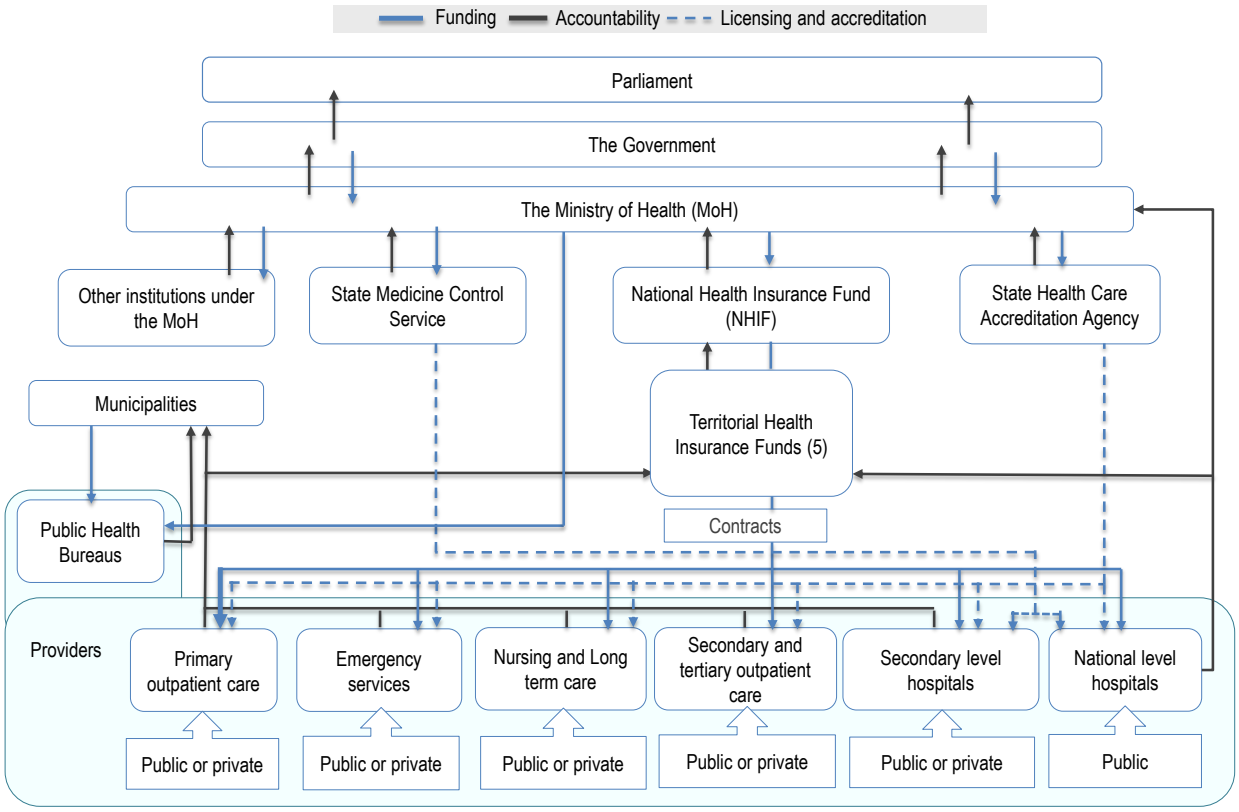
Leadership and Governance

Roles and responsibilities of public entities

48. In Lithuania, mental health care is provided primarily via the health care system. As in other EU countries, responsibility for the provision of mental health care falls to a range of different actors, including the Central Government and Parliament, the Ministry of Health, municipalities, and Public Health Bureaus. Other institutions, such as the State Medicine Control Service, the National Health Insurance Fund (NHIF), the State Health Care Accreditation Agency, and the State Mental Health Centre also have key roles in the management and oversight of mental health care.

49. The split of accountabilities between central and sub-national governments for the provision of personal health care is set out in the Law on the Health System of the Republic of Lithuania (1994, No. I-552). Municipal governments are responsible for the organisation of primary and secondary personal health care services, and the Ministry of Health is responsible for the organisation of tertiary health care, and for determining the extent of secondary and tertiary health care. The structure of the public health care system, which covers prevention and promotion services, is set out in the Law on Public Health Care of the Republic of Lithuania (2002, No. IX-886). Municipalities and Public Health Bureaus are accountable for public health care.

Figure 2.1. Organisation of the health care system



Source: Adapted from Lithuanian Ministry of Health

50. Within the health care system, functional responsibilities for the provision and regulation of mental health care span a range of actors (Figure 2.1):

- The **Ministry of Health** is accountable for setting health policy and for regulating the provision of personal health care services. The Minister of Health sets procedures for the provision of personal mental health care services across the health care system. The Ministry of Health is also responsible for tertiary mental health care, such as inpatient hospital care, and some secondary mental health care.

  The Ministry of Health additionally oversees a number of institutions with significant functional roles in monitoring and regulating mental health care:

  - The **State Medicine Control Service** is accountable for licensing and controlling pharmaceutical activities, clinical trials, and the registration of medicines.

  - The **National Health Insurance Fund** (**NHIF**) administers the national compulsory health insurance system, providing health care coverage to nearly the entire population (98 % in 2018) (OECD/European Observatory on Health Systems and Policies, 2019[1]). Coverage is mandatory and provides services for all residents subject to confirmation of their insurance status. The uninsured remain entitled to free emergency care.

  - The **State Health Care Accreditation Agency** is the accountable licensing authority for

health care institutions and health professionals, and regulates medical devices and health technology. The Agency is accountable for accrediting health care providers and professionals, and also controls health care quality and the implementation of patients' rights.

- The **State Mental Health Centre** is accountable for co-ordinating the implementation of national mental health policy (European Commission, 2013[28]). In practice, the implementation of mental health policy is split between the Ministry of Health and the State Mental Health Centre. The State Mental Health Centre also administers the national suicide prevention brand "TuEsi" ('you are'), and the national suicide prevention website.

- The **Institute of Hygiene** manages public health registers and statistics, and carries out public and occupational health research.

- **Municipalities** organise primary mental health care, and the majority of secondary mental health care. Municipalities also own a large share of primary care centres (particularly the polyclinics), primary mental health care centres, and the small to medium-sized hospitals (OECD/European Observatory on Health Systems and Policies, 2019[1]). Some municipalities also fund anonymous psychological consultations, which are provided in Public Health Bureaus. The private sector also plays a role in the delivery of primary and secondary mental health care, and private providers own a significant proportion of primary mental health care centres.

- **Public Health Bureaus** were established across municipalities following the State Programme for the Development of Public Health Care in Municipalities 2007-2010 (OECD, 2018[29]). Public Health Bureaus are a collaboration between central and municipal governments. They are accountable for the promotion of mental health and the prevention of mental disorders, planning and implementing local public health programs, and for monitoring a range of municipal public health indicators. Municipalities are encouraged but not required to establish a Public Health Bureau. Public Health Bureaus currently exist in 48 of 60 municipalities. Where municipalities do not establish a Public Health Bureau, they enter into a co-operation agreement with another municipality for the provision of such services.

  The range of promotion services provided in Public Health Bureaus has been expanded in recent years. In 2019, Public Health Bureaus began to promote mental health prevention in schools (OECD/European Observatory on Health Systems and Policies, 2019[1]). Since 2020, Public Health Bureaus have also begun to provide psychological well-being services through the provision of preventative psychological support, limited to five psychological consultations per person per year.

- Accountabilities for the provision of mental health care beyond the health care system are cross-sectoral:

  - The **Minister of Social Security and Labour** and the **Minister of Health** are jointly accountable for determining procedures for the provision of mental health care services in social care.

  - The **Minister of Justice** and the **Minister of Health** are jointly responsible for determining procedures for the provision of personal mental health services in correctional institutions and health care institutions in remand centres.

- The **Minister of Education, Science and Sport** is responsible for implementing mental health promotion and prevention programs in schools.

The legislative framework for mental health care

51. In Lithuania, a number of laws and procedures provide the legislative basis for the provision of mental health care. The primary legal instrument regulating the provision of mental health care is **the Law on Mental Health Care (1995, No. I-924)**. The Law on Mental Health Care sets out the principles guiding the provision of mental health care, the rights of patients with mental and behavioural disorders, conditions for the use of restrictive practices (including conditions for the use of seclusion, restraint and surveillance measures), and the conditions for involuntary hospitalisation and treatment. The Law legislates principles of minimum intervention, essentially entailing treatment via non-pharmaceutical measures such as psychological counselling and psychotherapy in the first instance, and treatment with medication and/or invasive or interventional measures only in the event that non-pharmaceutical measures are not effective. In practice, it is difficult to assess the extent to which application of the principle of minimum intervention is a reality in mental health services. Application of the principle is not recorded.

52. The Minister of Health has approved a number of ministerial Orders setting out procedures for the application of the norms and principles outlined in the Law on Mental Health Care:

- The **Description of the Procedure for Assessing the Patient's Mental Condition (2019, V-1433)** sets out the procedure for assessing patients' mental condition, including the responsibilities of family doctors, General Practitioners and mental health centres in the event that they suspect a patient is at risk of significant harm or death.

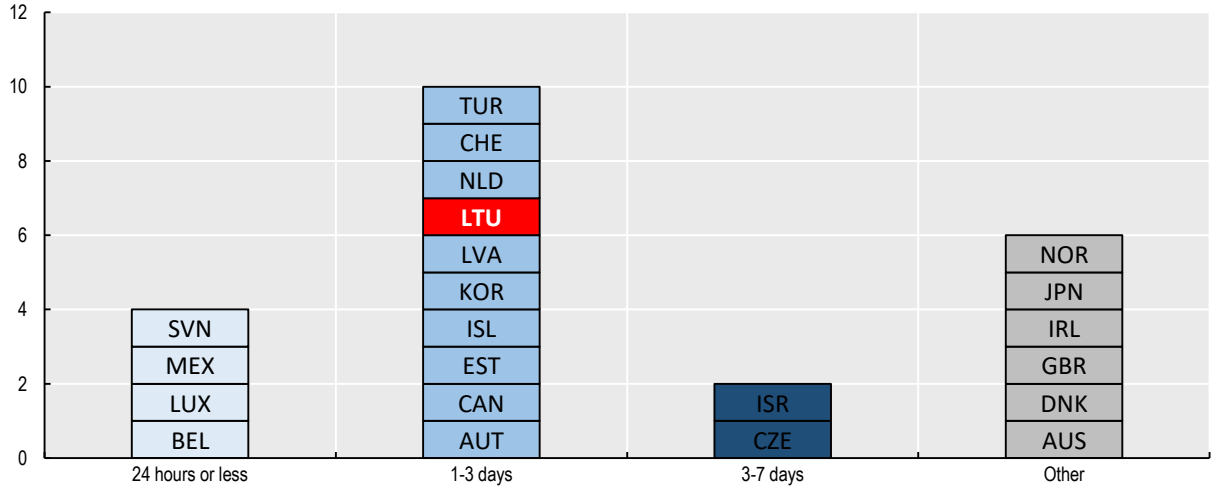
- The **Description of the Procedure for Monitoring the Application of Physical Restraint Measures to Patients with Mental and Behavioural Disorders and the Application of Physical Restraint Measures (2019, V-643)** sets out the procedure for the application and monitoring of physical restraint measures. The Law on Mental Health Care allows for the use of manual and physical restraint or seclusion in circumstances where a patient poses a potential harm to the health, life or property of themselves or others, and other measures are unavailable or ineffective. The Procedure sets out the process by which such measures may be applied, and requires personal health care institutions providing inpatient mental health care and emergency medical services to report to the Ministry of Health annually on the application of such measures.

- The **Description of the Procedure for the Monitoring of Cases of Involuntary Hospitalisation and Involuntary Hospitalisation of Patients with Mental and Behavioural Disorders (2019,V-587)** sets out the procedure for involuntary hospitalisation and its monitoring.

53. Across countries, legal frameworks for the use of involuntary admission set out the circumstances under which it is lawful for people to be detained on mental health grounds. International human rights treaties and principles provide international guidance on the development of national-level frameworks to protect human rights and guard against the inappropriate use of involuntary admission (OECD, 2021[4]). Despite international guidance, legal frameworks across OECD countries differ in the criteria for involuntary admission, the stakeholders involved in admission, and the length of time that people can be detained involuntarily without review by a judge (OECD, 2021[4]). There are also significant differences across countries in terms of the application of an involuntary hold (for instance, involvement of multiple medical professionals and/or legal actors; right of appeal by the person held; right of renewal of the hold), which makes comparison of days of involuntary hold across countries very challenging.

54. There is considerable variation across OECD states with respect to the length of time that a person can be held involuntarily under mental health legislation, ranging between 24 hours and 7 days (Figure 2.2).

Figure 2.2. Days a person can be held involuntarily under the Mental Health Act without review of a judge



Note: In addition to international variation, there can also be national-level differences with respect to legislation regarding involuntary admission. In countries listed under 'Other' (Australia, Denmark, the United Kingdom, Ireland, Japan, Norway), there are national differences in the number of days a person can be held involuntarily, for example depending on the jurisdiction, the assessment of a medical doctor, or the type of detention order

Source: (OECD, 2021[4])

55. In Lithuania, there is a 3 working day maximum on involuntary hospitalisation without review by a judge, and the patient or their representative has the right to participate in court proceedings deciding on involuntary hospitalisation. If they are unable to attend in person due to physical or mental health reasons, their appearance must be accommodated remotely, and such right can only be restricted by the Court.

56. In addition to the Law on Mental Health Care, there are a number of ministerial Orders which set out procedures for the delivery of mental health care. There are a number of specific ministerial Orders which set out the requirements of mental health care providers in the event of a suicide risk, for instance:

- The **Description of the Procedure for Providing Assistance to Those at Risk of Suicide, Those in a Suicide Crisis and Survivors of a Suicide Crisis (2018, No. V-859)** sets out the national suicide prevention procedure, regulating the health system response in the event of a suicide risk or attempt. It sets out the roles and responsibilities of different actors in identifying suicide risk and aiding those at risk. The procedure regulates the provision of continuing assistance to people who have been provided emergency assistance, and the flow of information between different providers of care. It requires institutions who provide emergency care to notify the patient's primary mental health care providers to ensure that ongoing care is provided.

  Local municipal assistance procedures have been developed by several municipalities to adapt the national procedure to local contexts. While municipal assistance procedures are developed on the initiative of municipalities, EU funds are made available to municipalities to finance their implementation. Municipal procedures can expand on the national suicide prevention procedure

(by setting out additional accountabilities at a municipal level, for instance), but cannot contradict it. Over 20 municipalities have introduced municipal suicide prevention procedures.

The National Suicide Prevention Procedure represents a significant effort to ensure the quality and continuity of care for those at risk of suicide, and is particularly significant given the period following attempted suicide is a period of peak suicide risk (Dadašev et al., 2016[30]). Its implementation represents concrete action on a finding by the National Audit Office in 2017 that there was no national suicide-prevention scheme for the provision of aid to those at risk of suicide, nor any mechanism regulating the flow of information across institutions with respect to patients found to be at risk (National Audit Office, 2017[31]).

While the procedure represents a significant step in the right direction, discussions with stakeholders have highlighted challenges with its implementation in practice, associated with a lack of funding for the completion of its requirements. Primary mental health care providers have indicated that the funding available for completion of the assessment outlined in the procedure is insufficient to cover the cost of conducting it, making it un-economical for primary mental health care providers to conduct an assessment of those identified to be at risk of suicide. Work is ongoing with the National Health Insurance Fund (NHIF) to review the size of the payment made to primary mental health care providers, and the broader assistance system is currently being reviewed by the Ministry of Health (OECD Interviews, 2021).

- The **Description of the Procedure for Psychosocial Assessment of Persons Surviving a Suicide Crisis (2018, No. V-856)** expands on the national suicide prevention procedure and sets out the requirements for the psychosocial assessment of people surviving a suicide crisis. It sets out requirements for the preparation of a plan for the provision of assistance to people who survive a suicide risk, regulates the flow of information between different institutions (requiring inpatient providers to notify outpatient providers), and sets out the obligations of providers in the event a patient refuses a psychosocial assessment.

57. In addition to the procedures that regulate the health system response in the event of suicide risk, there are also a number of ministerial orders setting out procedures with respect to the organisation of mental health care services, care delivery, and the compensation of providers. An overview of the relevant procedures is contained in Chapter Annex A.2.

Box 2.1. Strategic Planning

A number of national strategies set out guiding policies for the development of mental health care services in Lithuania.

Lithuanian Mental Health Strategy

The Lithuanian Mental Health Strategy (2007, No. X-1070) sets out a number of policies for the development of effective mental health services in primary care, schools and social services. Amongst the objectives of the Strategy are the development of community-based mental health services, strengthening the role of General Practitioners (GPs) and primary care physicians in the treatment of mental health disorders, encouraging the development of independent primary mental health care centres, reducing the number of services provided in psychiatric institutions, and developing measures to monitor and enforce the quality of mental health care services (OECD, 2018[29]). The Action Plan for the Implementation of the Mental Health Strategy and Suicide Prevention Plan for 2016-2020 (2016, No. V-213) sets out the implementation plan for the strategy.

National Suicide Prevention Plan

The National Suicide Prevention Action Plan for 2020 – 2024 (2020, No. V-2008) sets out a number of cross-sectoral policies for a subset of the population considered to be at high risk of suicide, namely men at risk of suicide, families and young people at social risk, people with mental health disorders, and people with severe chronic diseases and chronic pain. It sets a target for the reduction of Lithuania's suicide rate to 18 per 100 000 of the population by 2024. The Suicide Prevention Plan sets out a number of policy initiatives around four key objectives; improving the psychological well-being of those considered at high risk of suicide; ensuring the quality, availability and consistency of psychological assistance to those considered at high risk; developing the suicide prevention system; and developing and implementing good performance indicators. Notably, the National Suicide Prevention Plan (NSPP) aims to provide training for GPs on the recognition and treatment of depression and anxiety disorders, strengthen the continuity of assistance in the transition from inpatient to outpatient services, and increase the availability of psychological services in mental health centres by reducing the ratio of mental health specialists to population served.

The NSPP 2020 – 2024 succeeds the NSPP for 2016-2020. However, discussions with stakeholders and a 2017 review by the National Audit Office have highlighted limitations to the implementation of the 2016-2020 suicide prevention plan due to a lack of funding (National Audit Office, 2017[31])(OECD Interviews, 2021). It is therefore critically important that implementation of the NSPP 2020 – 2024 is appropriately resourced and monitored.

The COVID-19 Action Plan

The Action Plan to Reduce the Long-term Negative Consequences of the COVID-19 Pandemic on Public Mental Health (2020, Order No. V-1087) was developed to mitigate the potential long-term negative consequences of the COVID-19 pandemic on population mental health. The Action Plan sets out policies for the expansion and adaptation of existing services, the introduction of new services, such as psychological community crisis teams, and increases in the availability of public health promotion services. The Plan contains a number of cross-sectoral measures to bolster the provision of mental health care across health, education and social services, around a number of key priorities. The priorities include: raising public awareness of mental health issues, primarily through communications; expanding access to support for those with mental ill-health, including by reducing the ratio of psychologists to population served, and through the development of remote and telehealth services;

strengthening the competencies of and support available to personal health care professionals and specialists in the field of mental health; bolstering the monitoring of public health; supporting members of the public who suffered trauma or loss during the pandemic; and strengthening mental health in schools, and for older people.

Ongoing Hospital Reform

Alongside policy efforts to strengthen the provision of mental health care, the Lithuanian government is continuing deliberations on a large-scale hospital restructuring reform in the health care sector. Several attempts have been made in recent years to concentrate specialist services in larger centres and re-profile smaller hospitals, though the reform had stalled (OECD, 2018[29]).

Efforts to combat stigma

58. Good leadership and governance on mental health requires concerted efforts to reduce the stigma surrounding mental ill-health (OECD, 2021[4]). Stigmatising attitudes around mental ill-health not only place an additional burden on those living with mental health conditions, but can affect the take-up and quality of treatment. Stigma can serve as a barrier to help-seeking, reduce adherence to treatment or the efficacy of treatment, reduce openness to intervention, and generate resistance to the presence of mental health services in communities (OECD, 2021[4]).

59. Research suggests that stigmatising attitudes towards mental ill-health and suicide may be particularly prevalent in Lithuania, stemming in part from its unique cultural and historical context. During the Soviet era, psychiatry is reported to have been used to "deal with people who openly expressed criticism of the Soviet system" (Dadašev et al., 2016[30]). The structure of the Lithuanian mental health system during this time was characterised almost exclusively by medication, institutionalisation, and the consequent social exclusion of those with mental illness (Dadašev et al., 2016[30]). While Lithuania has since moved a significant proportion of mental health care into deinstitutionalised care settings, research conducted in Lithuania suggests that the stigma surrounding mental ill-health remains persistently stubborn.

60. The present-day impact of stigmatisation has been the subject of some discussion in Lithuanian research, which suggests a range of formal and informal modes of stigmatisation remain (Doblytė, 2021[27]) (Šumskienė, Petružytė and Klimaitė, 2018[32]). Formally, there remains legislation which prohibits people who have been diagnosed with certain mental health conditions from holding specified professional positions (such as judges and prosecutors), and performing certain activities (such as holding a driver's license). Qualitative research in Lithuania and discussions with stakeholders suggest these measures continue to serve as a significant barrier to help-seeking and treatment, with some users choosing to forego treatment on learning about the restrictions associated with diagnosis (Doblytė, 2021[27]). Positive steps have been taken in recent years to revise and repeal formal restrictions for those with mental health conditions, but remaining forms of formal stigmatisation should be repealed as a matter of priority.

61. Lithuania, like other EU countries, has made the reduction of stigma a policy priority. A number of measures have been introduced in Lithuania to combat stigma and increase mental health literacy:

- The government has introduced a public information campaign to increase mental health literacy;
- The government convenes a working group which reviews the list of professions and activities from which people with mental health conditions are barred;
- Public Health Bureaus have been allocated additional funding for prevention and promotion measures;
- In 2019, Lithuania launched its first nationally representative survey on attitudes related to mental health and stigma, including a translated version of the Attribution questionnaire AQ-9 and a compilation of other questions related to trends and priorities related to mental health stigma (OECD,

2021[4]); and

- The government has also engaged an expert to support on development of a methodology to measure levels of stigma amongst the general public, and to pilot a study to test the methodology.

62. While these measures represent significant steps in the right direction, discussions with stakeholders suggest that stigma remains one of the most significant barriers to help-seeking. Research conducted in Lithuania highlights this challenge. Qualitative research conducted with a small sample of adult patients hospitalised following a suicide attempt found that almost every participant (20/21) avoided help-seeking prior to their suicide attempt due to a perception that others are unwilling or unable to help (for example, due to the perception that others are indifferent or that their concerns would be met with negative reactions), a perception that people must cope independently, a preference to avoid sharing one's problems, a desire not to trouble others, or the perception that displays of emotion are a sign of weakness (Dadašev et al., 2016[30]).

63. Interviews with Lithuanian mental health experts suggest that stigmatisation is particularly likely to act as a barrier to help-seeking for older adults and those living in rural areas, potentially due to higher levels of stigma amongst these groups (OECD Interviews, 2021). For example, one service provider reported a sizeable change in the demographic of their users on changing the location of their practice so that users could attend the center without being seen to be accessing mental health services. Given the considerable impact that stigma likely continues to have on reducing the take-up of mental health care, it is critically important that efforts to redress stigmatisation are continued, funded and monitored.

Funding and Spending

Funding mechanisms for mental health care

64. The Lithuanian health care system is organised around the National Health Insurance Fund (NHIF), which provides health care coverage to almost the entire population (OECD/European Observatory on Health Systems and Policies, 2019[1]).

65. The NHIF funds mental health care delivered via the health care system. The Fund derives its revenue from several sources: compulsory earmarked payroll contributions from employers and employees; transfers from the state to cover economically inactive population groups; compulsory contributions from the self-employed and others; and transfers from the state for specific programs (OECD/European Observatory on Health Systems and Policies, 2019[1])

66. The publicly-funded benefits package covers inpatient and outpatient psychotherapeutic, psychological and social therapies (Doblytė, 2021[27]). Publicly-funded mental health care services are free at the point of access. There are no limitations on access to publicly-funded services, save for a limit on the number of psychotherapy sessions covered by the NHIF outside of primary care settings (30 sessions per year, per person), and a limit on the number of psychiatric day services covered by the NHIF (30 services per year, per person).

67. Psychologists and psychotherapists can have private practices, but these services are not covered by the NHIF, meaning that users must pay for them out of pocket. The cost of these services is often very high or prohibitive for the majority of the population (Kazlauskas, Zelviene and Eimontas, 2017[33]). Those who access private mental health care services are not required to have their personal details recorded in public records meaning that, in practice, those who can afford private mental health care are able to avoid the restrictions associated with formal stigmatisation measures, which raises equity concerns.

Public health bureaus

68. Public Health Bureaus are based on a joint funding model, and are funded through a mix of state, municipal and NHIF funds. At times, additional funds for Public Health Bureaus are also made available from EU Structural and Investment funds.

Strategic initiatives

69. Funding for the implementation of specific policy initiatives is determined separately. The National Suicide Prevention Plan is funded from state, municipal and EU Structural and Investment funds, and the NHIF also funds a number of measures in the plan. Policy initiatives in the COVID-19 Action Plan are funded from state budget funds, EU technical assistance funds, and by the NHIF.

70. Funding for mental health care services delivered outside of the health care sector is also determined separately. The Ministry of Social Security and Labour funds a small network of non-governmental organisations (NGOs), for instance, which provide social rehabilitation services.

Provider payment mechanisms

71. The NHIF purchases mental health care services through five regional branches (the Territorial Health Insurance Funds), which enter into contracts with public and private care providers for the provision of mental health care services. Outpatient and inpatient mental health care providers are compensated according to different payment methods.

Primary care facilities

72. Publicly-funded primary care facilities are paid using a combination of age-adjusted capitation fees (with an additional per capita amount for rural facilities), incentive payments associated with a list of specific services, and a pay-for-performance element.

73. Primary care facilities derive most of their revenue from capitation fees. In 2016, a little less than three quarters (72.9%) of publicly-funded primary care facilities' revenue came from the capitation component, 7.1% of revenue came from the additional per capita amount for rural facilities, 10.7% came from the fee-for-service component, and 9.3% of revenue came from the pay-for-performance component (OECD, 2018[29]).

Primary mental health care facilities

74. Primary mental health care facilities are compensated in the same way as primary care facilities, though capitation payments for primary outpatient mental health care services are paid at a flat rate and are not age or location adjusted. Primary mental health care facilities are required to employ a multidisciplinary team of psychiatrists, psychologists, mental health nurses and social workers (at a minimum), at a rate of one of each specialist post per 17,000 of the registered population, save for psychologists where the specified ratio is one psychologist per 10 000 of the population. Capitation payments are adjusted downwards if patient to specialist ratios exceed these requirements.

75. A number of mental health care services are included in the list of incentive services, including mental health care for people with a disability, primary psychological-psychotherapeutic interventions for individuals, groups and families, and early risk assessments of alcohol consumption. There is one pay-for-performance indicator relating to the provision of primary outpatient mental health care, which is the rate of avoidable hospitalisation of patients with schizophrenia. The 'good performance payment' made to providers is assessed every six months, at which time performance targets are re-calibrated.

76. The majority of primary mental health centres' revenue is derived from capitation fees. In 2019, capitation accounted for 88% of payments made to primary mental health care centres. The proportion of revenues that primary mental health care centres derive from capitation has decreased only marginally in recent years, from 89.6% in 2014 to 87.9% in 2019. The proportion of revenues that primary mental health care centres derive from incentive services has decreased, while the proportion of revenue derived from the good performance component has increased. The proportion of payments made for incentive services decreased by 4.5 percentage points between 2014 and 2019, from 9.4% to 4.9%. The share of payments made for good performance in mental health care increased by approximately 6 percentage points in the same period, from 0.9% in 2014 to 7.3% in 2019.

77. Discussions with Lithuanian mental health experts have highlighted a number of challenges with respect to the payment system for primary mental health care, particularly with respect to the fee-for-service and pay-for-performance components. Specifically, Lithuanian mental health experts suggest that the overall level of reimbursement for the provision of psychotherapeutic services is low relative to the cost of providing them, making it uneconomical for many primary mental health care providers to provide such services. Lithuanian experts have also raised a number of challenges with respect to the metric used to incentivise high quality mental health performance. These challenges are discussed in further detail in Chapters 3 (Care Delivery) and 4 (Quality and Outcomes) respectively.

Secondary and tertiary mental health care facilities

78. Secondary and tertiary mental health care providers are paid according to basic prices, which are itemised in a number of ministerial Orders. These are described in further detail in Chapter Annex 2.A.

79. To account for the fact that case-based systems can financially incentivise increases in the number of hospitalisations, contracts between the NHIF with individual facilities include volume ceilings for in-patient services which are decreased year-on-year (OECD, 2018[29]). If volumes exceed the contractual volumes, providers are not reimbursed. Contracts also contain volume ceilings for secondary and tertiary outpatient services. If volumes for these services exceed the contractual volumes, additional cases are reimbursed at a lower rate. Since 2012, "day-cases" (which include hospitalisations typically less than 24 hours but can be extended up to 48 hours) are not capped, to encourage their development (OECD, 2018[29]).

80. Given the potential for case-based systems to financially incentivise hospitalisations, there is a risk that the incentive structures for inpatient mental health care and outpatient primary mental health care could conflict if not monitored appropriately. Primary mental health care providers have raised concerns that conflicting financial incentives could play some role in accounting for a drop in the continuity of care between inpatient and outpatient settings, particularly given there is currently no financial incentive for the handover of patients from inpatient to outpatient providers, and case-based payments are not contingent on patient handover (OECD Interviews, 2021). It is therefore critically important that volume ceilings continue to be monitored and adjusted to ensure alignment of payment systems. Consideration could also be given to incentivising better coordination between inpatient and outpatient providers. This challenge is discussed in further detail in Chapter 3 (Care Delivery).

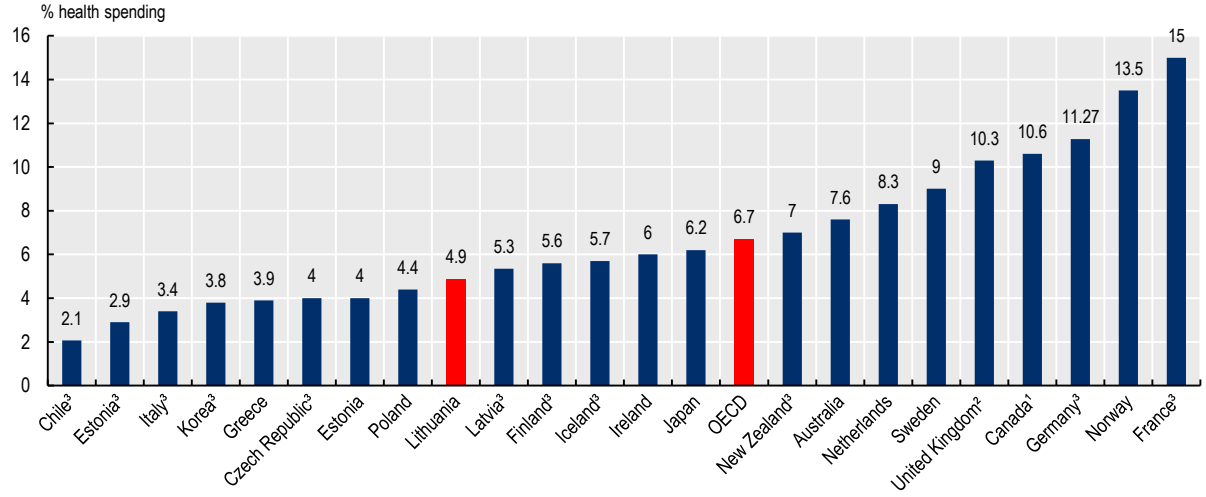
Spending on mental health care

81. Comparisons of national expenditure on mental health are challenging given variations across countries in terms of the scope of services included, and variations in whether government expenditure or all expenditure is included (OECD, 2021[4]). While international comparisons of mental health expenditure must therefore be interpreted with some caution, data suggests that Lithuania spends less on mental health care as a proportion of total government health spending (4.9%) than the OECD average (6.7%, based on the 23 OECD countries for which data was available). In 2018, Lithuania's estimated mental health spending accounted for 4.9% of total government health spending, somewhat lower than comparator

country Latvia's spending of 5.3%, and considerably lower than comparator countries Norway and France, who dedicated 13.5% and 15% of health care expenditure to mental health respectively (Figure 2.3).

Figure 2.3. Lithuania spends less on mental health care as a proportion of total government health expenditure than the average of OECD countries for which data is available

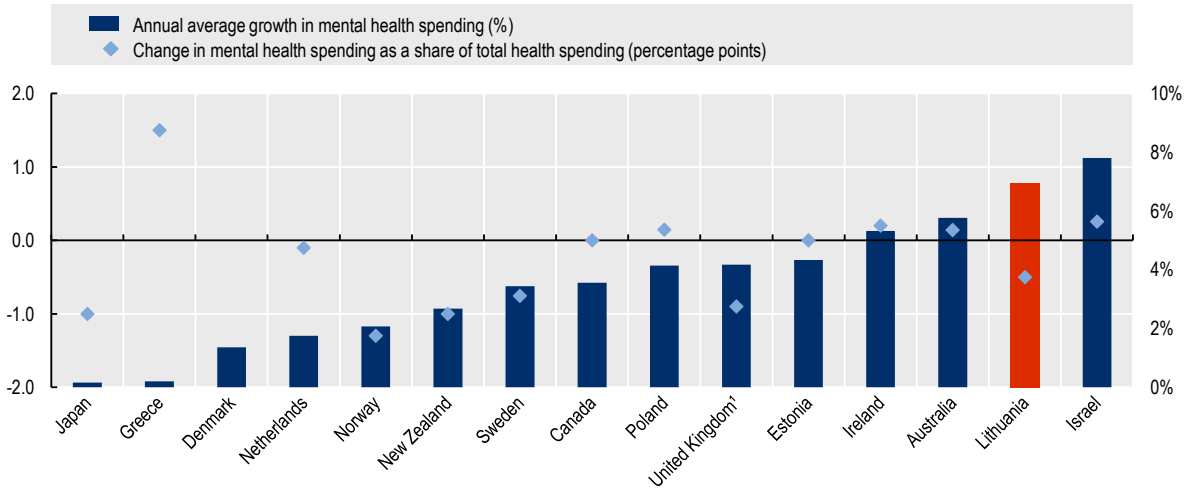
Estimated mental health spending as percentage of total government health spending, 2018 (or latest year)



Note: Reporting methods differ by country, including the range of services covered and whether spending can be disaggregated by age (adult only). Therefore caution should be taken in comparing spending across countries.
[1]Includes dementia; [2]Data for England; [3]WHO Atlas 2017 - % of total government health expenditure.
Sources: Adapted from (OECD, 2021[4])

82. National expenditure on mental health care has grown in all OECD countries over the past decade, though the share of health expenditure dedicated to mental health has generally remained relatively stable, and in some countries has fallen (OECD, 2021[4]). This trend is also evident in Lithuania, where funding has generally grown in absolute terms, though the share of health expenditure dedicated to mental health has declined. In Lithuania, funding for mental health care increased steadily in the period between 2014 and 2019, increasing from €51.5m in 2014 to €84.9m in 2019. While absolute funding for mental health care has generally increased, however, the proportion of spending on mental health care as a percentage of total health spending declined by 0.5% in the years between 2015 and 2019 (Figure 2.4). The absolute value of funding for mental health care also dipped somewhat in 2020 (falling to €78m), due to a reduction in the availability of mental health care services stemming from service disruptions caused by the COVID-19 pandemic and associated confinement measures.

Figure 2.4. Spending on mental health care as a proportion of total health expenditure has been declining in Lithuania

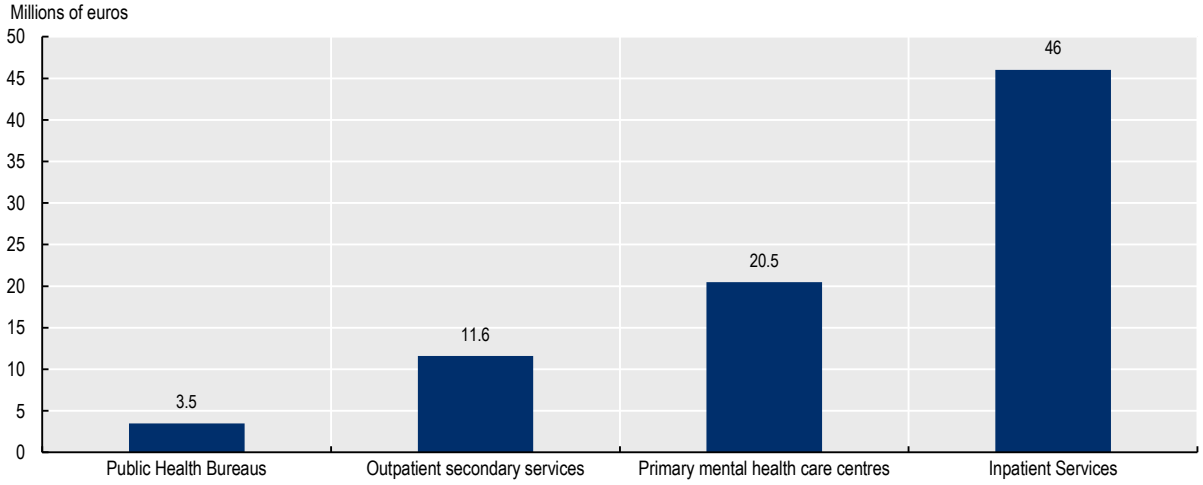


Note: Change in mental health spending as a share of total health spending (in percentage points) is reported on the primary (left-hand) axis. The annual average growth in mental health spending (%) is reported on the secondary (right-hand) axis. Data for Australia is for 2009-2018, Canada (2011-2019), Denmark (2011-2018), Estonia (2015-2017), Greece (2009-2018), Ireland (2014-2019), Japan (2009-2018), Lithuania (2015-2019), Netherland (2015, 2017), New Zealand (2009-2019), Norway (2013-2017), Poland (2009-2019), the United Kingdom (England) (2017-2018).
Source: (OECD, 2021[4])

83. The majority of health funding for mental health care is dedicated to inpatient services. In 2020, the total health care budget for mental health care (excluding funding for Public Health Bureaus) was €78m. Funding for inpatient services accounted for €46m, representing 59% of mental health funding in the health care sector in 2020 (excluding funding for Public Health Bureaus) (Figure 2.5). The share of funding dedicated to primary mental health care and outpatient specialised secondary services is significantly lower, comprising €20.5m (26.3%) and €11.6m (14.9%) respectively in 2020. The proportion of funding dedicated to mental health activities within Public Health Bureaus is low, comprising €3.5m in 2020.

Figure 2.5. Inpatient services absorb the majority of mental health funding in Lithuania

Ministry of Health funding for mental health care, 2020



Note: Funding for Public Health Bureaus (PHBs) refers to the proportion of PHB funding allocated to mental health, and includes funding for prevention and promotion as well as the provision of preventative mental health care services (psychological counselling)
Source: Lithuanian Ministry of Health

84. While the proportion of NHIF funding dedicated to inpatient services remains high, it has decreased in recent years. The share of NHIF funding dedicated to inpatient services decreased by approximately 7 percentage points between 2014 and 2020, from 66% in 2014 (€34m) to 59% in 2020 (€46m). This trend pre-dates the COVID-19 pandemic: the share of funding dedicated to inpatient services declined steadily between 2014 and 2020 (save for in the year 2017, when there was a slight increase). This trend may be indicative of the considerable efforts that have been made to increase the role of primary care providers in the provision of mental health care, and efforts to shift a substantial part of institutionalised psychiatric and substance abuse services into community-focused systems of care (OECD, 2018[29]).

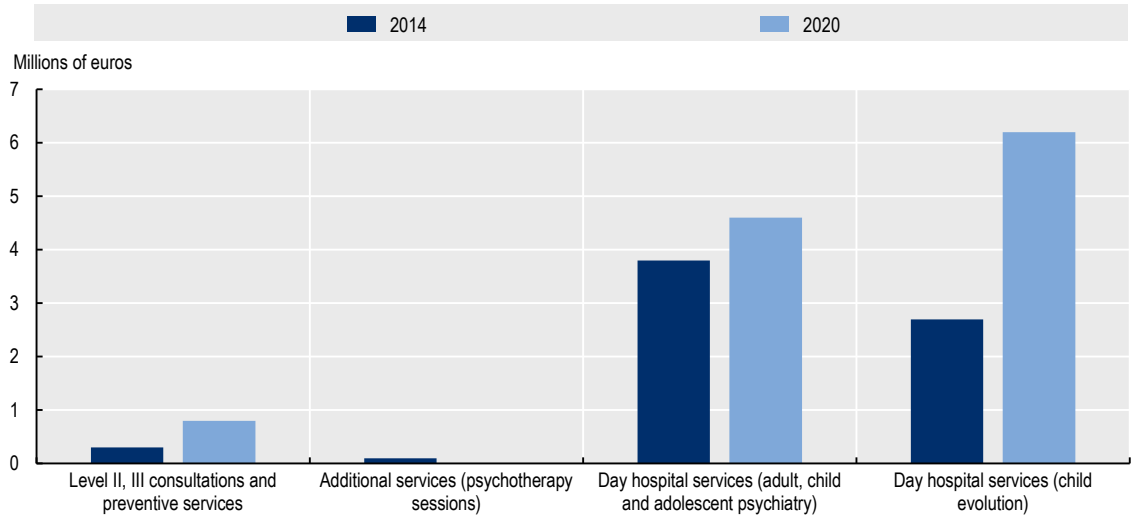
85. The proportion of funding dedicated to primary mental health care centres remained relatively stable in the period between 2014 and 2019, accounting for 20.6% of NHIF funding on average. In 2020, the share of funding dedicated to primary mental health care centres increased sharply, rising to 26.3% of the total NHIF budget for mental health.

86. The proportion of funding devoted to specialised outpatient secondary services fluctuated between 2014 and 2020, ultimately increasing by 1.5 percentage points from 13.4% in 2014 to 14.9% in 2020 (and reaching a peak in 2019, when 17.6% of the NHIF budget for mental health was devoted to specialised outpatient services).

87. The majority of funding for specialised outpatient secondary mental health care services is allocated to day hospital services (Figure 2.6). The absolute value of funding for day hospital services grew steadily in the period between 2014 and 2019, though dipped somewhat in 2020, also due to service disruptions stemming from the COVID-19 pandemic and associated containment measures (falling from €14.1m in 2019 to €10.8m in 2020). Funding for the provision of specialised outpatient psychotherapy services is negligible, comprising approximately 1.1% of the budget for specialised outpatient services on average in the period between 2014 and 2019, and 0% in 2020.

Figure 2.6. The majority of funding for specialised (non-primary) outpatient mental health care is allocated to day hospital services

NHIF funding for specialised (non-primary) outpatient mental health care, 2014 and 2020



Source: National Health Insurance Fund

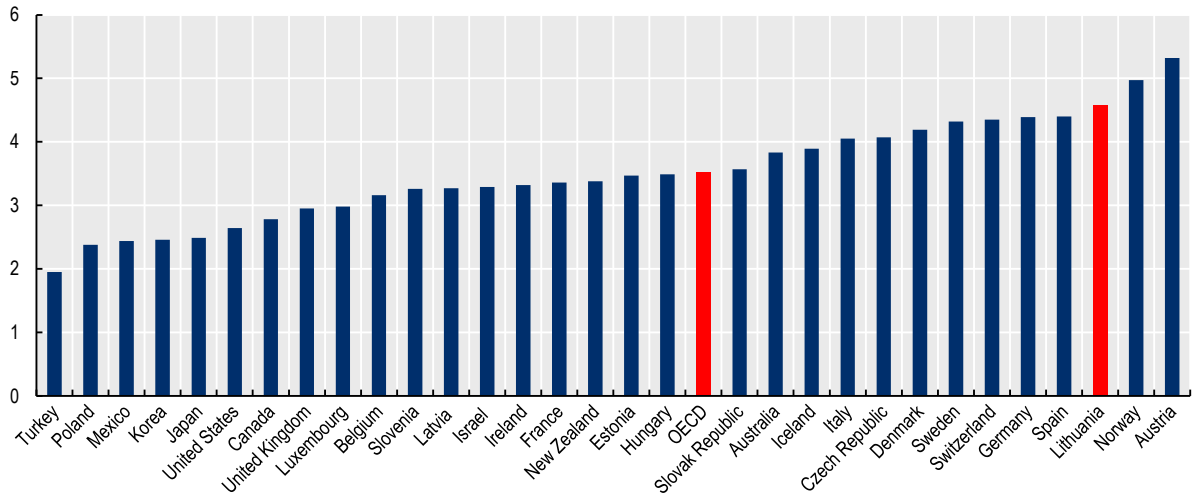
Workforce

Primary (non-specialised) mental health care

88. In Lithuania, as in other OECD countries, mental health care is provided by specialised and non-specialised primary care providers. Lithuania has one of the highest rates of doctors per 1 000 population in the OECD (Figure 2.7). In 2019, Lithuania had 4.57 doctors per 1 000 population, compared to the OECD average of 3.52.

Figure 2.7. Lithuania has one of the highest rates of doctors per 1 000 population in the OECD

Doctors per 1 000 inhabitants, 2019 or nearest year



Note: Doctors are defined as "practising" doctors providing direct care to patients. However, for some countries (Canada, France, the Netherlands, Slovakia and Türkiye), due to lack of comparable data, the figures correspond to "professionally active" doctors, including doctors working in the health sector as managers, educators, re-searchers, etc. (adding another 5-10% of doctors). Doctors are usually generalists who assume responsibility for the provision of continuing care to individuals and families, or specialists such as paediatricians, obstetricians/gynaecologists, psychiatrists, medical specialists and surgical specialists. This indicator is measured per 1 000 inhabitants.
Data for Luxembourg is for 2017, Poland (2017), Denmark (2018), Japan (2018), Sweden (2018).
Source: (OECD, 2021[34])

89. As outlined earlier in this Chapter, the Lithuanian Mental Health Strategy (2007, No. X-1070) sets out to strengthen the role of general practitioners and primary care providers in the treatment of mental health disorders. However, Lithuanian stakeholders have highlighted a number of challenges with respect to the treatment of mental health disorders by General Practitioners, noting high rates of onward referral (OECD, 2018[29]). These challenges are described and discussed in further detail in Chapter 3 (Care Delivery).

The specialised mental health workforce

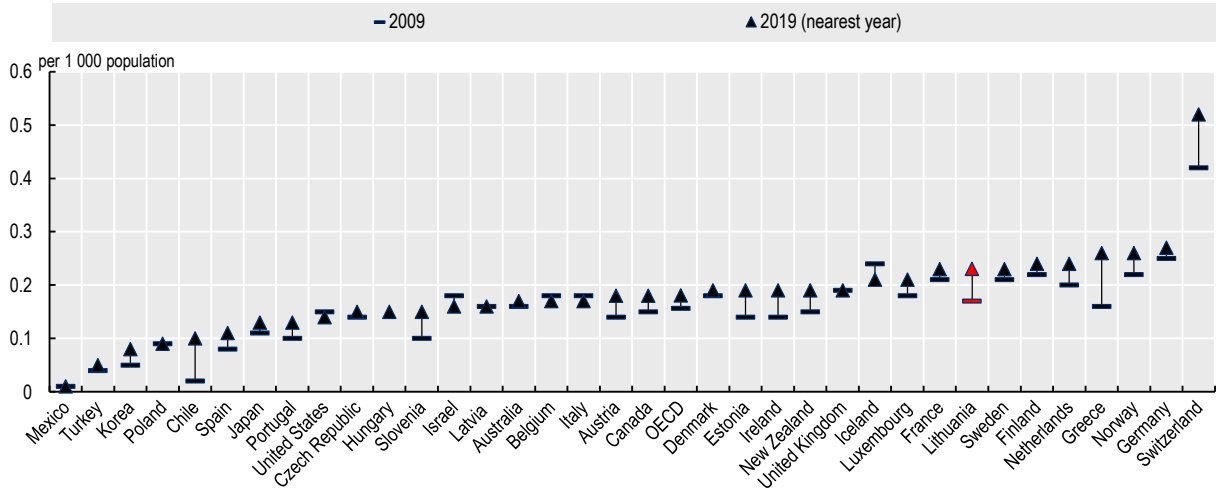
90. The specialised mental health workforce varies significantly across OECD countries, and comparable data is not available for all workforce categories (OECD, 2021[4]). International comparisons of mental health resources are rendered difficult due to challenges with the availability of national-level data and variation across countries in classification and reporting practices for workforce types (OECD, 2021[4]). Nevertheless, what data is available indicates considerable variation across countries in both the

composition and capacity of the mental health workforce. The rate of psychiatrists per 1 000 population in 2019 ranged from 0.01 in Mexico to 0.42 in Switzerland, for instance (Figure 2.8) (OECD, 2021[4]).

91. In Lithuania, as in many OECD countries, mental health nurses and psychiatrists make up a significant proportion of the mental health workforce. In 2019, Lithuania employed 0.23 psychiatrists per 1 000 population, slightly above the OECD average of 0.18 (Figure 2.8).

Figure 2.8. Lithuania employs more psychiatrists per 1 000 population than the OECD average, and the ratio of psychiatrists to population served has increased significantly

Psychiatrists per 1 000 population, 2009 and 2019 or nearest year



Source: (OECD, 2021[4])

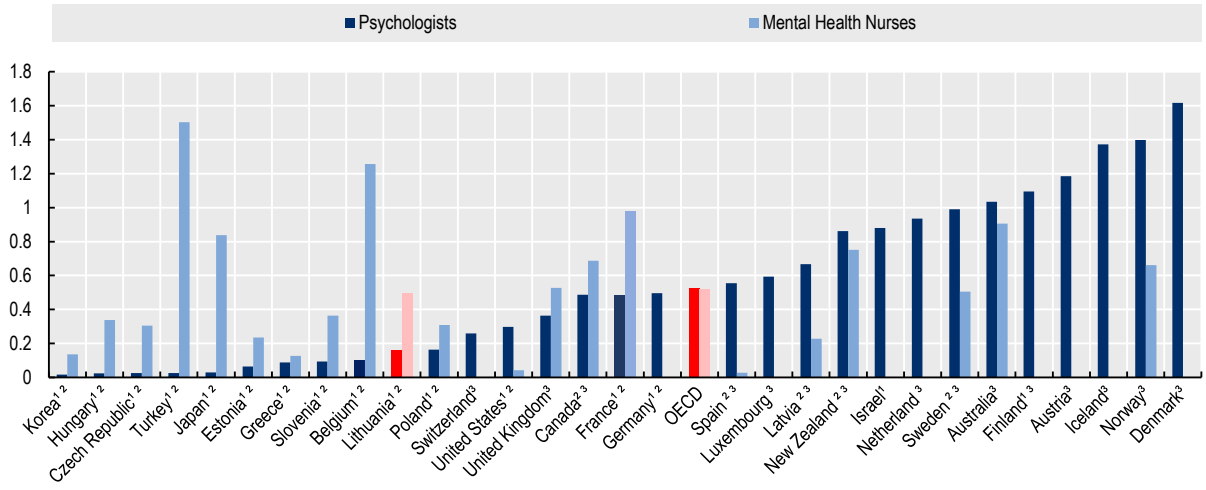
92. In Lithuania, as in other OECD countries, the rate of psychiatrists per 1 000 population increased between 2009 and 2019 (OECD, 2021[4]). On average, the rate of psychiatrists increased across the OECD from 0.16 per 1 000 population in 2009 to 0.18 per 1 000 population in 2019. The rate of psychiatrists per 1 000 population has increased at a significantly higher rate in Lithuania, increasing by over 30% from 2009 to 2019, from 0.17 per 1 000 population to 0.23 per 1 000 population.

93. The rate of psychiatrists per 1 000 population has grown at a higher rate than comparator countries France and Latvia, which show small increases in the proportion of psychiatrists to population served, while the rate of psychiatrists per 1 000 population in Norway increased at marginally lower rate (by 4 percentage points between 2009 and 2019). This could be due to population decline, as the Lithuanian population has declined by more than 20% since 2000 in 70% of municipalities (OECD, 2018[29]).

94. An international comparison of the rate of psychologists in 2018 suggests that Lithuania has one of the lowest rates of psychologists per 1 000 population in the OECD. Lithuania employed 0.16 psychologists per 1 000 population in 2018, which is considerably lower than the OECD average of 0.53 per 1 000 (Figure 2.9). While this data must be read cautiously given challenges with respect to the comparability of the data across countries, discussions with Lithuanian mental health experts have highlighted significant challenges with respect to the recruitment of psychologists, particularly in the public system, and particularly in rural areas (OECD, 2018[29])(OECD Interviews, 2021).

Figure 2.9. Lithuania has one of the lowest rates of psychologists per 1 000 population in the OECD

Psychologists and mental health nurses per 1 000 population, 2018 or latest year



Note: [1]Data on number of psychologists taken from WHO Mental Health Atlas 2017 [2]Data on mental health nurses taken from WHO Mental Health Atlas 2017 [3]National sources used
Source: (OECD, 2021[4])

95. In 2021, there were 994 registered clinical (medical) psychologists in Lithuania, and 563 clinical (medical) psychologists were employed in health care institutions.

Challenges with the recruitment of psychologists and child and adolescent psychiatrists

96. Lithuanian stakeholders have consistently referred to shortages of specific specialists, particularly clinical psychologists and child and adolescent psychiatrists (OECD Interviews, 2021). These challenges have been echoed in the broader literature (Šumskienė, Petružytė and Klimaitė, 2018[32]). Recent investment contained within the Government of Lithuania's COVID-19 Action Plan to increase the number of psychologists in primary mental health care centres in order to reduce burgeoning patient to psychologist ratios are therefore to be welcomed: from August 2021, the mandatory ratio of psychologists to population served was adjusted downwards, and additional funding was made available to primary mental health care centres to recruit medical psychologists.

97. However, interviews with Lithuanian mental health experts have suggested that underfunding, low wages and private sector competition continue to pose challenges with respect to the recruitment of specialists in the public health care system. Interviewees indicated these challenges may be even more pronounced in rural areas, as the private sector may play less of a role in service delivery, and demand on public services might therefore be higher. Primary mental health care providers have also highlighted that the skills of mental health nurses are often under-utilised on administrative work, as funding is provided for professionals but not administrators (OECD Interviews, 2021).

98. In addition to these challenges, Lithuanian mental health experts have noted a number of unique challenges with respect to the recruitment of child and adolescent psychiatrists. In 2020, there were only 60 child and adolescent psychiatrists in the mental health care system, serving as many municipalities (National Health Insurance Fund). The overwhelming majority of publicly-funded and privately-owned mental health care institutions did not employ a child and adolescent psychiatrist in 2020 (FTE, National Health Insurance Fund). In circumstances where mental health care institutions do not employ a child and adolescent psychiatrist, legislation allows for general psychiatrists to treat children and adolescents.

However, primary mental health care providers have suggested that there is consequently insufficient incentive for providers to recruit child and adolescent psychiatrists as their salaries are higher than those of general psychiatrists, and it is therefore more economical for primary mental health care providers to employ general psychiatrists. Lithuanian stakeholders have indicated that, in practice, children and adolescents are often seen by general psychiatrists, which may have implications for the quality of the mental health care provided, and could result in a diagnosis and treatment gap for children and adolescents (OECD Interviews, 2021).

Geographic imbalances in the distribution of the primary mental health care workforce

99. The distribution of the mental health workforce is a persistent challenge across OECD countries (OECD, 2021[4]). Within countries, psychiatrists and other mental health specialists are not necessarily well distributed across the population (OECD, 2021[4]).

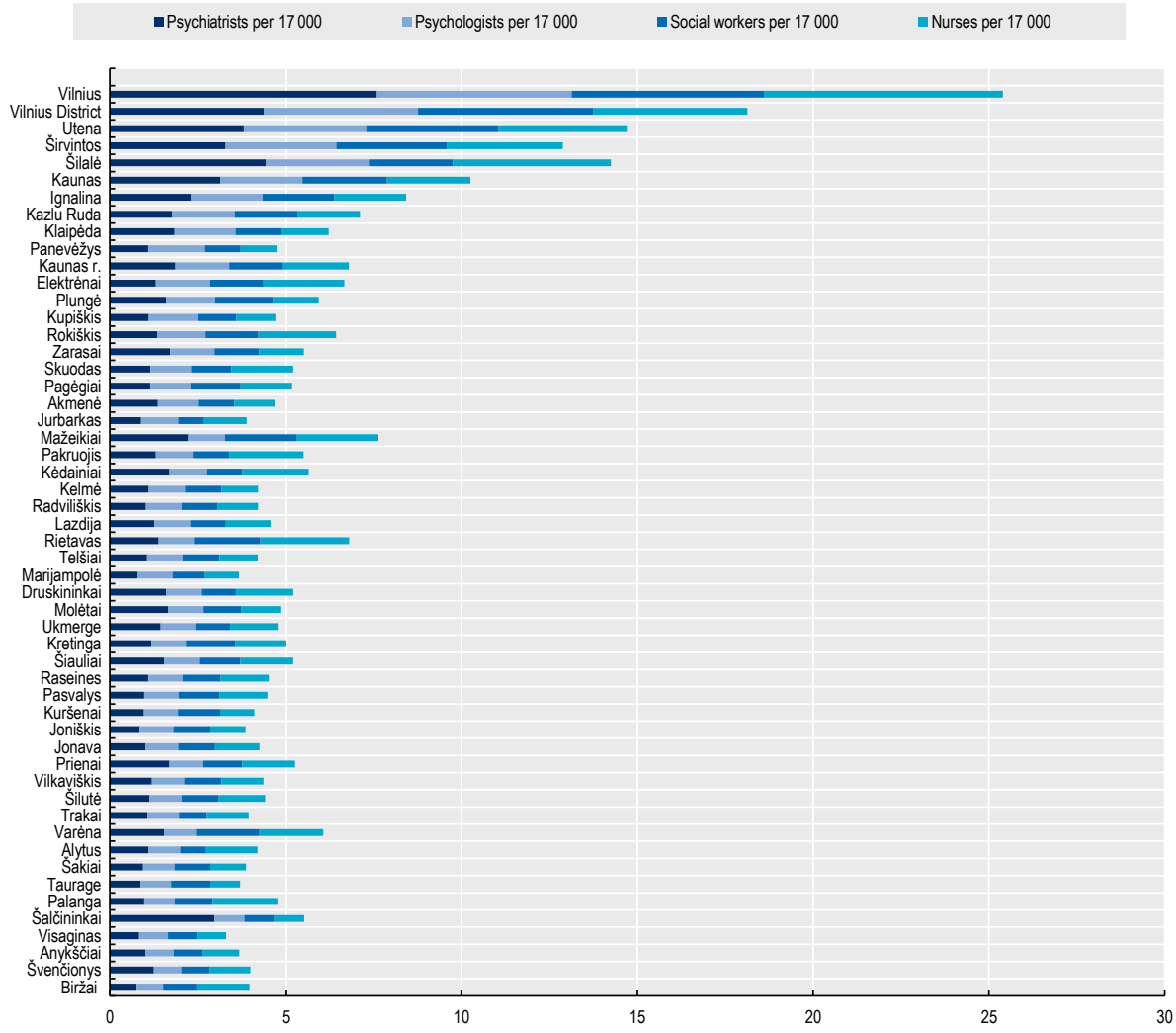
100. In Lithuania, stakeholders have repeatedly referred to challenges with respect to the geographical distribution of the primary mental health care workforce, raising concerns about the accessibility of primary mental health care specialists for users, and the capacity of primary mental health care centres to treat complex mental health disorders.

101. While legislation sets minimum specialist to patient ratios and minimum daily working hours (6 hours), challenges with respect to the recruitment of specialists has translated to persistent geographic imbalances in the distribution and availability of the workforce (European Commission, 2013[28]). A 2017 review by the Lithuanian National Audit Office found, for instance, that in 31% of surveyed mental health care centres, experts worked less than five hours per day, and in more than one in three mental health care centres (38%) the entire team of experts were not available every day (National Audit Office, 2017[31]).

102. Data on the geographical distribution of the primary mental health care workforce highlights this challenge. The average municipal ratio of mental health specialists to 17 000 of the population varied widely across specialists and municipalities in 2019 (Figure 2.10). The average ratio of psychiatrists varied from 0.76 per 17 000 population served in Biržai to 7.57 per 17 000 population served in Vilnius. The average ratio of psychologists per 17 000 population served varied from 0.76 per 17 000 population served in Biržai to 5.56 in Vilnius. The average ratio of social workers per 17 000 population served varied from 0.71 per 17 000 in Jurbarkas to 5.47 in Vilnius, and the ratio of mental health nurses varied from 0.83 per 17 000 in Visaginas to 6.79 per 17 000 in Vilnius.

Figure 2.10. There is considerable variation across municipalities with respect to the ratio of specialists to population served

Average municipal ratio of mental health specialists per 17 000 population, 2019



Note: Data refers to the average (mean) municipal ratio of mental health specialists per 17 000 of the population registered at mental health care centres on 31 December 2019. The average (mean) municipal ratio of MH specialists per 17 000 of the registered population was calculated by aggregating and averaging data on the ratio of specialists to population served at all primary mental health care centres within each municipality. Data for 104 mental health care centres was considered. Incomplete data for three primary mental health care centres (which did not report the registered population) has been excluded. Data for Kaišiadorys municipality has also been excluded due to very low user numbers in one mental health centre

Source: Lithuanian Ministry of Health

103. Interviews with primary mental health care providers have highlighted that the spread of few resources across a high number of primary mental health care centres means that, in practice, it can be challenging for some primary mental health care centres to provide services for people with complex mental health disorders. Where primary mental health care centres are not fully equipped with the necessary workforce, more complex cases may be referred to inpatient care. While the extensive network

and presence of primary mental health care centres across Lithuania is a strength, it cannot be fully utilised if they are not fully equipped with the necessary workforce specialties.

Conclusion

104. Considerable efforts have been made to expand the legislative framework for mental health care in recent years. A national suicide prevention procedure was introduced to regulate the health system response to suicide risk, though low levels of funding constrain its implementation in practice. Formal and informal modes of stigmatisation are prevalent in Lithuania, and continue to act as a barrier to the take-up of mental health care. Spending on mental health care is relatively low. Lithuania spends less on mental health care as a proportion of total government health spending than the OECD average, and spending on mental health care as a proportion of total health expenditure has been declining. Funding is skewed towards inpatient services, which currently absorb almost 60% of all mental health funding in the health care sector. Funding for primary mental health care services is low, and has only just begun to increase (having not increased substantially in the years between 2014 and 2019). Additionally, the mental health workforce is inequitably distributed, both in terms of its composition and its distribution. There are particular shortages of psychologists in the public system and of child and adolescent psychiatrists, and there are geographic imbalances in the distribution of the primary mental health care workforce.

Annex 2.A. The Legal Framework for Mental Health Care

Care Delivery

In addition to procedures that set out the requirements for the provision of mental health care in specific settings or circumstances, there are a number of legal acts governing care delivery:

- The **Description of the Procedure for the Provision of Primary Outpatient Mental Health Care Services (2012, No. V-861)** sets out the organisation and requirements for the provision of primary outpatient mental health care services funded by the NHIF, including remote services. It establishes the responsibilities of primary mental health care centres, and the functions and competences of team members in primary mental health care centres. The functions of primary mental health care centres are set out in further detail in Chapter 3 (Care Delivery).

- The **Description of the Procedure for Providing Psychosocial Rehabilitation Services to Persons with Mental Disorders (2012, V-788)** sets out the basic principles and prices for the provision of psychosocial rehabilitation services to patients with specified conditions (in accordance with ICD-10-AM classifications, as assessed in accordance with a General Performance Assessment Scale), on referral from a psychiatrist.

- The **Description of the Requirements for the Provision of Mental Health Care Services for Children and Adolescents (2019, V-730)** sets out the principles of psychiatric and psychotherapeutic services for children and adolescents. It sets limits on the ratios of specialists to patients, provides recommendations with respect to maximum bed numbers, and sets out the procedure for the payment of child and adolescent psychiatry services from the budget of the NHIF.

- The **Procedure for Outpatient Compensatory Treatment of Schizophrenia, Schizotypal and Delusional Disorders (2012, V-733)** sets out the procedure for the diagnosis and outpatient treatment of schizophrenia, schizotypal and delusional disorders. It regulates treatment with compensatory drugs and the evaluation and monitoring of effectiveness of treatment. According to the procedure, schizophrenic disorders are diagnosed in accordance with a prescribed lists of symptoms and specified timescales with respect to the presentation / persistence of those symptoms.

- The **Procedure for Outpatient Treatment of Representative Medicines for Depression and Mood (Affect) Disorders (2012, V-841)** sets out the procedure for the diagnosis and outpatient compensatory treatment of depression and mood (affective) disorders, including depression, bipolar affective disorder, mania, and mania with symptoms of psychosis. According to the procedure, these disorders are diagnosed in accordance with a prescribed list of symptoms and specified timescales with respect to the presentation / persistence of those symptoms. It sets out the circumstances under which family doctors can diagnose and provide medication-based treatment for depression, and sets limits on the length of time for which family doctors are allowed to diagnose and prescribe anti-depressants (6 months), after which, referral must be made to a psychiatrist. It sets out general principles of anti-depressant treatment, including guidelines for

which medications should be used in which circumstances. The procedure also sets out rules for the evaluation and monitoring of the effectiveness of treatment, including rules for the duration of antidepressant treatment, the competence of specialists to determine completion of treatment, and criteria for remission in treatment (which differ for adults and children).

- The **Description on the Procedure for the Provision and Payment of Psychotherapy Services (2019, V-1292)** sets out the competence of psychotherapists, and the procedure for the provision and payment of secondary outpatient and inpatient psychotherapeutic services.

Payment System

Additionally, a number of ministerial Orders set out the payment system for mental health care services:

- The **Order on the Organization of the Provision of Primary Outpatient Personal Health Care Services and the Approval of the Description of the Procedure for the Payment of the Costs of These Services (2018, No. V-124)** sets out the payment system for primary care practices and primary outpatient mental health care services.

- The **Order on the List of Specialized Outpatient Health care Services the Costs of Which Are Covered By the Compulsory Health Insurance Fund Budget and Their Basic Prices** (2008, No. V-436) sets out the list of specialized outpatient personal health care services and their basic prices, including addiction treatment services, other specialized consultations and specialized psychotherapeutic services.

- Outpatient secondary and inpatient psychotherapy services are paid for according to basic prices as set out in the **Order on Basic Prices (1998, No. 329)**.

- Inpatient and outpatient psychosocial rehabilitation services for adults are reimbursed at basic rates, in accordance with the **Procedure for the Provision of Psychosocial Rehabilitation Services for Persons with Mental Disorders (2019, No. V-788)**. Inpatient services are paid per bed day, and outpatient services are paid per visit.

- The **Requirements for the Provision of Primary, Secondary and Third Levels of Psychiatric Services for Adults and Basic Prices for Adult Psychiatric Day In-Station Services (1999, Order No. 256)** sets out the basic prices and requirements for secondary outpatient and inpatient psychiatric care for adults, tertiary inpatient and outpatient services for adults, and psychiatric day inpatient services for adults (by ICD code).

- Specialized outpatient psychiatric services for children and adolescents are paid in accordance with basic prices. Inpatient crisis mental health care for children and adolescents are paid using diagnosis-related group-based (DRG) payments.

3 Care Delivery

Introduction

105. This chapter discusses the delivery of mental health care in Lithuania, with a specific focus on the roles, responsibilities and activities of different levels of care providers, the coordination of care between providers, and the measures in place to ensure the consistency of care across providers. It discusses the organisation and availability of care at different levels of service provision, and provides a brief comparison on the consumption of medication for mental health disorders across EU countries.

The Delivery of Mental Health Care

106. In Lithuania, mental health care is delivered by primary, secondary and tertiary-level care providers.

Primary (non-specialised) care

107. Primary care physicians can diagnose and treat mental health disorders, or refer patients directly to a mental health professional (Kazlauskas, Zelviene and Eimontas, 2017[33]).

108. Lithuania's Mental Health Strategy (2007, No. X-1070) sets an ambition for General Practitioners (GPs) to treat a majority of mental health conditions. However, research conducted in Lithuania suggests that mental health conditions are poorly identified and managed in primary care (OECD, 2018[29]). In practice, direct referral from a General Practitioner to a psychiatrist or psychologist is the most common action (OECD, 2018[29]).

109. Research conducted in Lithuania suggests low rates of treatment and high rates of onward referral amongst primary care providers may be driven in part by low self-reported confidence amongst GPs in the treatment of mental disorders (Jaruseviciene et al., 2014[35]). A survey completed by over 400 GPs in Lithuania found that GPs generally felt responsible for managing their patients' mental health conditions, but that only 8.8% of GPs reported sufficient knowledge in mental health care (Jaruseviciene et al., 2014[35]). In the same survey, 81% of GPs indicated that they immediately refer patients to a psychiatrist or psychologist if they suspect a mental health problem (Jaruseviciene et al., 2014[35]).

110. There are a number of legal instruments which set out the types of treatment that GPs are able to provide for mental health disorders (see Chapter Annex 2A). In the case of mood (affect) disorders, GPs can administer diagnostic interviews and manage medication. Clinical guidelines for the outpatient treatment of schizophrenic disorders require GPs to refer patients to a psychiatrist or child and adolescent psychiatrist in circumstances where they suspect a schizophrenic disorder. There is currently no provision for GPs or nurses to be reimbursed for brief psychological therapies or counselling.

111. Discussions with Lithuanian mental health experts suggest that low treatment rates amongst GPs may also be driven in part by weak financial incentives for GPs to treat mental health disorders (OECD Interviews, 2021). Survey research conducted with Lithuanian GPs supports this possibility. When asked which measures would increase GP's involvement in the provision of mental health care, 40% of GPs

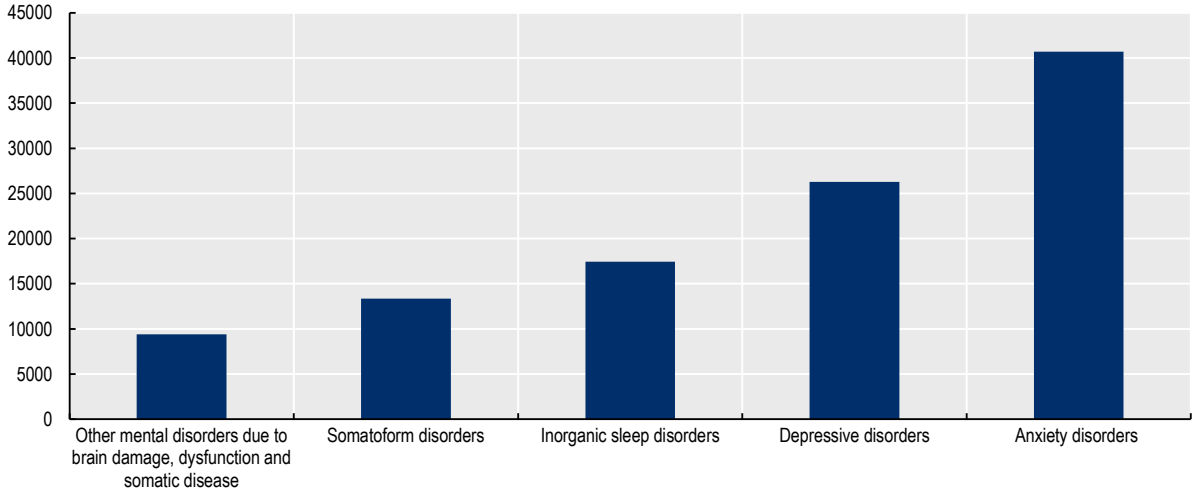
highlighted a need for greater knowledge and skills in the provision of mental health care, 23% of GPs highlighted a need for policy measures such as financial incentives for the provision of mental health care, clinical guidelines for the treatment of mental disorders and increased capacity for the prescription of psychotropic drugs, and approximately 18% of GPs highlighted a need for greater coordination and collaboration across primary care, including greater clarity over the role of specialised and non-specialised primary care providers, an expanded role for community nurses in the provision of mental health care, and greater collaboration between specialised and non-specialised primary care providers (Jaruseviciene et al., 2014[35]).

112. Additional efforts are required to increase the capacity of GPs to recognise, treat and manage common mental disorders (OECD, 2018[29]). Strengthening the role of General Practitioners in the provision of mental health care is a policy priority in Lithuania and measures contained in the National Suicide Prevention Plan 2020 – 2024 to provide training for general practitioners on recognising and treating depression and anxiety disorders should help to bolster confidence in the treatment of these conditions.

113. Anxiety and depressive disorders currently make up a significant proportion of primary (non-specialised) care contacts for a mental health disorder (Figure 3.1). In 2019, 31% of all contacts at primary care practices by those with a mental health disorder were for anxiety disorders, and 20% were for depressive disorders (excluding dementia and developmental disorders) (National Health Insurance Fund).

Figure 3.1. Anxiety and depressive disorders make up a significant proportion of primary (non-specialised) care contacts with a primary diagnosis of a mental health condition

Number of visits made to primary care practices by service user's diagnosis, 2019



Note: Data excludes dementia (ICD-10 codes F00-F03) and developmental disorders (ICD-10 codes F70 – F89). Data for dementia (ICD-10 code F05.1) is included. Data for anxiety disorders (ICD-10 codes F40 and F41) and depressive disorders (ICD-10 codes F32 and F33) has been grouped. Only data for the top 5 number of visits (by diagnosis) is shown
Source: Lithuanian National Health Insurance Fund

Primary mental health care

Organisation

114. Specialised primary mental health care services are delivered in 116 mental health care centres across Lithuania, which are usually co-located within primary care centres (such as polyclinics) without legal or financial independence. Users can access primary mental health care services directly without a referral, but can also be referred by a general practitioner or hospital (OECD, 2018[29]). Together with primary care practices, primary mental health care centres are the first points of contact for people with a mental health condition.

115. The **Procedure for the Provision of Primary Outpatient Mental Health Care Services** (**2012, No. V-861**) sets out the roles and responsibilities of mental health care centres. Users can visit mental health care centres for any mental health condition, and mental health care centres refer patients to secondary or tertiary outpatient services for matters that fall outside of their competence. Onwards referrals are also encouraged in circumstances where certain mental health disorders worsen. The procedure also allows for the provision of remote mental health care services, such as the prescription of re-examinations or medicines, or the provision of psychological services provided that it is safe and appropriate to provide them remotely given the user's condition.

116. Services in mental health care centres are required to be delivered by multi-disciplinary teams of psychiatrists, psychologists, mental health nurses and social workers for six hours per day (at a minimum), at a ratio of one specialist per 17 000 registered population, save for psychologists where the ratio has recently been revised to 1 psychologist per 10 000. As outlined in Chapter 2, however, in practice workforce shortages and geographical imbalances in the distribution of the primary mental health care workforce mean that the full range of specialists are available inconsistently, with considerable implications for the quality and availability of care that primary mental health care centres are able to provide, and users are able to access.

117. Lithuanian mental health experts have indicated that high rates of onward referral amongst General Practitioners can lead to the potential for overcrowding at mental health care centres (Doblytė, 2021[27]) (Puras et al., 2004[36]). Overcrowding – in combination with workforce shortages – have been suggested to have implications for the type and quality of care that mental health care centres are able to provide, and users are able to access (noting in particular challenges with respect to the geographic distribution of the workforce outlined in Chapter 2).

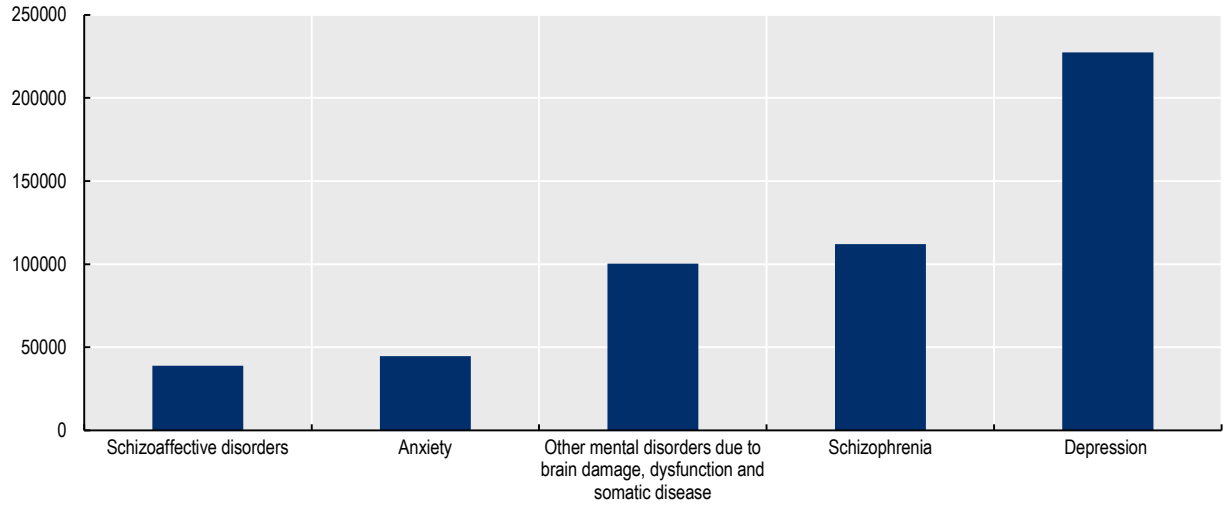
118. Taken together, these challenges mean that mental health care centres – particularly where there are workforce shortages - can be geared towards treatment of mental health conditions with lower levels of complexity for a number of inter-related reasons. Firstly, the referral of high numbers of patients with mild mental health conditions to some mental health centres may leave mental health centres with less capacity to treat patients with moderate and severe mental health conditions (Doblytė, 2021[27]) (Puras et al., 2004[36])(OECD Interviews, 2021). Secondly, overcrowding at mental health care centres can constrain the time available for treatment, and the time available for communication with patients or other specialists (Puras et al., 2004[36])(OECD Interviews, 2021). Thirdly, low staffing levels and shortages in the availability of particular specialists (Chapter 2) can mean there can be insufficient capacity (skill) to treat certain disorders. When the appropriate skills mix is unavailable, or available infrequently, complex treatment for certain disorders cannot be provided (OECD Interviews, 2021). Finally, low levels of funding for primary mental health care centres constrain the scope of services that mental health care centres are able to provide, because more intensive treatments are more costly both in terms of the specialists required to deliver them, and the time taken to deliver them (OECD Interviews, 2021). This may mean there is insufficient capacity for the treatment of disorders which require more intensive treatments.

119. Lithuanian mental health experts have indicated that, in practice, lack of capacity in the primary care system to treat moderate / severe disorders translates to increased rates of referral to inpatient care for patients that could potentially be treated in outpatient care if there were sufficient capacity to do so (OECD Interviews, 2021).

120. Depressive disorders make up a significant proportion of primary mental health care contacts (Figure 3.2). In 2019, 36% of all contacts with primary mental health care centres by those with a diagnosed mental health disorder were for depressive disorders, 18% were for schizophrenia, 16% were for other mental disorders due to brain damage, dysfunction and somatic disease, 7% were for anxiety disorders, and 6% were for schizoaffective disorders (Figure 3.2).

Figure 3.2. Depressive disorders make up a significant proportion of specialised primary mental health care contacts by those with a diagnosed mental health condition

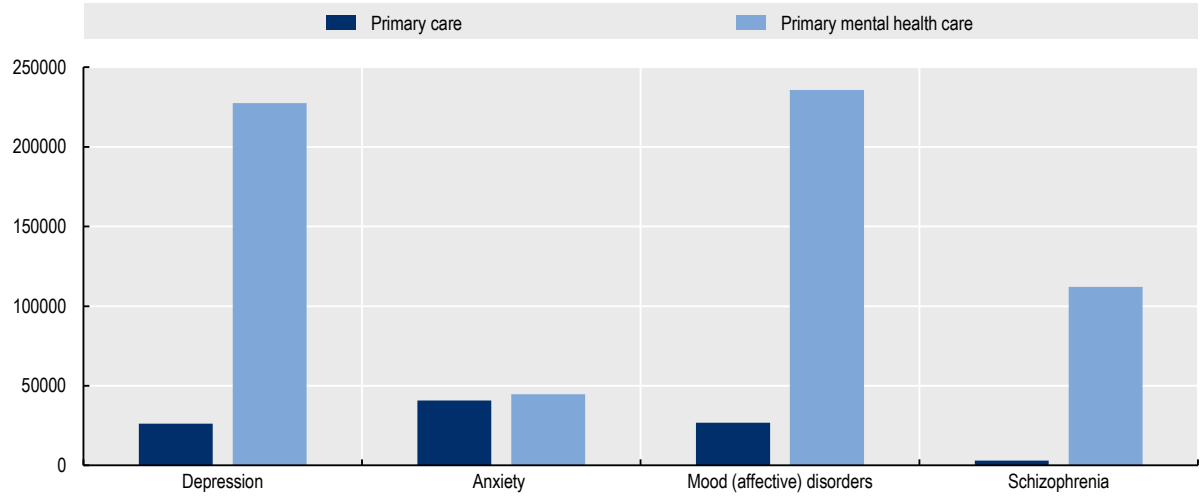
Number of visits made to primary mental health care centres by service user's diagnosis, 2019



Note: Data excludes dementia (ICD-10 codes F00-F03) and developmental disorders (ICD-10 codes F70 – F89). Data for dementia (ICD-10 code F05.1) is included. Data for anxiety disorders (ICD-10 codes F40 and F41) and depressive disorders (ICD-10 codes F32 and F33) has been grouped. Only data for the top 5 number of visits (by diagnosis) is shown
Source: Lithuanian National Health Insurance Fund

121. The bulk of primary mental health care is delivered in primary mental health care centres (Figure 3.3). In 2019, primary mental health care centres recorded over eight times more contacts for users with mood (affective) disorders than primary care practices. Similarly, primary mental health care centres recorded over eight times more contacts for users with depressive disorders than primary care practices in 2019, with primary mental health care centres recording 227 499 contacts, and primary care practices recording 26 265 contacts for users with depression. Data for depression here refers to data for both depressive disorder and recurrent depressive disorder, and includes mild, moderate and severe depressive episodes or disorders. While a comparison therefore does not provide an indication of the severity or complexity of mental disorders treated in different primary care settings, the magnitude of the difference in the number of contacts recorded by primary care and primary mental health care providers nonetheless indicates low rates of diagnoses and/or treatment in primary care practices. The number of contacts recorded for people with anxiety are relatively comparable between primary care and primary mental health care providers, while primary mental health care centres recorded almost all primary care contacts for people with schizophrenia in 2019.

Figure 3.3. Primary mental health care centres deliver the bulk of primary mental health care



Note: Data is for 2019 and excludes dementia (ICD-10 codes F00-F03) and developmental disorders (ICD-10 codes F70 – F89). Data for dementia (ICD-10 code F05.1) is included. Data for anxiety disorders (ICD-10 codes F40 and F41) and depressive disorders (ICD-10 codes F32 and F33) has been grouped
Source: Lithuanian National Health Insurance Fund

System Capacity for the Provision of Psychotherapeutic Care

122. In addition to challenges with respect to the type of conditions that mental health care centres are able to treat, there are challenges with respect to the methods by which they are able to treat mental health conditions.

123. Legislation governing the provision of primary outpatient mental health care sets out that mental health centres should provide psychopharmacotherapy, psychological counselling and psychotherapy, psychiatric and psychosocial rehabilitation, and social assistance services.[3] However, Lithuanian mental health experts have highlighted a lack of systems capacity for the provision of psychotherapeutic services. Primary mental health care providers in particular have suggested that there is currently insufficient overall funding and incentive for the provision of psychotherapeutic services, which – in combination with the workforce and overcrowding challenges outlined earlier in this Chapter – mean it is currently not financially sustainable for many primary mental health care providers to provide psychotherapeutic care (OECD Interviews, 2021).

124. Lithuanian mental health experts have pointed to a number of inter-related resource and funding constraints on the provision of psychotherapeutic services. Firstly, Lithuanian mental health experts have highlighted that there are particular shortages of psychotherapists in the public system (OECD Interviews, 2021). In Lithuania, psychotherapeutic services in primary mental health care centres can be delivered by psychiatrists, child and adolescent psychiatrists and medical psychologists with specific training and qualification in psychotherapeutic techniques (Procedure for the Provision of Primary Outpatient Mental Health Care Services, Order No V-861, 2012). As outlined In Chapter 2, however, there are few psychologists and child and adolescent psychiatrists in the public system. Stakeholders have indicated that many psychotherapists emigrate or choose to work in private practices, where salaries are higher (OECD Interviews, 2021). Additionally, low levels of funding for primary mental health care centres constrain the scope of services that mental health care centres are able to provide because

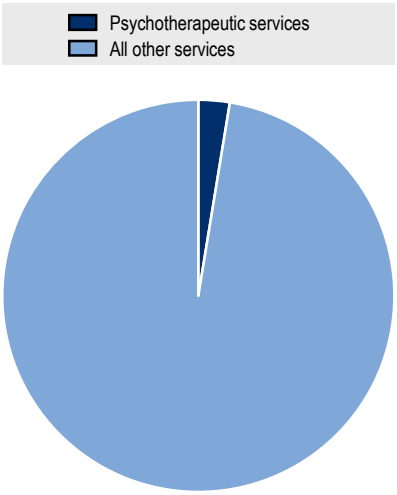
[3] Procedure for the Provision of Primary Outpatient Mental Health Care Services (Order No V-861, 2012)

psychotherapeutic services are more costly to provide than medication-based services, both in terms of the specialists required to deliver them, and the time taken to deliver them (OECD Interviews, 2021). Indeed, some primary mental health care providers have indicated that there is a broader range of services that they may be able to deliver if they were sufficiently funded and resourced to do so (OECD Interviews, 2021).

125. In 2019, psychotherapeutic services accounted for less than 3% of all services provided in primary mental health care centres (Figure 3.4).[4] The bulk of these services were delivered for individuals, and the use of both group psychotherapy and psychotherapy for families was very low. In 2019, primary mental health care centres delivered 20 598 psychotherapeutic services for individuals, 3 899 psychotherapeutic interventions for families, and 2 193 group psychotherapy services.

Figure 3.4. Psychotherapeutic services make up less than 3% of all services provided in primary mental health care centres (including dementia and developmental disorders)

Number of psychotherapeutic services provided in primary mental health care centres as a proportion of all services provided in primary mental health care centres, 2019



Note: Data includes dementia and developmental disorders. Psychotherapeutic services refers to the provision of incentivised psychotherapeutic interventions for individuals, families and groups
Source: Lithuanian Ministry of Health

126. Mental health experts in Lithuania have repeatedly indicated that the insufficient availability and use of psychotherapy translates to an over-reliance on medication-based treatment. Qualitative research conducted with 50 Lithuanian mental health experts and service users highlights this challenge. Both mental health experts and service users noted a heavy reliance on medication-based treatment, with psychiatric consultations noted as a particular prompt for psychotropic medication, and service users indicating that psychotherapy is not always offered (Šumskienė, Petružytė and Klimaitė, 2018[32]).

[4] Data on the number of psychotherapeutic services reported in this paragraph relates to psychotherapeutic services provided by psychiatrists, child and adolescent psychiatrics or medical psychologists with training in psychotherapeutic techniques, in accordance with the Procedure for the Provision of Primary Outpatient Mental Health Care Services (Order No. V-861, 2012). It therefore differs from intensive psychotherapy delivered by fully trained psychotherapists

127. Data with respect to the provision of mental health services seems to support this possibility, as 32% (34 of 107) of mental health care centres for which data was available provided no psychotherapeutic services at all in 2019.[5] Additionally, not all mental health centres provided all types of psychotherapeutic services: of the 107 mental health care centres for which data was available, 49% provided no psychotherapeutic services for individuals (with another 10% each providing less than 100 such services in total), 56% provided no psychotherapeutic services for families, and 75% provided no group psychotherapeutic services. Data also indicates geographical imbalances with respect to the availability of psychotherapeutic services, with psychotherapeutic services for individuals and families delivered most frequently in larger cities such as Vilnius and Kaunas. These imbalances may also have implications for accessibility: in 2019, 75% of all group psychotherapy services delivered in primary mental health centres were delivered in centres which served only 33% of the population registered at mental health centres in Lithuania.

128. Over the course of interviews, service users and service user organisations reported that publicly-funded psychotherapies are often unavailable, that many patients have to pay for such services out of pocket, and that psychotherapy is subsequently inaccessible to a significant proportion of the population (OECD Interviews, 2021). This challenge was echoed in qualitative research conducted in Lithuania. Qualitative research conducted with a small sample of adult mental health care users who had recently received outpatient care in primary mental health care centres found that service users noted a heavy reliance on medication-based treatment, and consequently reported a perceived "lack of attentive and empathic communication" with providers stemming from their perception that providers did not talk to them, but only prescribed medication (Doblytė, 2021[27]).

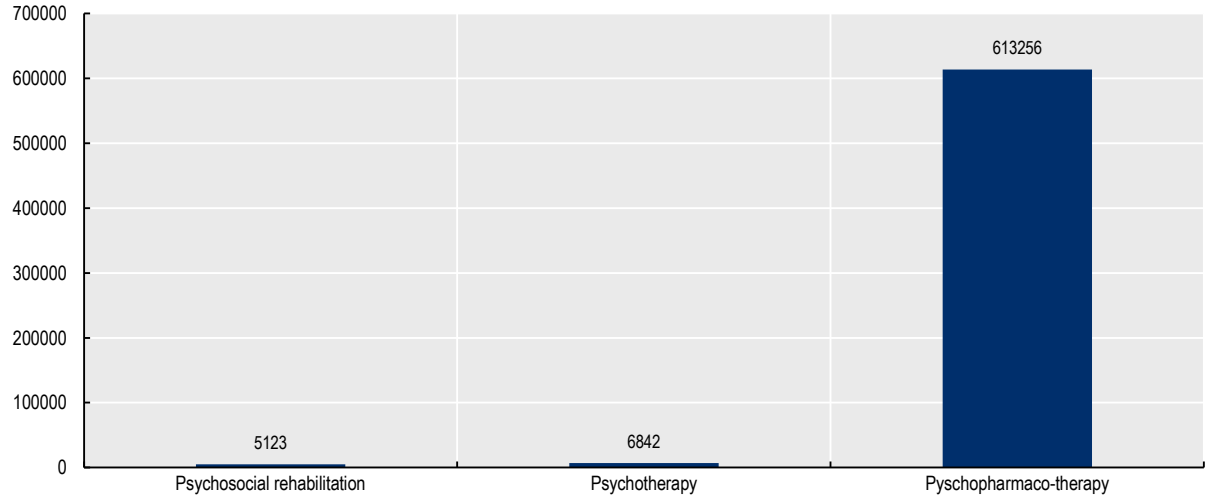
129. In 2019, primary mental health care centres issued over fifty times more prescriptions for the treatment of mental health disorders than the total number of psychotherapeutic and psychosocial rehabilitation services combined. In 2019, primary mental health care centres issued 613 256 prescriptions for users with all mental and behavioural disorders (Figure 3.5). In the same year, primary mental health care centres provided 6 842 psychotherapeutic services and 5 123 psychosocial rehabilitation services for people with mental health disorders (Figure 3.5).[6] Data for prescriptions includes dementia and developmental disorders and must therefore be read with caution. Additionally, it must of course be noted that medication-based treatment and psychological therapies are not mutually exclusive; often, comprehensive treatment for mental health disorders may warrant the use of both medication and other types of treatment such as talking therapies. Nevertheless, the magnitude of the difference indicates a heavy reliance on medication-based treatment.

[5] Data on the number of psychotherapeutic services reported in this paragraph relates to psychotherapeutic services provided by psychiatrists, child and adolescent psychiatrics or medical psychologists with training in psychotherapeutic techniques, in accordance with the Procedure for the Provision of Primary Outpatient Mental Health Care Services (Order No. V-861, 2012). It therefore differs from intensive psychotherapy delivered by fully trained psychotherapists

[6] Data on the number of psychotherapeutic services reported here relates to psychotherapeutic services provided by fully qualified psychotherapists who have undertaken a three year post-diploma programme in psychotherapy, in accordance with the Procedure for the Provision and Payment of Psychotherapy Services (2019, V-1292).

Figure 3.5. While legislation provides for a range of treatment methods, services in primary mental health care centres are heavily skewed towards psychopharmacotherapy

Number of specified services provided in primary mental health care centres, 2019



Note: Psychopharmacotherapy refers to the number of prescriptions issued for all ICD-10 codes F00-F99, including dementia and developmental disorders. Psychotherapy refers to the provision of psychotherapeutic services for individuals, families and groups by fully qualified psychotherapists who have undertaken a three-year diploma programme in psychotherapy
Source: Lithuanian National Health Insurance Fund

Medication and pharmaceutical consumption for mental health conditions

130. Given Lithuanian mental health experts, service providers and service users have indicated a heavy reliance on medication-based care, this section provides a brief comparison of the rates of pharmaceutical consumption for mental health disorders across EU countries.

131. Overall, the consumption of medication for mental health disorders is lower in in Lithuania than the EU average, though the consumption of anxiolytics is higher (Figure 3.6). The consumption of medication for mental health disorders is disaggregated by hypnotics and sedatives, antidepressants, and anxiolytics. In 2019, pharmaceutical consumption in Lithuania was 80 Daily Defined Dosages (DDDs) per 1 000 population, compared to the EU average of 99 DDDs per 1 000 population. The consumption of anxiolytics in Lithuania was 33 DDDs per 1 000 population in the same year, compared to the EU average of 23 DDDs per 1 000 population. The consumption of antidepressants in Lithuania was significantly lower than the EU average in 2019, at a rate of 35.4 DDDs per 1 000 population, compared to the EU average of 59.5 DDDs per 1 000 population.

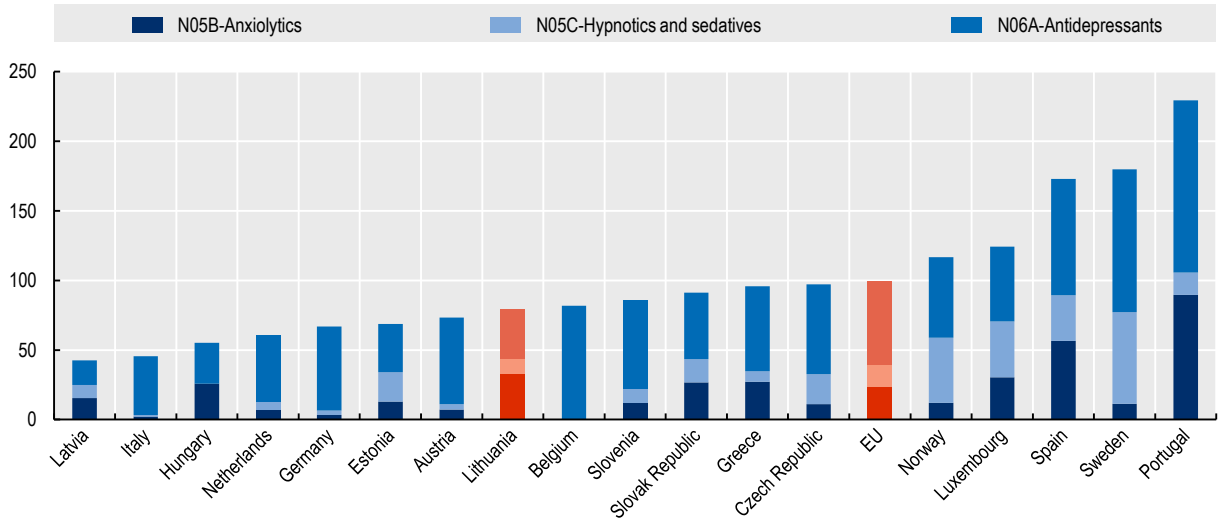
132. The consumption of medication for mental health disorders has increased in Lithuania over the past decade, as in other EU18 countries, though trends in consumption vary depending on the type of medication (OECD.Stat, 2021[37]).The consumption of anxiolytics generally declined across EU18 countries in the period between 2010 and 2019, including in Lithuania where consumption decreased from 36.4 DDDs to 32.8 DDDs per 1 000 population in the period between 2010 and 2019 (OECD.Stat, 2021[37]). The trend in the consumption of hypnotics and sedatives across EU18 countries in the period between 2010 and 2019 is somewhat more variable, with consumption increasing in some countries and decreasing in others. In Lithuania, consumption of hypnotics and sedatives increased from 5.2 DDDs per 1 000 population in 2010 to 11.4 DDDs per 1 000 population in 2019. Antidepressant consumption increased across EU18 countries in the period between 2010 and 2019, in some countries significantly, including in

Lithuania where antidepressant consumption increased from 19.2 DDDs to 35.4 DDDs per 1 000 population.

133. While the rate of pharmaceutical consumption for mental health disorders is lower in Lithuania than the EU18 average, it is important to note that this does not necessarily contradict the challenges raised by stakeholders with respect to a reliance on medication-based care. The rate of pharmaceutical consumption within countries (as measured by DDDs) does not provide an indication of the rate of consumption per person (whether few people consume a significant amount of medication or many people consume a small amount of medication), nor does it provide an indication of the availability of alternatives to medication-based treatments for mental health disorders. While the data suggests overall pharmaceutical consumption in Lithuania is below the EU18 average, therefore, the data outlined earlier in this Chapter also suggests limited systems capacity for alternatives to medication-based treatment.

Figure 3.6. Pharmaceutical consumption for mental health disorders is lower in Lithuania than the EU18 average, though the use of anxiolytics is higher

Daily Defined Dosages (DDDs) per 1000 population, 2019



Source: (OECD.Stat, 2021[37])

Existing payment methods discourage treatment of severe mental health conditions

134. Municipalities own a majority of primary mental health care centres, but a significant proportion are owned by private organisations. Private entities that provide publicly funded mental health care services are required to operate in the same way as public providers, and are compensated in accordance with the same rules. In 2020, municipalities owned 65% of mental health care centres (Ministry of Health). Publicly-owned primary mental health care centres serve the majority of the population registered at mental health care centres: in 2019, 72% of the population registered at primary mental health care centres were registered at publicly-owned primary mental health care centres (National Health Insurance Fund). [7]

[7] The National Health Insurance Fund records the number of people registered in a mental health care centre by their registration status on the final day of the calendar month. The number of registered users may include users who have left the centre. In 2019, 2 999 653 users were registered at mental health care centres, exceeding the statistical

135. Lithuanian mental health experts have raised concerns that publicly-funded private providers may be engaged in 'cream skimming' practices, through the over-selection of patients with mild and moderate mental health conditions, and the avoidance of patients with 'severe' mental health conditions. Because mental health care centres receive a flat rate capitation payment for each user registered at their mental health care centre irrespective of the cost of their care (Chapter 2), they may be incentivised to avoid 'high-cost' patients with 'severe' mental health conditions where the cost and complexity of care is higher, particularly if they are resource constrained.

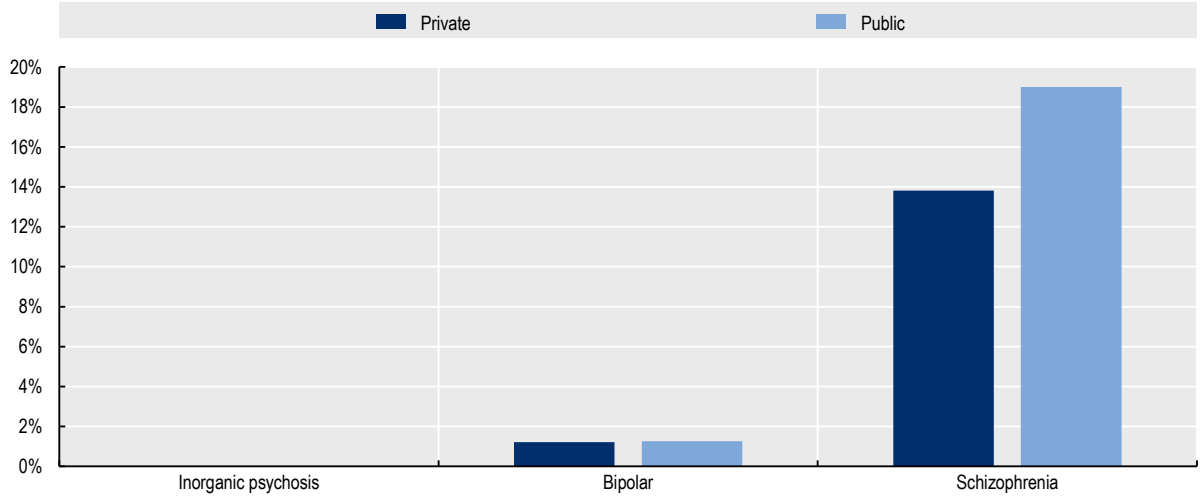
136. Considering whether public or private providers provide a greater share of publicly-funded services for people with severe mental health conditions is complicated by the fact that there is no national or internationally-agreed definition of what constitutes a 'severe' mental health condition. A number of countries maintain severe mental illness registers, but the type of conditions included in the registers differs. The UK, for instance, maintains a severe mental illness (SMI) register which includes individuals who receive a diagnosis of schizophrenia or bipolar affective disorder, and those who have experienced an episode of non-organic psychosis (National Health Service, 2018[38]). Common mental health conditions such as anxiety and depression can also manifest in severe, enduring, and debilitating forms, which seriously compromise an individual's health, and demand a more specialised and intensive intervention. As data for depressive disorders was not disaggregated by mild, moderate and severe depressive disorders, schizophrenia, bipolar affective disorder and non-organic psychosis are considered here for the purposes of a cursory comparison of the services provided by public and private providers. Nonetheless, it would be critically important that adopting such a classification does not imply that persons with other severe or enduring mental health conditions, such as anxiety and depression, should be excluded from more intensive forms of care and support.

137. Data indicates that public primary mental health care providers record a somewhat greater share of contacts for people with diagnosed 'severe' mental health disorders than publicly-funded private providers, though differences amongst providers are more marked for schizophrenia (Figure 3.7). Patients with schizophrenia represented 19% of all contacts for those with a diagnosed mental health disorder in public primary mental health care centres (excluding dementia and developmental disorders), compared to 14% in private mental health care centres (Figure 3.7). Differences between public and private providers in the share of contacts for bipolar affective disorder and inorganic psychotic disorders are considerably less marked. In 2019, contacts for bipolar affective disorder represented 1.26% of contacts in public mental health care centres, and 1.22% of contacts in private mental health care centres. The total number of contacts with patients with inorganic psychotic disorders in 2019 was very low (only 112 services were recorded in total), and the overwhelming majority of such contacts (99) were recorded in public mental health care centres.

population of Lithuania. The proportion of users served by 'public' and 'private' mental health care centres must therefore be read with caution

Figure 3.7. Public providers record a greater share of contacts with patients with specific 'severe' mental health conditions than publicly-funded private providers

Share of contacts for users with specified diagnoses as a proportion of all contacts with public and private primary mental health care providers (excluding dementia and developmental disorders), 2019



Note: Data excludes dementia (ICD-10 codes F00-F03) and developmental disorders (ICD-10 codes F70 – F89). Data for dementia (ICD-10 code F05.1) is included. Data for inorganic psychotic disorders (ICD-10 code F28) and unspecified inorganic psychosis (ICD-10 code F29) has been grouped. 'Private' providers refers to publicly funded services provided by privately-owned mental health care centres which hold contracts with the National Health Insurance Fund
Source: Lithuanian National Health Insurance Fund

138. Provider capacity could be limited by the provision of care for those with dementia or developmental disabilities. Accordingly, the proportion of visits made by patients with 'severe' mental health disorders has also been considered with reference to the total number of all visits to mental health care centres for mental and behavioural disorders (including dementia and developmental disabilities). Differences between public and private providers in the share of visits made by those with 'severe' mental health disorders do not vary significantly depending on whether or not the number of visits for dementia and developmental disorders are also considered (Table 3.1).

Table 3.1. Differences between public and private providers in the share of contacts recorded with users with 'severe' mental health disorders do not differ significantly based on whether or not contacts for dementia and developmental disorders are also considered

Number of contacts for users with a 'severe' mental health disorder as a proportion of all contacts for mental and behavioural disorders in public and private mental health care centres, 2019

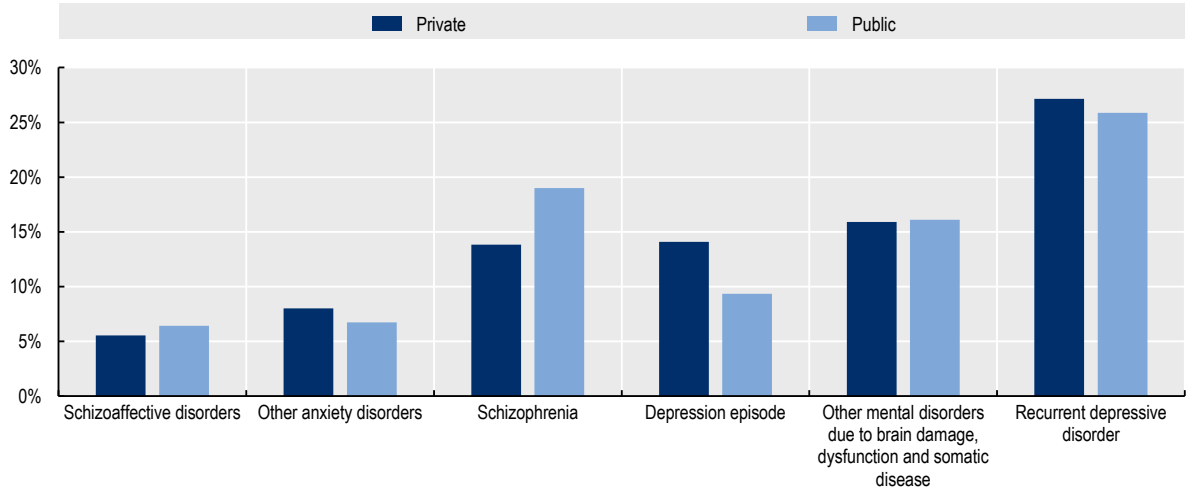
Disorder	Proportion of all contacts – excluding dementia and developmental disorders			Proportion of all contacts – including dementia and developmental disorders		
	Private providers	Public providers	Difference (percentage point)	Private providers	Public providers	Difference (percentage point)
Schizophrenia	13.82%	19.00%	5.18%	11.99%	16.22%	4.23%
Bipolar affective disorder	1.22%	1.26%	0.04%	1.06%	1.08%	0.02%
Inorganic psychosis	0.01%	0.02%	0.01%	0.01%	0.02%	0.01%

Source: Lithuanian National Health Insurance Fund

139. There are differences in the composition of the treatment profiles of public and private primary mental health care providers (as measured by the number of registered contacts) in addition to those outlined above. The most significant differences between public and private providers in the share of contacts recorded for different mental health disorders relate to schizophrenia (a greater share of contacts recorded by public providers), and the treatment of depressive episodes and recurrent depressive disorder (a greater share of contacts recorded by private providers). In 2019, 26% of all contacts in public primary mental health care services were for recurrent depressive disorders, 19% were for schizophrenia, 16% were for other mental disorders due to brain damage, dysfunction and somatic disease, 9% were for depressive episodes, 7% were for anxiety disorders, and 6% were for schizoaffective disorders. In 2019, the share of contacts in private mental health care centres was differentially distributed: 27% of contacts were for recurrent depressive disorders, 16% of contacts were for other mental disorders due to brain damage, dysfunction and somatic disease, 14% of contacts were for depressive episodes, 14% of contacts were for schizophrenia, 8% were for other anxiety disorders, and 6% were for schizoaffective disorders (Figure 3.8).

Figure 3.8. The composition of contacts recorded with public and private primary mental health care providers differs slightly

Share of contacts for users with specified diagnoses as a proportion of all contacts recoded in public and private mental health care centres (excluding dementia and developmental disorders), 2019



Note: Data excludes dementia (ICD-10 codes F00-F03) and developmental disorders (ICD-10 codes F70 – F89). Data for dementia (ICD-10 code F05.1) is included. 'Private' providers refers to publicly funded services provided by privately-owned mental health care centres which hold contracts with the National Health Insurance Fund. Only data for the top 6 number of visits (by diagnosis) is shown
Source: Lithuanian National Health Insurance Fund

140. While differences in the types of mental health disorders treated by public and private providers are not extreme, such differences – particularly those relating to severe mental health disorders such as schizophrenia – could nonetheless exacerbate pressures on public providers.

Outpatient mental health care

141. Outside of primary mental health care centres, out-patient treatment is provided primarily in clinics of mental disorders and private centres, and in 41 day hospitals for adults and 10 day hospitals for children and adolescents (Ministry of Health) (OECD Mental Health Benchmarking Questionairre). Tertiary-level

outpatient services for the treatment of complex mental health disorders are delivered across three health care institutions located in Lithuania's largest cities, Vilnius and Kaunas.

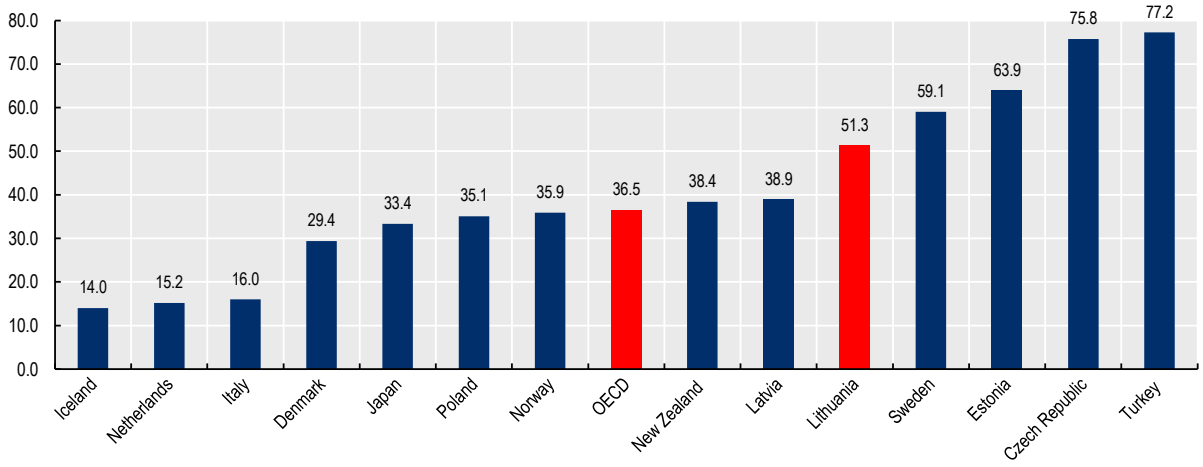
142. Specialised outpatient services consist of psychiatrist consultations, psychotherapeutic consultations, psychosocial rehabilitation, other types of medical rehabilitation services, and day services for adults, children and adolscents. Psychiatrist consultations are provided upon referral from a family doctor or other specialist, and can be delivered by adult or child and adolescent psychiatrists. The NHIF funds up to 30 psychotherapeutic sessions per calendar year which can be delivered to individuals, families or groups (with the possibility of extension for an additional 10 sessions), and such services are provided only following psychotherapeutic consultation. While psychiatric, psychosocial and psychotherapeutic outpatient specialised services are currently delivered separately, the Government of Lithuania is considering moving to an integrated model of service delivery where psychosocial and psychotherapeutic outpatient specialised services are delivered together. Outpatient psychosocial rehabilitation services and other types of medical rehablitation services are provided on referral from a psychiatrist.[8] Publicly-funded day services for adults, children and adolecents are limited to 30 services per patient.

143. At an international level, it is difficult to compare the community care capacity of mental health systems. Only 16 OECD countries were able to provide data on the number of individuals attending outpatient clinics throughout the OECD's mental health benchmarking exercise (OECD, 2021[4]). Even where data is available, comparisons are rendered difficult by the fact that outpatient and community services may play different roles in different countries, and that data differs across countries in the extent to which it includes services for substance abuse, dementia, and intellectual disabilities (OECD, 2021[4]). What limited data is available suggests significant variation across OECD countries in terms of community care capacity, ranging from 14.0 individuals per 1 000 population attending mental health outpatient clinics in Iceland, to 77.2 per 1 000 population in Türkiye in 2018 (Figure 3.9). The rate of individuals attending mental health outpatient clinics in Lithuania was 51.3 per 1 000 population in 2018, above the OECD average of 36.5 per 1 000, and the rate of comparator countries Latvia (38.9 per 1 000) and Norway (35.9 per 1 000) (Figure 3.9).

[8] Outpatient psychosocial rehabilitation services consist of evaluation, consulting, training, support and general health interventions, including assessments of mental conditions and personal care, counseling or psychosocial counseling, psychological or psychososocial assistance, skills development training in personal care and life skills, health care support services, and general health interventions including social work and occupational therapy (Procedure for the Providing Psychosocial Rehabilitation Services to Persons with Mental Disorders, Order No. V-788, 2012).

Figure 3.9. The number of individuals attending mental health outpatient clinics in Lithuania is higher than the average of OECD countries for which data is available

Individuals attending mental health outpatient clinics, 2018 or latest year (rate per 1 000 population)



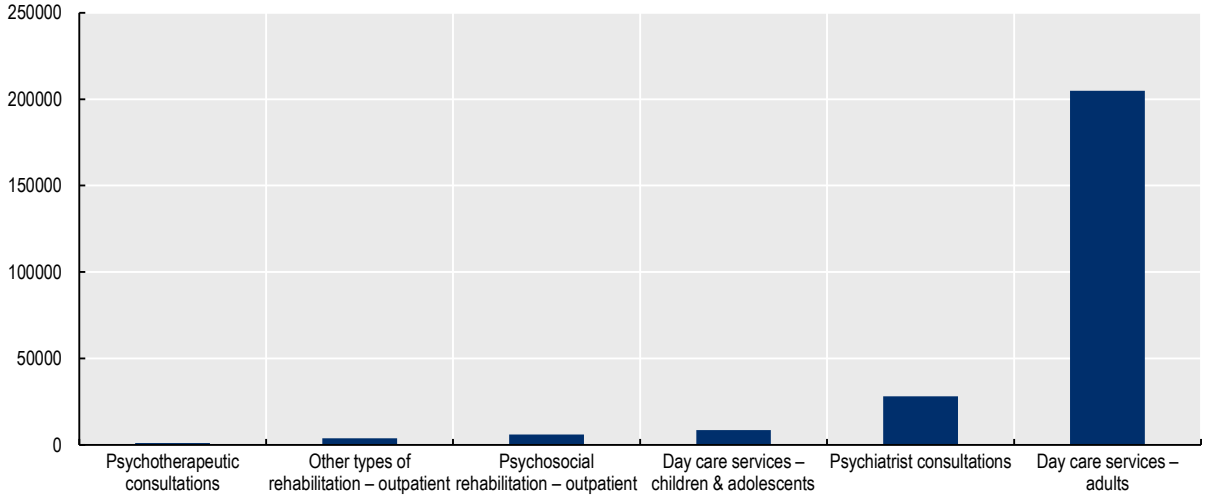
Note: There is variation across countries as to the type of care settings included for the purposes of reporting on the number of individuals attending mental health outpatient clinics. For example, data for Iceland refers to outpatient hospital care, while data for Czech Republic refers to outpatient clinics. Data for Mexico and Greece has been excluded
Source: Adapted from (OECD, 2021[4])

144. At a national level, data suggests secondary specialised outpatient services are currently geared towards the provision of day care services, and psychiatric over psychosocial and psychotherapeutic consultations. In 2019, there were 204 759 day care services provided for adults, 28 038 psychiatrist consultations, 5 888 psychosocial rehabilitation services, and only 1 054 psychotherapeutic consultations (Figure 3.10).

145. The absolute number of specialised outpatient psychotherapeutic services increased in the period between 2016 and 2019, but not significantly. The number of publicly funded outpatient specialist psychotherapeutic services increased from 8 444 services in 2016 to 9 734 services in 2019, representing approximately a 15% increase overall. Taken together with the relatively low numbers of psychotherapeutic services provided in primary care settings, these findings indicate a lack of systems capacity for the provision of psychotherapeutic care in outpatient settings.

Figure 3.10. The majority of specialised outpatient services in Lithuania are day care services for adults, and psychiatric consultations

Number of specialised outpatient services by type of service, 2019



Source: National Health Insurance Fund

146. In addition to specialised outpatient services, a number of preventative community-based services are available in Public Health Bureaus, where people with mental health conditions are able to access psychological counselling (see Box 3.1). Additionally, the Government of Lithuania is currently considering the introduction of a number of additional outpatient services as part of ongoing efforts to strengthen community-based mental health care, including psychiatric crisis intervention teams and community-based psychosocial re-adaptation services for people with mental health conditions, to be provided by non-governmental organisations.

Box 3.1. Preventative mental health services

Public Health Bureaus

As outlined in Chapter 2, Public Health Bureaus have recently begun to offer publicly-funded preventative psychological support for adults, children and adolescents with mental health conditions, limited to five consultations per year. Public Health Bureaus are provided funding for the delivery of preventative psychological services to people with mental health conditions, and granted discretion to decide how such services are organised; they can recruit psychologists directly, or they can use the funding to procure psychological services. Where specialists suspect that a patient has a mental health disorder and would benefit from more intensive treatment, they are required to refer the patient to a mental health centre for further consultation. In 2020, Public Health Bureaus provided psychological support services for 14 212 users, 82% of which were female.

There are currently no regulations co-ordinating the flow of information between Public Health Bureaus and outpatient mental health care providers. Interviewees indicated that in practice, there is currently little coordination between Public Health Bureaus and outpatient mental health care providers (OECD Interviews, 2021).

Emotional Support

Lithuania operates a number of emotional support lines where users can apply for emotional and psychological support. These emotional support lines can be accessed anonymously. As outlined in Chapter 2, the State Mental Health Center also owns and operates the national suicide prevention website (www.tuesi.lt), where users are able to access information about the mental health care services available to them.

Hospital care

147. In Lithuania, inpatient hospital care for people with a mental health disorder is provided in general hospitals with divisions for mental health, and specialist psychiatric hospitals / clinics.

General hospital

148. The Lithuanian health system remains geared towards hospital care (OECD/European Observatory on Health Systems and Policies, 2019[1]). Lithuania has one of the highest ratios of hospital beds per 1 000 population in the EU. The rate of hospital beds per 1 000 population in Lithuania (6.6) is 30% higher than the EU average of 5.0 beds per 1 000 population (OECD/European Observatory on Health Systems and Policies, 2019[1]). High rates of hospital discharges and relatively low rates of occupancy in acute care beds also indicate an overuse of hospital care, and some degree of hospital overcapacity (OECD/European Observatory on Health Systems and Policies, 2019[1]).

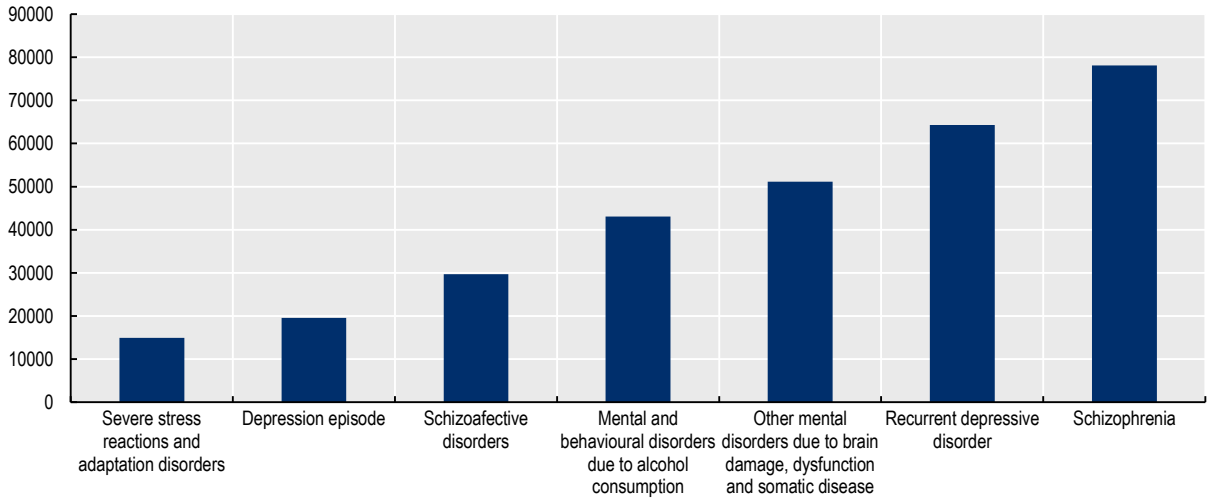
149. Some general hospitals in Lithuania have inpatient units for mental health, which provide services for individuals who require acute assistance. In 2019, 24 hospitals had licenses for psychosomatic or psychiatric inpatient units in general hospitals or psychiatric hospitals, and had psychiatric beds. Hospitals with psychiatric beds are located primarily in Lithuania's most populous cities, such as Vilnius, Kaunas, Klaipėda and Šiauliai (Ministry of Health). In 2020, there were general hospitals with units for mental health in 14 of 60 Lithuanian municipalities (Ministry of Health). There are currently no legal instruments which regulate the procedure for health care providers in circumstances where an individual requiring acute assistance arrives at a general hospital without a mental health ward. A Lithuanian mental health expert

has indicated that in such circumstances, general hospitals ordinarily make contact with another hospital to organise transfer of the patient (Ministry of Health).

150. In 2019, the majority of inpatient services for people with mental health disorders provided in general hospitals were for schizophrenia (78 075 bed days), recurrent depressive disorder (64 314 bed days), other mental disorders due to brain damage, dysfunction and somatic disease (51 160 bed days), mental and behavioural disorders due to alcohol consumption (43 037 bed days), schizoaffective disorders (29 716 bed days), depressive episodes (19 592 bed days) and severe stress reactions and adaption disorders (14 941 bed days) (Figure 3.11)

Figure 3.11. The majority of inpatient services for mental and behavioural disorders in general hospitals are for schizophrenia, depression, alcohol-related disorders and other mental disorders due to brain damage, dysfunction and somatic disease

Number of services (bed days) in general hospitals for mental and behavioural disorders, 2019



Note: Data excludes dementia (ICD-10 codes F00-F03) and developmental disorders (ICD-10 codes F70 – F89). Data for dementia (ICD-10 code F05.1) is included. Only the top seven services (by number of bed days) are shown
Source: National Health Insurance Fund

Psychiatric hospital care / clinics

151. There are currently 11 specialised psychiatric hospitals, located in Vilnius, Kaunas and other Lithuanian districts (European Commission, 2013[28]). Planned admissions to specialised mental health care hospitals occur via referral from primary or secondary care physicians (Puras et al., 2004).

152. The use of inpatient mental health care remains high in Lithuania compared to other OECD countries. Lithuania has one of the highest rates of psychiatric beds per 1 000 population in the OECD (Figure 3.12). In 2018, Lithuania had 0.98 psychiatric beds per 1 000 population, above the OECD average of 0.68 per 1 000 and the rate of psychiatric beds in France (0.83 per 1 000), but lower than comparator countries Latvia (1.22 per 1 000) and Norway (1.05 per 1 000).

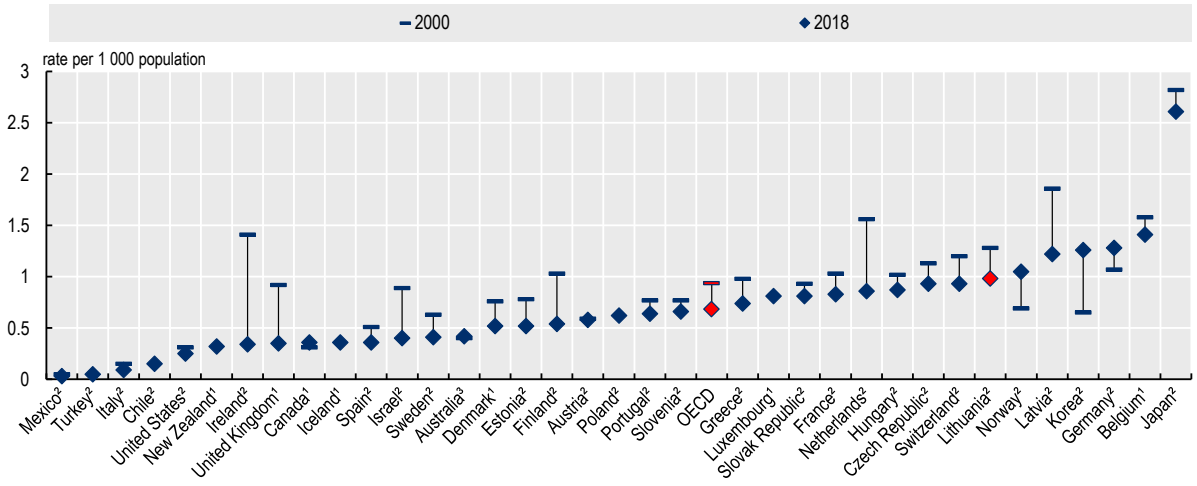
153. While the Lithuanian health systems remains geared towards hospital care, Lithuania, like other OECD countries, has made the transition to community-based mental health care a policy priority. Over the past 15 years, Lithuania has moved a substantial part of institutionalised psychiatric and substance abuse services into general hospitals and outpatient settings, whilst making investments to improve infrastructure conditions in many psychiatric facilities (OECD, 2018[29]). In Lithuania, as in other OECD

countries, the number of psychiatric beds per 1 000 population declined between 2000 and 2018 (Figure 3.12).

154. The rate of psychiatric beds in Lithuania has declined at a greater rate than the OECD average. The rate of beds fell from 1.28 to 0.98 per 1 000 population in the period between 2000 and 2018, declining at a greater rate than the OECD average, but a somewhat slower rate than comparator country Latvia, which saw a particularly significant fall in the rate of psychiatric beds during this period (from 1.86 beds to 1.22 beds per 1 000 population). Alongside these changes, Lithuania has made significant changes in the delivery of psychiatric services, with considerable reductions in the durations of admissions, alongside the development of community-based mental health services (Kamal et al., 2021[39]).

Figure 3.12. Lithuania has one of the highest rates of psychiatric beds per 1 000 population in the OECD, though the ratio is declining

Psychiatric beds per 1 000 population, 2000 and 2018 or nearest year

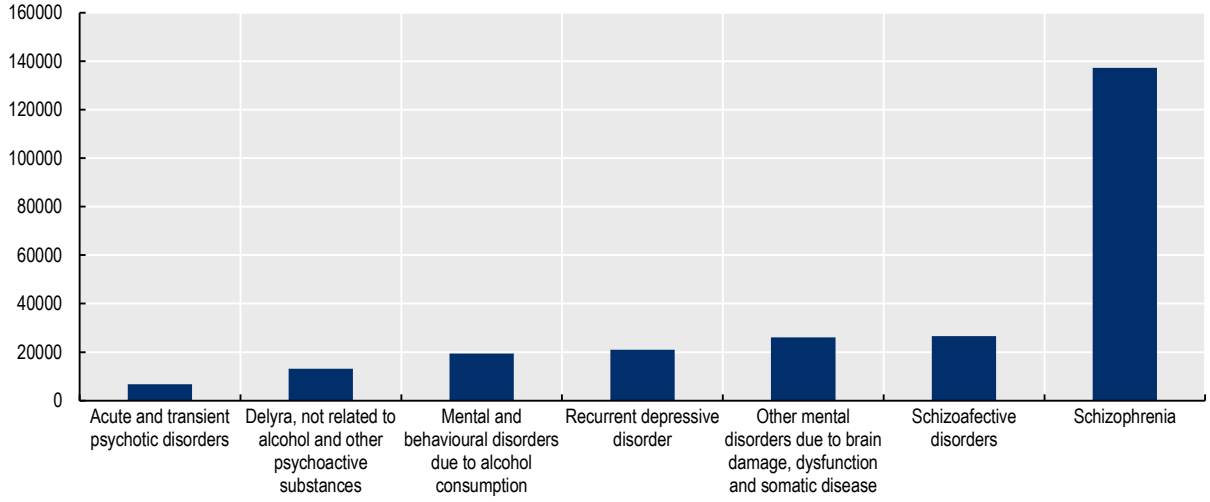


Note: 1. Data from 2019; 2. Data from 2018; 3. Data from 2016
Source: (OECD, 2021[4])

155. In 2019, the majority of inpatient services provided in specialised mental health hospitals were for patients with schizophrenia (Figure 3.13). In 2019, 137 294 services (bed days) were recorded for patients with schizophrenia in specialised mental health hospitals. After schizophrenia, the greatest number of services provided in specialised mental health hospitals were for patients with schizoaffective disorders (26 644 bed days), other mental disorders due to brain damage, dysfunction and somatic disease (26 085 bed days), recurrent depressive disorders (20 927 bed days) and mental and behavioural disorders due to alcohol consumption (19 449 bed days).

Figure 3.13. The majority of inpatient services for mental and behavioural disorders in specialised mental health hospitals are for schizophrenia

Number of bed days in specialised mental health hospitals for mental and behavioural disorders, 2019

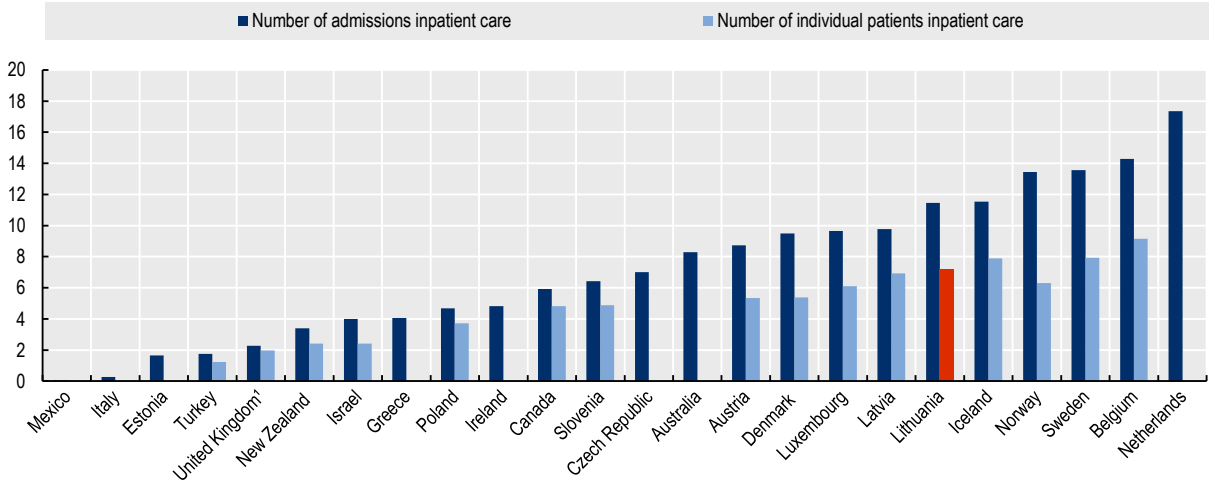


Note: Data excludes dementia (ICD-10 codes F00-F03) and developmental disorders (ICD-10 codes F70 – F89). Data for dementia (ICD-10 code F05.1) is included. Only the top seven services (by number of bed days) are shown
Source: National Health Insurance Fund

156. The rate of admissions to inpatient mental health care remains high in Lithuania (Figure 3.14). In 2019, the number of admissions to inpatient care was 11.47 per 1 000 population, amongst the higher rates of admissions in the OECD. This was somewhat higher than comparator country Latvia (9.78 per 1 000 population), though somewhat lower than comparator country Norway (13.45 per 1 000 population) (OECD, 2021[4]).

Figure 3.14. The rate of admissions to inpatient mental health care remains high in Lithuania

Admissions to inpatient care per 1 000 population, 2019 or latest year



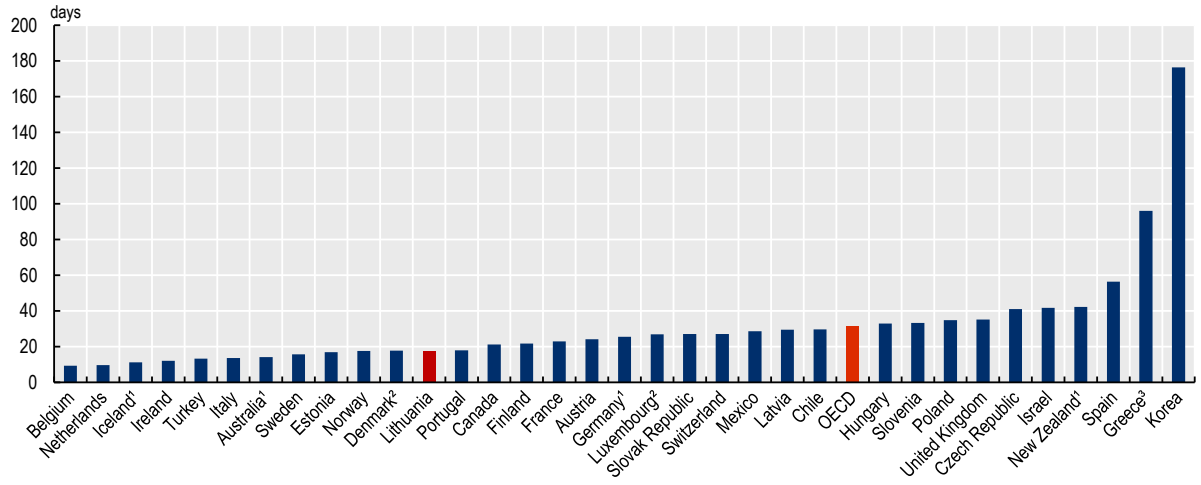
Note: Years included range from 2010 to 2019. [1]England
Source: (OECD, 2021[4])

157. OECD countries differ in their reliance on inpatient mental health care (OECD, 2021[4]) In general, there tend to be fewer inpatient admissions in countries with fewer inpatient beds (OECD, 2021[4]). While it is unclear whether this trend is driven by a tendency to 'use available beds' or by a greater reliance on inpatient mental health services, data collected by the IMHL/NHS Benchmarking Project suggests that bed availability is a key driver of inpatient admission rates (OECD, 2021[4]).

158. The average length of inpatient stay in Lithuania is almost half the OECD average (Figure 3.15). In 2018, the average length of inpatient stays for those with a mental and behavioural disorder was 31 days, and most OECD countries reported average hospital stays ranging between 10 and 40 days (OECD, 2021[4]) The average length of inpatient stay in Lithuania was 17.7 days in 2018, considerably lower than comparator country Latvia (29.5 days). The average length of stay was comparable to that in comparator country Norway, where the average was 17.5 days in 2018.

Figure 3.15. The average length of inpatient stay in Lithuania is almost half the OECD average

Average length of inpatient stay, mental and behavioural disorders, 2018 or latest year



Note: Years range from 2014 to 2018, ¹2017, ²2016, ³2014.
Source: (OECD, 2021[4])

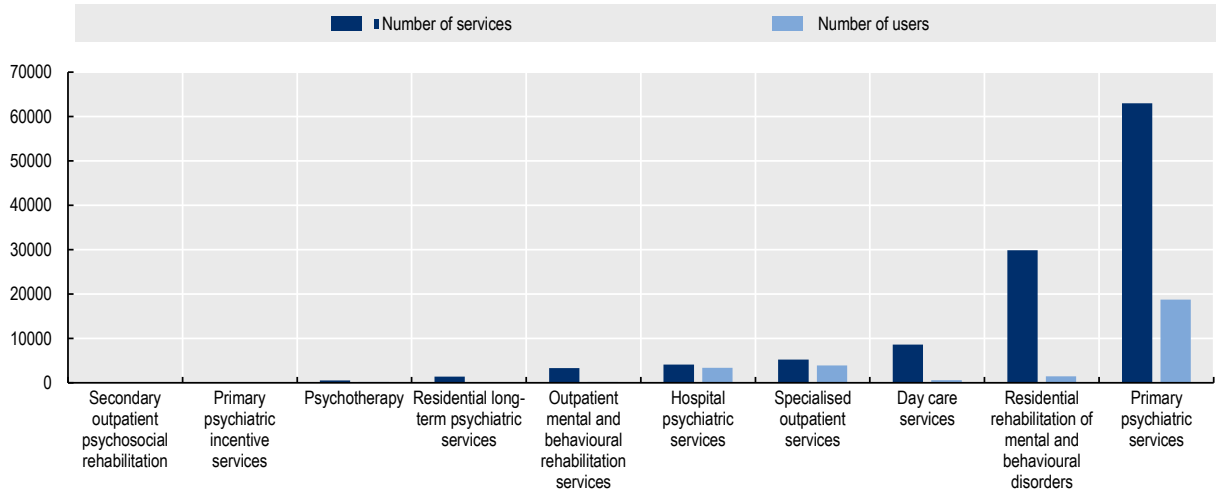
Child and adolescent services

159. In Lithuania, services for children and adolescents are available at primary, secondary and tertiary levels. There are five institutions providing psychiatric day care treatment for children and adolescents, 18 secondary level outpatient institutions for children, and 48 early intervention centres for children (OECD Mental Health Benchmarking Questionnaire). A 2019 ministerial order stated that the network of institutions providing psychiatric day care would be expanded from five institutions to ten (OECD/European Observatory on Health Systems and Policies, 2019[1]). There are five health care institutions that provide inpatient care for children and adolescents, which, in 2018, provided 102 hospital beds for children and adolescents.

160. Lithuanian mental health experts have repeatedly indicated that there are acute shortages of services for children and adolescents. As outlined in Chapter 2, there is a shortage of child and adolescent psychiatrists, particularly at primary care level, which may affect the diagnosis and treatment of mental health disorders for children and adolescents. Outside of primary care, data on the number of visits to secondary specialised outpatient services suggests the network of outpatient services for children and adolescents outside of primary care is not yet well developed (Figure 3.16).

Figure 3.16. The number of children and adolescents accessing outpatient mental health services outside of primary care is low

Children and adolescents receiving psychiatric services, 2019



Note: Data refers to the provision of services to children and adolescents aged up to 18 years old. Data for childcare services and specialised outpatient services for children and adolescents with developmental disorders has been excluded
Source: Lithuanian Ministry of Health

161. In 2019, the bulk of services for children and adolescents were provided at primary care level, and the number of children and adolescents accessing outpatient mental health care services outside of primary care was low (Figure 3.16). Primary psychiatric services were provided to 18 707 children and adolescents in 2019, and specialised outpatient services were provided for 3 880 children and adolescents. Lithuanian mental health experts have indicated that the under-development of secondary services is particularly challenging given low system capacity for the inpatient care of children and adolescents, and that there are consequently long waiting times for such services (OECD Interviews, 2021). Taken together, these challenges suggest significant shortages of suitable services for children and adolescents in Lithuania.

Substance abuse services

162. Mental health services for alcohol and substance abuse are delivered in primary mental health care centres and five specialised centres for addiction and disease control (Republican Centre for Dependent Diseases or RPLC) located in major cities in Lithuania. In 2019, there were 47 dedicated drug and alcohol abuse beds located in hospitals in Vilnius and Kedainiai. Additionally, centres for addiction and disease control have inpatient units with a small number of beds. In 2019, there were 148 drug and alcohol abuse beds in centres for addiction and disease control, representing approximately 30 beds per centre, together with 89 drug and alcohol abuse rehabilitation beds (National Health Insurance Fund).

163. The majority of substance abuse services are provided at primary care level. In 2019, users made 23 203 visits to institutions providing primary mental health care for mental and behavioural disorders due to substance abuse (those categorised with ICD-10 codes F10-F19), and 1 364 visits to a centre for addiction and disease control (Ministry of Health). However, mental health experts have indicated that there is a lack of systems capacity for the treatment of substance abuse conditions at primary care level, and acute shortages of services for their treatment elsewhere (OECD Interviews, 2021). This is problematic given the rate at which the diagnoses of mental health conditions due to alcohol and substance abuse are

increasing (see Chapter 1). At a primary care level, primary care providers have indicated that there is significant demand for alcohol and substance abuse services, but that there are currently insufficient incentives for their provision, making it uneconomical for many providers to provide such services (OECD Interviews). Access to substance abuse services beyond primary care is limited, as outlined above, and their geographical distribution also presents a challenge. A majority of specialised services in centres for addiction and disease control are provided in Vilnius and Kaunus, which primary care providers report to be challenging for users in rural areas, particularly those with weaker transport links (Ministry of Health).

Coordination amongst Providers

164. In Lithuania, as in other OECD countries, coordination between providers is recognised as a significant challenge (OECD, 2018[29]). Research indicates a low level of collaboration between GPs with mental health care teams for the provision of mental health care services, and a lack of coordination with social workers (Jaruseviciene et al., 2014[35]). Coordination between inpatient and outpatient providers is also particularly challenging, with many Lithuanian mental health experts noting a significant drop in the continuity of care between inpatient and outpatient settings (OECD Interviews, 2021). A 2017 review by the National Audit Office called for renewed efforts to ensure a continuity of care for those identified to be at risk of suicide, in particular, emphasising the need for greater information sharing across institutions (National Audit Office, 2017).

165. As outlined in Chapter 2, legislative requirements for the coordination of care between inpatient and outpatient providers are outlined in various legal instruments. These regulations mandate that inpatient facilities notify primary mental health care providers in the event of suicide attempt. In practice, however, interviews with Lithuanian mental health experts have highlighted that such notifications largely do not take place, with one primary care provider describing the link between inpatient and outpatient care as “non-existent” (OECD Interviews, 2021). A number of interviewees also indicated that insufficient support is provided to patients on discharge from hospital. Several care providers and experts by experience indicated that many patients are discharged from inpatient care without a care plan, recommendations, medication, or information about the support available to them (OECD Interviews, 2021).

166. There are a number of potential drivers for coordination challenges between inpatient and outpatient providers. Lithuanian mental health experts and care providers point to workforce, systems and funding/incentive challenges in particular as factors accounting for a drop in the continuity of care. Specifically, workforce shortages may mean that finding time for communication and patient handover is challenging, particularly given a lack of dedicated non-clinical time for professionals. Secondly, while an e-Health system is in use in Lithuania, its use in mental health care is limited; it currently holds only information with respect to prescriptions, and there are significant restrictions on access by specialists (for example, many psychologists are currently unable to access e-Health systems and are therefore unable to view their patients’ prescription history) (OECD Interviews, 2021). The Government of Lithuania is currently considering expanding both the use of and access to the e-Health system for mental health care, including the use of automated notifications between inpatient and outpatient providers for high-risk events such as suicide attempts. Such an approach could increase efficiency and help to ensure the continuity of care by reducing the amount of time required for coordination amongst providers, noting of course the need for sensitive management of patient records. Finally, there are insufficient financial incentives for hospital providers to ensure patient handover, as case-based payments are currently not contingent on such handover having taken place, and payment structures for inpatient and outpatient providers could conflict if volume caps are not designed and monitored carefully (Chapter 2). As such, further efforts are required to ensure that incentive structures are appropriately designed to ensure robust patient handovers between care settings.

167. In addition to supply-side barriers to the continuity of care, research conducted in Lithuania also indicates the possibility of demand-side barriers. Researchers attempting to recruit a small sample of

patients hospitalised following a suicide attempt in Lithuania, for instance, found that many patients did not wish to be contacted, or agreed to participate but fell out of contact at a later stage (Dadašev et al., 2016[30]). The high rate of dropout could be a function of the stigma surrounding mental ill-health or feelings with respect to the need for self-sufficiency, which may prevent users from accessing outpatient care following hospitalisation (Dadašev et al., 2016[30]);(Chapter 2). In addition to the alignment of incentive structures, it is therefore critical that efforts to address stigma are continued and monitored.

Conclusion

168. While significant efforts have been made to shift the provision of mental health care into de-institutionalised care settings, international comparisons of bed capacity and admissions to inpatient care indicate that the Lithuanian mental health system remains hospital-centric. While the Mental Health Strategy sets an ambition for the majority of mental health disorders to be treated at primary care level, there are currently low rates of diagnoses and high rates of onward referral amongst primary care physicians, potentially stemming from low self-reported confidence amongst General Practitioners and insufficient capacity and incentives for the provision of mental health care. High rates of onward referral can lead to overcrowding in primary mental health care centres, which - in combination with workforce and funding challenges – provides insufficient capacity for the provision of psychotherapeutic care, and there is consequently a high reliance on medication-based treatment. Additionally, there are a number of areas of acute shortage, such as services for children and adolescents and alcohol and substance abuse services. Additional efforts are required to ensure coordination amongst providers, particularly in the critical transition from inpatient to outpatient care.

4 Quality and Outcomes

Introduction

169. This chapter discusses the quality of mental health care in Lithuania. It provides a comparative perspective on mental health system performance in Lithuania, reports on mental health service users' assessments of quality and outcomes, provides an overview of the indicators in use to measure the quality of mental health care, and discusses the mechanisms in place to improve care quality.

Quality Measures and Oversight

170. Countries across the OECD have been making concerted efforts to improve the quality of their mental health care services. Defining what constitutes a good treatment 'outcome' remains challenging, given the complex and often chronic nature of mental health conditions, and challenges in measuring and monitoring the severity of mental health symptoms (OECD, 2021[4]).

171. National and international measures of mental health care quality, and mental health care outcomes, have been developed to bring insights into the performance of mental health systems. Mental health system indicators have long been limited to 'inputs' such as numbers of hospital beds or service contacts, but there is growing recognition that the indicators operationalised to measure the quality of mental health care must incorporate insights into the outcomes of care if they are to provide a meaningful measure of whether or not the care provided is improving an individual's condition (OECD, 2021[4]) (Box 4.1).

172. Important gaps remain in the availability of information on mental health care outcomes (OECD, 2021[4]). At an international level, the OECD collects international benchmarking data with respect to a number of mental health indicators, such as excess mortality for individuals with schizophrenia and bipolar affective disorder (OECD, 2021[4]). The OECD's Mental Health Benchmark also reported on a number of quality and outcome measures, and international comparisons drawing on a range of those measures are summarised below, and outlined in greater detail in Chapter Annex 4.A.

Box 4.1. Measuring mental health care quality

Dimensions of Care Quality

Assessing mental health care quality and outcomes can be challenging due to the complexity of mental health conditions and the range of dimensions by which the quality of care can be measured. Measures of care quality can incorporate both the clinical and social 'outcomes' of care, in terms of improvements to one's condition or their capacity to participate in employment and other meaningful activities, or service users' experiences of care, for instance. Indeed, across the OECD, countries are beginning to place increasing emphasis on patient-reported outcome and experience measures (OECD, 2021[4]).

Principle 2 of the OECD Mental Health Performance Framework: Accessible, High-Quality Mental Health Services

The OECD's Mental Health Performance Framework established a number of guiding principles for accessible, high-quality mental health care.

"Accessible and high-quality mental health services are the foundation of a high performing mental health system, and mean that people experiencing mental distress can get the help and support they need. In particular, accessible and high-quality services should:

- Be evidence-based;
- Be developed close to the community;
- Be provided in a timely manner;
- Account for and respect the unique needs of vulnerable groups;
- Ensure continuity of care;
- Deliver improvement of individual's condition;
- Be safe."

Source: (OECD, 2021[4])

Mental Health System Performance in Lithuania – Quality and Outcomes

Available quality and outcomes measures

173. As outlined in this Chapter, OECD countries are making concerted efforts to improve the quality of mental health care. Chapter Annex 4.A provides a comparative perspective on a range of key quality and outcome measures for mental health care.

174. The indicators reported to the OECD in 2020 covering mental health care quality and outcomes give some insights into the performance of mental health systems. However, significant challenges remain in using this limited set of indicators to understand mental health performance (OECD, 2021[4]). Firstly, there are differences in the data and reporting practices between countries – for example, for indicators such as involuntary admissions or follow-up after discharge. Secondly, it is difficult and sometimes impossible to interpret such indicators in isolation and further information and/or contextual measures are needed, which are not always available; for example, inpatient suicide is a 'never event' and a major patient safety failing, but delivering a low rate of inpatient suicide by the extensive use of restraint in inpatient settings would not point to high-quality care.

175. The OECD Mental Health Performance Benchmark 2021 (OECD, 2021[4]) found that all mental health systems had considerable scope to improve performance, including in terms of delivering good outcomes and high quality care. Even for countries that appeared comparatively 'top' performers, room for improvement remains. Against this backdrop, based on the range of available quality and outcome measures, Lithuania tends to see middling performance compared to other countries able to submit data, although for some countries only a small number of countries were able to submit data.

176. A few areas of concern do emerge, notably unmet need for care, and coordination of care. In 2014, 4.7% of the Lithuanian population reported unmet needs for mental health services due to financial reasons, compared to the EU27 average of 3.2% (Eurostat, 2021[40]). When unmet needs due to waiting times or transport are also taken into account, the share of the population reporting unmet needs is significantly higher, reaching 30% in 2016 in Lithuania.

177. The somewhat high rate of repeat admissions to inpatient care, and high rate of suicide following discharge from inpatient settings, could point to challenges around coordination of care following discharge and/or in community settings more generally. In 2019, the rate of repeat admissions in Lithuania (11%) was close to the average for those countries able to submit data (12 countries, average repeat admissions of 12.1%). In addition, in Lithuania, 11% of patients who received inpatient active or long-term care services for mental and behavioural disorders were re-hospitalised within 90 days (OECD questionnaire, 2021). Worryingly, Lithuania has one of the highest rates of post-discharge suicide amongst countries able to submit data, with 52.7 deaths by suicide within one year of discharge for 10 000 patient discharges, a rate only higher in only Slovenia and the Netherlands (of 10 countries able to submit data). This high rate of death by suicide after discharge may also point to challenges in post-discharge care.

178. The relatively low rate of follow-up after discharge within the recommended 14 days in Lithuania may also point to challenges with post-discharge care coordination, although the rate is improving. In Lithuania, the percentage of patients who received a follow up within the nationally mandated or recommended period following discharge of 14 days was 56.9% in 2018, up from 52.4% in 2015 (OECD, 2021[4]). This trend also aligns with challenges raised by Lithuanian mental health experts with respect to a gap in the continuity of care following discharge from hospitals (Chapter 3) (OECD Interviews, 2021).

Mental health service user representation in Lithuania

179. A person-centred approach is critical to ensuring the provision of high-quality mental health care (OECD, 2021[4]).

180. The mental health sector has been instrumental in prioritising the voices of mental health service users in many OECD countries. Of the 29 countries which responded to the OECD Mental Health Performance Benchmarking Data and Policy questionnaire, 21 countries reported the existence of national groups or coalitions which include representation for mental health service users (OECD, 2021[4]). Such service user groups are often a primary point of contact for consultation on national mental health policies and strategies (OECD, 2021[4]).

181. There is considerable variation across OECD countries in terms of the organisation of mental health service user representation. OECD countries differ in the structure of service user representation, in terms of the level at which representation is organised (whether national or otherwise), and the degree of centralisation of representation (whether there is a single representative group for service users) (Table 4.3) (OECD, 2021[4]). In Australia, for instance, the National Mental Health Consumer & Carer Forum (NMHCCF) comprises 28 members, and provides consumer and carer input into national policy development (OECD, 2021[4]). In Norway, the Norwegian Council for Mental Health ('Rådet for psykisk helse') comprises 31 member organisations (OECD, 2021[4]).

Table 4.1. The organisation of mental health service user groups differs across OECD Countries

Type of Mental Health Service User Representation	
National mental health service user groups or coalition	Australia, Austria, Czech Republic, Ireland, Japan, Korea, the Netherlands, Norway, Portugal
Multiple national mental health service user groups	Belgium, Canada, Denmark
Multiple mental health service user groups but no national umbrella or national organisation	Iceland, Latvia, **Lithuania**, Mexico, Slovenia, Sweden, Switzerland, Türkiye
No national or coalition group, but service users systematically consulted in policy development	England

Source: Adapted from (OECD, 2021[4])

182. In Lithuania, there are multiple mental health service user groups, but no national umbrella or representative organisation (Table 4.3). For example, "Viltis" (Lithuanian Welfare Society for People with Mental Illnesses) is a non-governmental association comprising of more than 11 000 members, focused primarily on the provision of social services for people with mental disabilities (OECD, 2021[4])(OECD Interviews, 2021).

Mental health service user assessments of quality and outcomes in Lithuania

183. The OECD sought input from service user representatives for the purposes of informing this analysis. However, service user groups contacted for the purposes of this work were limited in the extent to which they were able to report on the experiences of service users with the mental health care system. Indeed, during the course of interviews, a number of Lithuanian mental health experts indicated that the network of user representation and advocacy for mental health care users is not extensively developed in Lithuania, and that civil society groups in this space are still emerging (OECD Interviews, 2021).

184. The OECD was able to gain a limited set of input from experts by experience with respect to the quality and accessibility of mental health care, primarily from service users with severe mental health disorders such as schizophrenia. A number of key themes emerged:

- While service users noted the accessibility of mental health care in larger cities a strength of the system, they expressed a desire for more comprehensive health and social support in managing their mental health disorders
- In particular, service users noted a heavy reliance on medication-based treatment, an inability to access publicly-funded psychotherapy, and a desire for greater assistance with social, emotional and vocational issues
- Service users also highlighted a need for expanded activities in day care settings; while they reported being able to access mental health specialists, they also reported a lack of meaningful activities to engage in at day care centres (OECD Interviews, 2021).

185. Interviews with service users highlighted that greater efforts are required to ensure that individuals are able to access respectful and inclusive mental health care which enables them to feel ownership of their care (OECD, 2021[4]). Service users noted the quality of hospital care as the most challenging aspect of their experience with mental health system. In particular, services users described a perceived lack of empathy from providers, feeling neglected in inpatient care, and feeling that they were not treated with dignity or respect. Importantly, service users' perceptions of care quality were linked to the types of treatment available to them, their relationship with their care provider, and their sense of autonomy in their care.

186. Service users noted low-quality hospital care in certain hospitals as characterised by high levels of supervision and surveillance, medication, and limited contact with mental health care specialists, and

expressed a desire for more comprehensive treatment and support. In particular, service users reported a reliance on medication-based inpatient care and a lack of alternative treatment options, which they described as disempowering and perceived to encourage passivity in the treatment of their disorder (OECD Interviews, 2021). One expert-by-experience also noted significant differences in the quality of treatment between cities. They reported travelling from one city to another every time they required hospital treatment as the quality of care was higher because providers took time to discuss their treatment with them, and 'treated them as equals in their care' (OECD Interviews). Additionally, service users reported insufficient support on discharge from hospitals, and noted that they were often discharged from hospital with no medication, care plan, or information about the support available to them (OECD Interviews, 2021). Finally, service users noted limited avenues to provide feedback on the quality of their care (OECD Interviews, 2021).

Mental health experts' assessments of quality and outcomes of care

187. During the course of interviews, health and social care providers and Lithuanian mental health experts also raised a number of challenges.

188. Social service providers in particular echoed that there is a lack of support for service users on discharge from hospital, but also emphasised the need for greater integration of health care and social services, and greater support for the family members and carers of people with mental disorders. Social service providers proposed a number of additional measures to improve communication with patients and across providers. Firstly, social service providers recommended that patients be provided with locally-adapted information on the health care and social services available to them on discharge from hospital. Secondly, social service providers called for increased communication and collaboration between health care and social providers; firstly, by notifying social service providers when their patients are discharged from hospital, and secondly, by building bridges between health care and social service providers, so that social service providers could consult mental health specialists in circumstances where their user's mental health conditions worsen (OECD Interviews, 2021). Social service providers indicated that currently, individual specialists make efforts to build bridges between health care and social services, but that there is no systematic approach to ensuring integrated support across different settings (OECD Interviews, 2021).

189. In Lithuania, mental health experts have indicated that service users and their families are not actively engaged in the design or evaluation of mental health care services (OECD Interviews, 2021). Empowering service users to co-design and deliver mental health services can provide a potential mechanism by which to deliver a more person-centred approach to mental health care (OECD, 2021[4]). Across the OECD, countries are beginning to move beyond consultation with service users to actively engaging them in the process of shaping and delivering services (OECD, 2021[4]). Ireland's Health Service, for instance, has developed an office of Mental Health Engagement and Recovery which enables service users, family members and carers to deliver and evaluate services (OECD, 2021[4]).

190. In Lithuania, user-led design is lacking and there are currently few mechanisms to elevate service user voice. Lithuania is not unique in this regard; while patient-reported experience and outcome measures (PREMs and PROMs) provide an important mechanism by which to facilitate and elevate user voice, not many countries currently systematically track and report on them. In 2018, only five of 12 countries surveyed by the OECD reported that they regularly collect PROMs and PREMs, and there is significant variation across countries as to the conditions, settings and interventions covered by the data (OECD, 2021[4]). Nevertheless, OECD countries are showing increased interest in their use; in 2021, 12 countries participated in an international pilot of patient-reported experience and outcome measures in mental health care, from which one indicator (share of inpatient and community mental health service users who were treated with courtesy and respect by care providers, 2021) was reported in the OECD's *Health at a Glance 2021* (de Bienassis et al., 2022[41]). Lithuania could look to begin collecting mental health care PREMs and

PROMs both as an important source of information on key dimensions of quality of care and outcomes (e.g. service users who report being treated with respect), and as a way of turning the system towards a more person-centred approach.

Mechanisms to Ensure and Improve the Provision of High-Quality Mental Health Care

Tracking quality and outcomes to improve performance

191. At a national level, OECD countries differ in their approach to setting quality and outcome indicators, both in terms of the range of indicators which are collected and their utilisation in mental health policy making and system governance. As of 2020, 17 out of 29 surveyed OECD countries have some type of quality and outcome framework in place, though the frameworks differ (OECD, 2021[4]). Such frameworks can be a way of deepening understanding of mental health system performance, tracking performance over time, and incentivising improvements in performance especially when indicators are reported at a disaggregated regional or local level. Denmark, for instance, uses a framework of indicators with respect to the outcomes of mental health care as part of the Danish Health care Quality Programme, which include a range of outcome and patient satisfaction indicators (OECD, 2021[4]).

192. A number of Lithuanian mental health experts have indicated a desire to expand the quality and outcome indicators framework in Lithuania, and a number of governmental and non-governmental working groups have already investigated the possibility of doing so (OECD Interviews, 2021). In 2019, a Ministerial Order (No. V-30) was issued by the Minister of Health establishing a working group to develop proposals to improve the quality performance measure in place for primary mental health care, and to improve the accessibility of mental health care. The Working Group proposed a number of measures, such as setting a minimum population for mental health centres to rationalise service delivery; re-calibrating the existing pay-for-performance metric to take into account the number of people with schizophrenia in a mental health care centre; incentivising the provision of services for problematic alcohol consumption; reducing the ratio of psychologists to population served; providing additional incentives for the recruitment of child and adolescent psychiatrists, and implementing additional measures to monitor the prescription and duration of specified medications, such as benzodiazepines (OECD Interviews, 2021).

193. Additionally, Lithuanian mental health experts have previously convened working groups by their own volition to research, agree and pilot a range of quality and outcome indicators that could be implemented using existing administrative data (OECD Interviews, 2021). The working group developed a framework of 32 quality indicators covering a rage of quality domains, including measures on the use and length of use of medication, the availability of psychotherapy, patient employment outcomes, and communication between providers, amongst others (OECD Interviews, 2021). To date, additional measures have not yet been determined. It would be beneficial to agree a subset of quality and outcome indicators for mental health care, and to routinely collect and report on them.

Licensing and accreditation

194. Accreditation, monitoring and enforcement mechanisms provide important avenues by which to ensure the provision of high-quality care. Regulatory processes and capacity vary across OECD countries. In Lithuania, the State Health Care Accreditation Agency is accountable for ensuring the quality of health care services, ensuring providers' compliance with legislative requirements concerning the quality of care, and conducting both planned and unplanned inspections of health care providers.

195. Licensing and accreditation processes for care providers provide one mechanism by which to ensure the quality of mental health care. In Lithuania, the State Health Care Accreditation agency licenses

health care institutions and professionals (OECD/European Observatory on Health Systems and Policies, 2019[1]). It is mandatory for all institutions who provide health care services to be licensed.

196. Licensing requirements and procedures for health care institutions are set out in the **Law on Health Care Institutions** (**1996, No. I-1367**) and the **Order on the Licensing of Personal Health care Institutions** (**2007, No. V-156**). To obtain a license, health care institutions are required to make an application to the State Health Care Accreditation agency with a number of certified specified documents, such as the institution's founding documents, its hygiene permit, the professional qualifications required for the provision of its services, confirmation of civil liability insurance, and so on. Applicants are also required to provide a list of the procedures to be followed to ensure the quality of the services provided, such as management procedures, complaints handling procedures, and mechanism for local (internal) audit. Additionally, institutions who hold a license are required to ensure that only health care specialists who have acquired the required professional qualifications provide services in the institution, and are required to submit proof of workers' qualifications within 30 days of receipt of their license.[9] The State Health Care Accreditation Agency has the right to refuse a license for a number of reasons, for example if the proposed activities of the institution do not comply with licensing requirements.

197. Lithuania has introduced a number of initiatives to encourage improvements in care quality (OECD, 2018[29]). In 2016, a voluntary accreditation program was launched whereby health care providers who have been operating for more than three years can apply to receive an accreditation certificate certifying their compliance with nationally-determined health care quality standards (OECD/European Observatory on Health Systems and Policies, 2019[1]) (State Health Care Accreditation Agency, 2017[42]). In 2017, financial incentives for voluntary accreditation were introduced by way of a marginally higher capitation payment for accredited providers (OECD/European Observatory on Health Systems and Policies, 2019[1]). However, as at 2017 only 16 institutions were accredited (OECD/European Observatory on Health Systems and Policies, 2019[1]).

198. The regulations and guidelines surrounding the activities of mental health professionals in Lithuania are currently incomplete (OECD, 2018[29]). The role of psychologists is not clearly defined by law, and there is a lack of clarity surrounding the types of therapies and treatment psychologists are able to provide (OECD Interviews, 2021). A 2017 review by the National Audit Office noted that a lack of national guidance on the scope of psychologists' services had led 35% of surveyed primary mental health care centres to determine their own (limited) number of free psychological consultations (National Audit Office, 2017[31]). Additionally, standardised psychological assessment instruments are currently unavailable. A review conducted by the National Audit Office in 2017 found that more than half (58%) of surveyed medical establishments were unable to ensure quality psychological services, with they attributed to a lack of properly adapted psychological assessment methods (National Audit Office, 2017[31]). Standardised psychological assessment instruments which have been properly adapted and tested within the Lithuanian context are critical to ensure quality mental health care. However, funding for the adaptation of such instruments has not been available (OECD Interviews, 2021).

Monitoring and enforcement mechanisms for care quality standards

199. Monitoring and enforcement mechanisms provide an important avenue by which to ensure that appropriate action is taken against care providers found not to have met quality standards.

200. As outlined in Chapter 2, the legislative framework for mental health care contains a number of care quality standards, such as specified ratios of workers to population served, rules with respect to the use of seclusion and restraint, and rules with respect to involuntary admissions.

[9] Order on the Licensing of Personal Health care Institutions (2007, No. V-156)

201. In Lithuania, quality assurance is heavily reliant on inspections (World Health Organization, 2017[43]). Rules with respect to inspections of health care institutions are set out in the **Law on Health Care Institutions** (**1996, No. I-1367**) and the **Rules for Checks Carried out by the State Accreditation Service for Health Activities Under the Ministry of Health** (Order No.TI-390, 2011). The State Health Care Accreditation Agency can carry out planned and unplanned inspections, and inspections in response to complaints. The regulations also place a legal obligation on municipalities (as owners) and administrators of health care institutions to make internal audit arrangements to ensure safety and care quality (World Health Organization, 2017[43]). If providers are found not to meet requirements, service provision can be stopped, temporary administration can be forced, or licenses can ultimately be revoked.

202. A 2015 OECD review of regulatory policy in Lithuania noted that inspections of health care institutions are predominantly complaints-based, and that fewer planned inspections are carried out (OECD, 2015[44]). The review also noted a number of gaps with respect to inspection processes, particularly with respect to the development of risk criteria used to carry out inspections (OECD, 2015[44]).

203. A number of Lithuanian mental health experts have echoed these concerns, noting that there is limited regulatory capacity to ensure that quality standards and legislative requirements for care providers are met. One primary care provider provided an example of an instance where they made efforts to contact the State Health Care Accreditation Agency with respect to a provider who was not meeting quality standards, but was informed that there was limited capacity for inspection (OECD Interviews, 2021). In addition to challenges with respect to regulatory capacity, there are currently few mechanisms in place to ensure the accuracy of the data provided to the National Health Insurance Fund by primary mental health care providers. As outlined in Chapters 2 and 3, primary mental health care providers are required to employ specified numbers of specialists, failing which their capitation payments are adjusted downwards. The National Health Insurance Fund calculates adjustments based on data provided by providers, but there are currently no measures in place to validate the accuracy of this data. Consideration could therefore be given to the implementation of additional assurance measures.

Clinical care guidelines

204. There is now a strong evidence base for what constitutes an effective mental health care intervention, and clinical guidelines for the diagnosis, treatment and management of mental health conditions are increasingly being used to disseminate evidence-based practices across OECD countries (OECD, 2021[4]).

205. In Lithuania, the regulations and guidelines surrounding the provision of mental health care are incomplete (OECD, 2018[29]) A number of Ministerial Orders contain clinical guidelines for the diagnosis and medicinal treatment of schizophrenia, schizotypal and delusional disorders, and depression and mood (affective) disorders (see Chapter Annex 2.A). However, the scope, breadth and depth of clinical guidelines could be extended significantly to ensure the consistency of care across different providers.

'Pay for performance' in mental health care

206. Across the OECD, countries have experimented with ways to leverage their payment systems to ensure high-quality mental health care (Hewlett and Moran, 2014[45]). In Lithuania, financial incentives linked to one mental health care quality and outcome measure are in place for primary care providers. Primary mental health care providers are given additional indicator-based payments linked to the rate of avoidable hospitalisations for patients with schizophrenia.

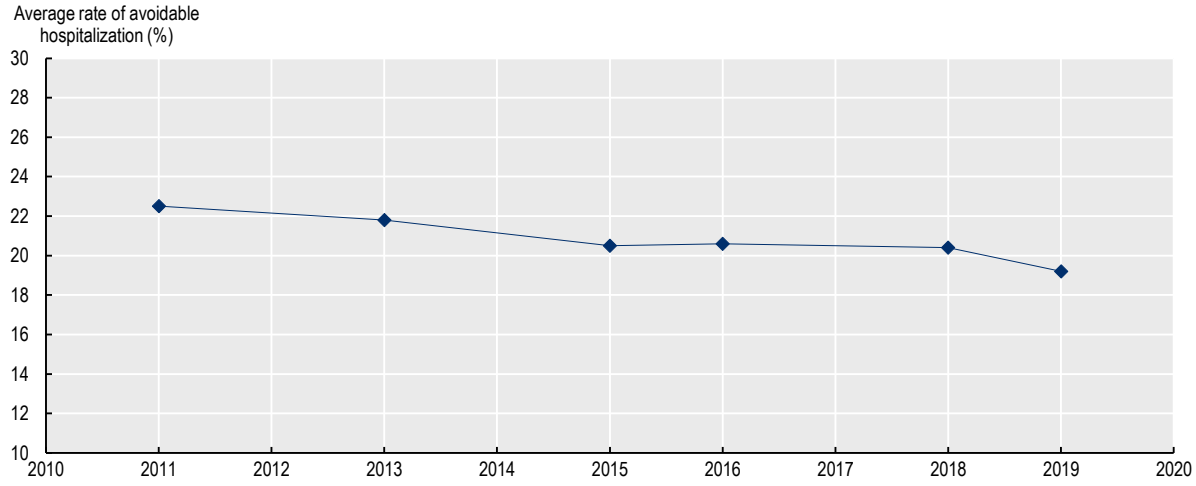
207. The pay-for-performance measure for primary mental health care providers is an upside only incentive, with additional incentive payments available to providers for 'good performance'. There are no penalties for 'poor' performers. The value of the incentive payment made to providers is determined by the National Health Insurance Fund in accordance with a rating scale comprising three incentive 'brackets'

where the value of the payment is higher in each bracket. The National Health Insurance Fund assesses primary mental health care providers' performance twice a year, and re-calibrates performance targets at the same time, based on the median provider performance during this period.

208. The rate of avoidable hospitalisations for patients with schizophrenia fell from 22.5% in 2011 to 19.2% in 2019 (Figure 4.1). However, there are a number of challenges associated with the design of the incentive measure. While well intentioned, there is potential for the measure to act as a disincentive for hospitalisation in circumstances where admission may be the most appropriate course of action for the patient. Additionally, primary care providers have indicated that the incentive measure is homelessness-sensitive, as homeless patients who spend extended periods of time in hospital (for example, during the winter), are 'attributed' to mental health centres (OECD Interviews, 2021). In these circumstances, the outcome of the indicator is influenced by factors beyond the provider's control. In general, incentivising providers on quality and outcomes is most effective when providers can directly influence the results, when the outcome is sensitive to effort, and where the metric encourages the provision of appropriate services and/or services in areas of clinical importance (OECD, 2018[29]).

Figure 4.1. The rate of avoidable hospitalisation of patients with schizophrenia has decreased since introduction of an incentive measure for mental health care

Rate of avoidable hospitalisation amongst patients with schizophrenia registered in primary mental health care centres, 2011-2019



Note: The pay-for-performance incentive metric for mental health care centres was introduced in 2011
Source: Lithuanian National Health Insurance Fund

209. The pay-for-performance metric in use in primary mental health care centres represents an attempt to leverage financial incentives to encourage the provision of high-quality care. The quality and outcome measure development underway in Lithuania, outlined earlier in this Chapter, has some potential to be tied to further financial incentives to encourage the provision of high-quality care. However, evidence on the effectiveness of performance-based financial incentives in health care, and mental health care, is mixed (OECD, 2016[46]). While OECD countries have experimented with the use of financial incentives to encourage the provision of appropriate services, financial incentives alone cannot overcome resource, workforce and systems constraints on the provision of high-quality care. When considering the expansion of incentives, therefore, careful consideration should be given to the appropriateness or otherwise of incentivising providers on quality and outcome measures. Where adopted, incentive structures should be

aligned with care delivery pathways and clinical guidelines, and should be designed to ensure robust transitions between inpatient and outpatient services.

Conclusion

210. Based on the limited number of quality and outcomes indicators available in Lithuania, and compared to other countries able to report similar indicators, Lithuania's mental health system performance appears to be middling. Particular attention needs to be paid to coordination of care, and in particular post-discharge care and follow up. The proportion of Lithuanians reporting unmet needs for mental health care due to financial reasons is also higher than the EU average, and unmet needs are particularly significant when also taking into account waiting times or transport. Additionally, interviews with service users appear to confirm challenges around care coordination, and also suggest shortcomings in terms of care delivery in inpatient settings, and limits to how 'person-centred' the system currently is.

211. A range of different mechanisms exist to assure and improve the quality of care in mental health care settings, including workforce licencing and accreditation, care quality standards, the use of a limited number of clinical guidelines, and payment incentives. Strengthening both clinical care guidelines and the guidelines and tools available to mental health professionals will be critical to ensuring the quality of mental health care provided across the system. To continue efforts toward a person-centred approach to the provision of mental health care, consideration should also be given to greater user involvement in the design and evaluation of mental health care services.

212. Lithuania currently employs a narrow indicator on the quality of mental health care in primary care settings, tied to a financial incentive. While implementation of the measure has been followed by some improvement in the rate of avoidable hospitalisations for those with schizophrenia, consideration should be given to the expansion of quality and outcome improvement mechanisms – both in terms of the range of mechanisms, and the breadth of their utilisation – in Lithuania, particularly in a manner that encourages and facilitates greater user voice. A particularly important – and possibly straightforward given existing data availability – starting point would be routine collection and reporting of a key set of indicators to track quality and outcomes in Lithuania. Ideally, such indicators would be available at a sub-national level, to enable constructive comparison between regions.

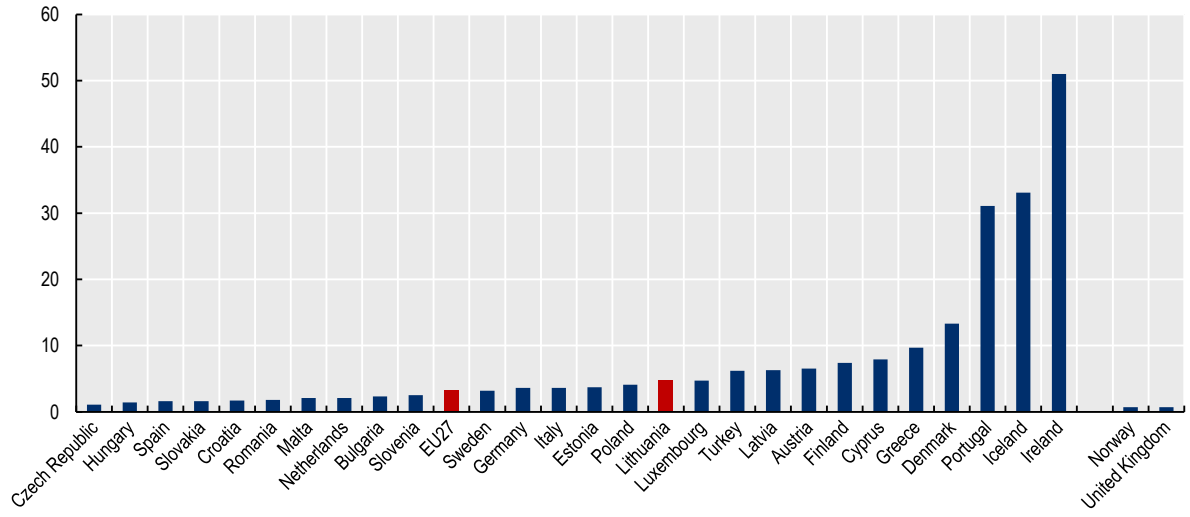
Annex 4.A. Quality and Outcome Measures

Unmet needs

213. In 2014, 4.7% of the Lithuanian population reported unmet needs for mental health services due to financial reasons (Eurostat, 2021[40]). This is lower than Latvia's rate of 6.3%, higher than Norway's rate of 0.7% and higher than the EU27 average of 3.2% (Figure 4.2). When unmet needs due to waiting times or transport are also taken into account, the share of the population reporting unmet needs in Lithuania is significantly higher, reaching 30% in 2016 (OECD, 2021[4]).

Figure 4.2. Unmet mental health care needs are higher in Lithuania than the EU average

Percentage of people who self-reported unmet needs for mental health services due to financial reasons in 2014



Source: (Eurostat, 2021[40])

214. Unmet needs are categorised by age and sex, level of education and level of urbanisation. In Lithuania, around 7% of people with less than lower secondary education reported unmet needs for mental health services due to financial barriers. However, among people with lower secondary education, 0% of men and 10% of women claimed financial barriers hindered their ability to access services. Unmet needs are lower among people with upper secondary education (3.6%), with 5.7% of men and 2.3% of women with upper secondary education reporting unmet need for mental health services. Overall 5.7% of people with tertiary education self-reported unmet need, with 4.6% of women and 7.8% of men with tertiary education reporting unmet need (Eurostat, 2021[40]).

215. The Eurostat dataset on unmet needs by urbanisation classifies geographic areas into cities, towns and suburbs, and rural areas. In Lithuania, 5% of people in cities reported unmet need for financial reasons compared to 6.4% of people in towns and suburbs, and 3.4% of people in rural areas. Within each area, unmet need does not differ greatly by sex, save for in towns and suburbs, where 26.3% of men but no women report unmet need for mental health services due to financial barriers. In cities, 4.1% of men and 6.8% of women report unmet need, while in rural areas, 2.7% of men and 3.9% of women report unmet need for mental health services due to financial barriers (Eurostat, 2021[40]).

216. In addition to unmet needs, data on waiting times for mental health care services can provide another indication of the accessibility of the mental health system. In 2019, the OECD collected data on average waiting times for mental health services as part of its mental health benchmarking exercise, though waiting times for mental health care in Lithuania were not available.

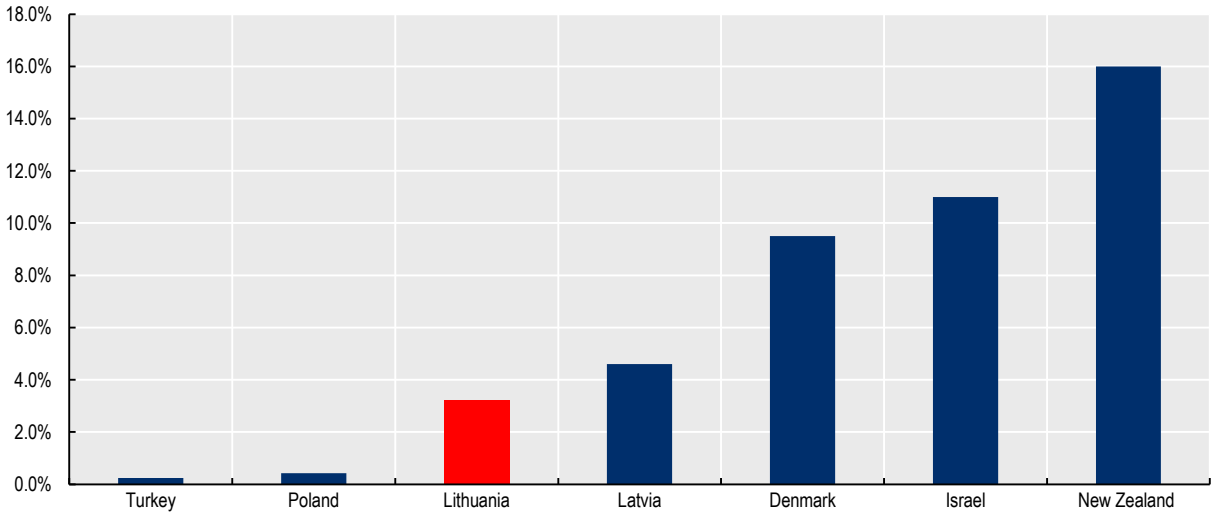
Repeat emergency department admissions

217. Repeat emergency department visits amongst people with a mental health condition can point to supply or demand-side barriers to the take-up of community-based mental health care (OECD, 2021[4]). The rate of repeat emergency department visits can therefore provide a useful indicator of the quality and accessibility of mental health care services.

218. In 2019, few OECD countries were able to provide data on the rate of repeat emergency department admissions. What little data is available suggests significant variation across OECD countries, ranging from almost 0% in Türkiye and Poland to 16% in New Zealand (OECD, 2021[4]). In Lithuania, 3.2% of people who visited the emergency department for mental health reasons returned to an emergency department at least four times in the same year in 2019 (Figure 4.3).

Figure 4.3. In Lithuania, around 3% of people who visited the emergency department were admitted at least four times in a year

Percentage of people who attended the emergency department for mental health reasons, who attended at least four times in a year, 2019 or latest year



Note: 1. Data from 2018
Source: (OECD, 2021[4])

Repeat admissions to inpatient care

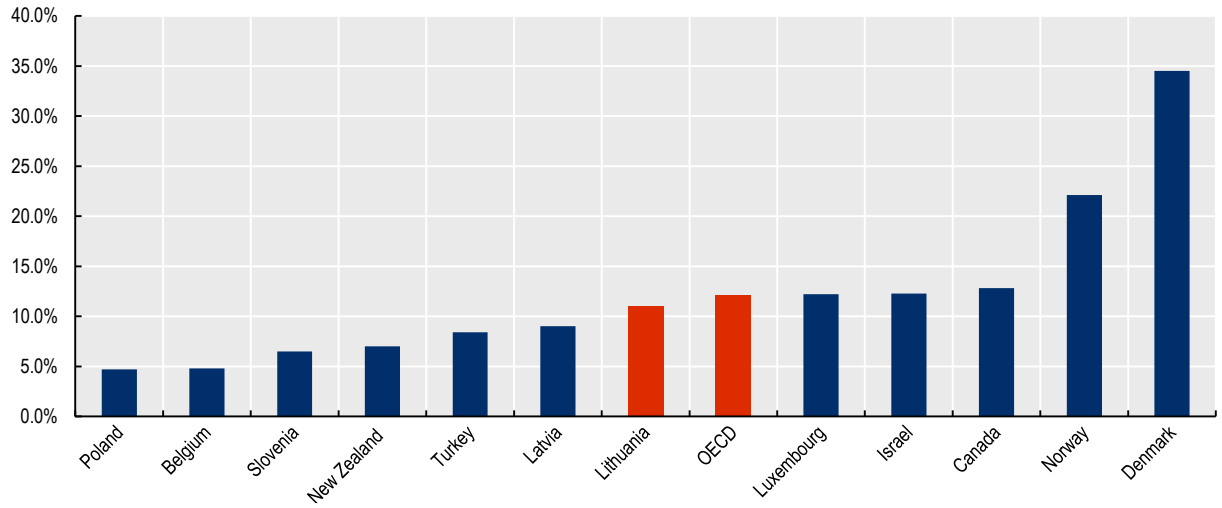
219. Repeat hospital admissions can be pre-arranged as part of a care plan, but in many cases they are indicative of repeated crisis events. Repeat admissions can therefore be symptomatic of poor care coordination, and/or a lack of community-based alternatives to inpatient care. The rate of repeat admissions to inpatient care can therefore provide another useful indicator of care quality (OECD, 2021[4]).

220. The rate of repeat admissions to inpatient care is measured here by the percentage of people admitted to inpatient care at least 3 times in a year. In 2019, few OECD countries were able to provide

data on the rate of repeat admissions. Where countries were able to provide data, the rate of repeat admissions varied widely, ranging from 5% in Poland, to 35% in Denmark. The rate of repeat admissions in Lithuania (11%) is close to the average for those countries able to submit data (12 countries, 12.1%) (Figure 4.4).

Figure 4.4. The rate of repeat admissions to inpatient care in Lithuania is in line with the OECD12 average

Percentage of people admitted to inpatient care at least three times in a year, 2019 or latest year



Note: It is not possible to distinguish between 'planned' and 'unplanned' repeat admissions. Some countries may include transfers across inpatient services as admissions, while other countries exclude transfers. Data from years 2019, 2018, 2016.
Source: (OECD, 2021[4])

221. In addition to the rate of repeat admissions, the rate of re-hospitalisation within 90 days of discharge from inpatient care can also provide a useful indicator of care quality. Re-hospitalisation within a relatively short period of discharge from hospital can point to gaps in the quality of care, or challenges with respect to the continuity of care. In Lithuania, 11% of patients who received inpatient active or long-term care services for mental and behavioural disorders were re-hospitalised within 90 days (OECD questionnaire, 2021).

Involuntary admissions

222. As outlined in Chapter 2, involuntary admissions are a particularly sensitive topic given the limitations on liberty and autonomy that they entail. While they are broadly accepted as a measure of last resort for patients who refuse treatment or pose a danger to themselves or others, it is critical that the use of such practices is appropriately monitored to ensure that they are used only as a measure of last resort, and that patients' rights are upheld (OECD, 2021[4]). High rates of involuntary admissions can also be indicative of services that are not appropriately adapted to the specific needs of service users, or particular groups of service users (OECD, 2021[4]). Rates of involuntary admission can therefore provide a useful insight into the quality of mental health care services.

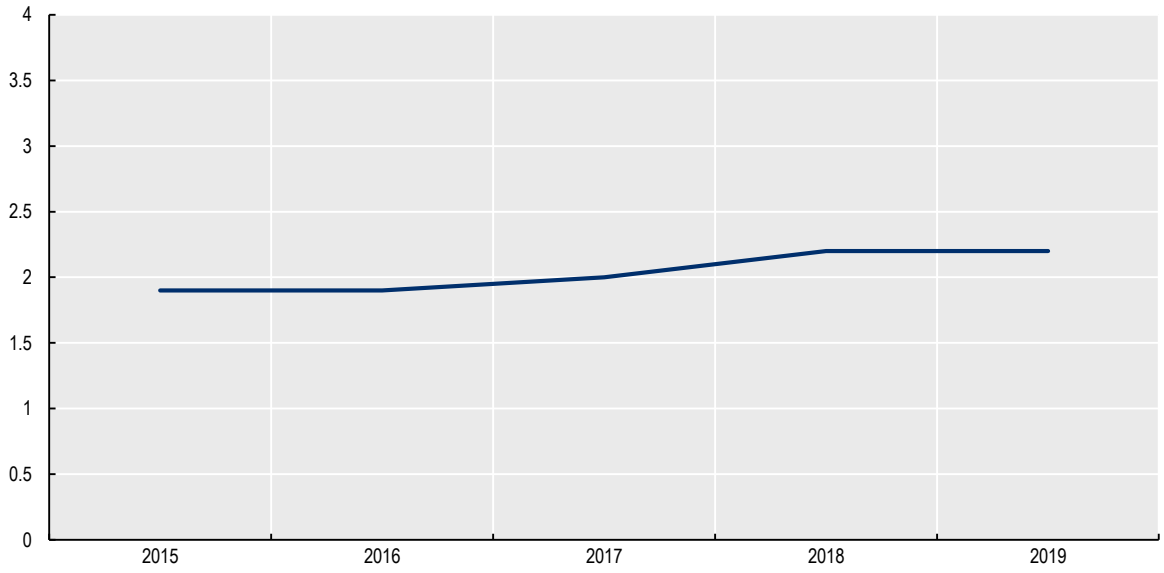
223. However, as outlined in Chapter 2, legislative frameworks for the use of involuntary admissions vary considerably across OECD countries in terms of the criteria of admission, the practitioners involved in decisions surrounding involuntary treatment, practice guidelines, right to appeal, and so on (OECD, 2021[4]). In light of these significant variations, rates of involuntary admission are currently not adept for

international comparisons (OECD, 2021[4]). Given rates of involuntary admission are not yet adept for international comparison, national-level data is reported here.

224. In Lithuania, the rate of involuntary hospitalisations of people with a mental health disorder has increased (Figure 4.5). The percentage of admissions that were involuntary increased from 1.9% in 2015 to 2.2% in 2019, representing a 16% increase in relative terms (OECD Mental Health Performance Benchmarking Data and Policy Questionnaires, 2020).

Figure 4.5. The rate of involuntary hospitalisations for people with a mental health disorder in Lithuania has increased

Percentage of involuntary admissions mandated under national mental health legislation, 2015 - 2019



Note: Data excludes dementia and developmental disorders
Source: OECD Questionnaire, 2019

Follow-up after discharge

225. Many OECD countries have established national mandates or guidelines specifying a maximum time limit within which providers should follow up with patients following their discharge from hospital (OECD, 2021[4]). While evidence is mixed, there are studies which indicate that following up with patients after discharge from hospital in a timely manner can be associated with lower rates of emergency department visits and subsequent re-hospitalisations (OECD, 2021[4]).

226. There is considerable variation across OECD countries as to the mandated or recommended timeframes specified for follow-up, ranging from 7 days in Australia, New Zealand, Sweden and England, to 30 days in Norway (Table 4.1). There is also considerable variation as to the rate of patients who receive a follow-up within the mandated or recommended period following discharge, ranging from 22% in Sweden to 95.8% in England (although the rate for England relates to a limited number of patients on the Care Programme Approach) (Table 4.1). In Lithuania, the percentage of patients who received a follow up within the mandated or recommended period following discharge in 2018 was 56.9%, up from 52.4% in 2015 (OECD, 2021[4]). This relatively low rate of follow-up is in line with challenges raised by Lithuanian mental

health experts with respect to a gap in the continuity of care following discharge from hospitals (Chapter 3) (OECD Interviews, 2021).

Table 4.2. In Lithuania more than half of patients receive a follow-up within 14 days of being discharged from inpatient care

Follow up after discharge from inpatient care within nationally mandated or recommended period, 2018 or latest year

	Percentage of patients who received a follow up within the mandated or recommended period following discharge from inpatient care	Nationally mandated or recommended period following discharge from inpatient care
Australia	75.2%	7 days
Israel	85%	Percentages where outpatient appointment was set (no time limit specified).
Italy	37.4%	Within 14 days
Lithuania	56.9%	14 days
Norway	70%	Within 30 days
New Zealand	66.50%	Within 7 days
Sweden[1]	22%	7 days or 8 days, depending on county
Türkiye	79.2%	Rate reported for within 14 days, but ideal time for follow up is set at 7 days.
United Kingdom (England)	95.80%	Patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge

Note: [1]Data only reported by 1/3 of the Swedish counties
Source: (OECD, 2021[4])

227. While significant difficulties remain in terms of cross-country comparisons, available data suggest that the percentage of children and adolescents who receive a follow up within the mandated or recommended period following discharge from inpatient care is generally lower than that of adults across OECD countries for which data is available, with the exception of Sweden. In 2018, 52.6% of children and adolescents in Lithuania received a follow-up within 14 days, up from 43.1% in 2015 (Table 4.3) (OECD Mental Health Performance Benchmarking Data and Policy Questionnaires, 2020).

Table 4.3. A lower share of children and adolescents receive a follow-up within 14 days of being discharged from inpatient care compared to the adult population

Follow up after discharge from inpatient care within nationally mandated or recommended period, 2018 or latest year

	Percentage of patients who received a follow up within the mandated or recommended period following discharge from inpatient care	Nationally mandated or recommended period following discharge from inpatient care	Age definition
Australia	73.1%	7 days	0-14
Lithuania	52.6%	14 days	0-18
Norway[1]	67%	Within 30 days	0-17
Sweden[2]	43%	7 days or 8 days, depending on county	0-17 (up until 18th birthday
Türkiye	74.4%	Rate reported for within 14 days, but ideal time for follow-up is set at 7 days	

Note: [1]Data refers to 2017; [2]Data only reported by 1/3 of the Swedish counties; [3]Includes public services provided by state/territory governments only. Does not include private office-based psychiatry or general practice. Includes all age groups.
Source: (OECD Mental Health Performance Benchmarking Data and Policy Questionnaires, 2020)

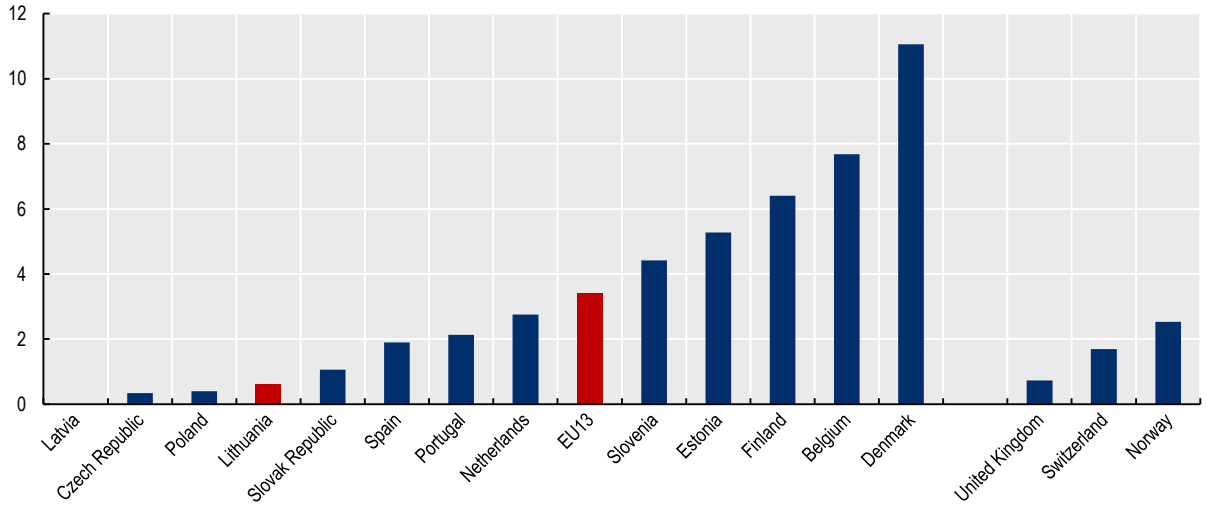
Inpatient suicide

228. Across the OECD, countries have implemented measures to prevent inpatient suicide, such as removing access to potentially lethal means in care settings, safe staffing levels, and risk assessment and surveillance for service users at risk of self-harm. Inpatient suicide can therefore provide some indication of the quality of hospital care (and its safety) for people with mental health disorders (OECD, 2021[4]).

229. The rate of inpatient suicide varies across countries. In most cases, however, the ratio remained below 10 deaths per 10 000 patients between 2015 and 2017 (with the exception of Denmark, which registered 11.1 deaths per 10 000 patients during this period). Lithuania records low levels of inpatient suicide, with an average ratio of 0.6 in the years 2015-2017, considerably lower than the EU13 average over the same period (3.4 per 10 000) (Figure 4.6).

Figure 4.6. Lithuania's inpatient suicide rate is below the EU average

Inpatient suicide amongst patients with a psychiatric disorder per 10 000 patients, 2015-2017 (or nearest years)



Source: Adapted from (OECD, 2021[4])

Suicide following discharge from hospital

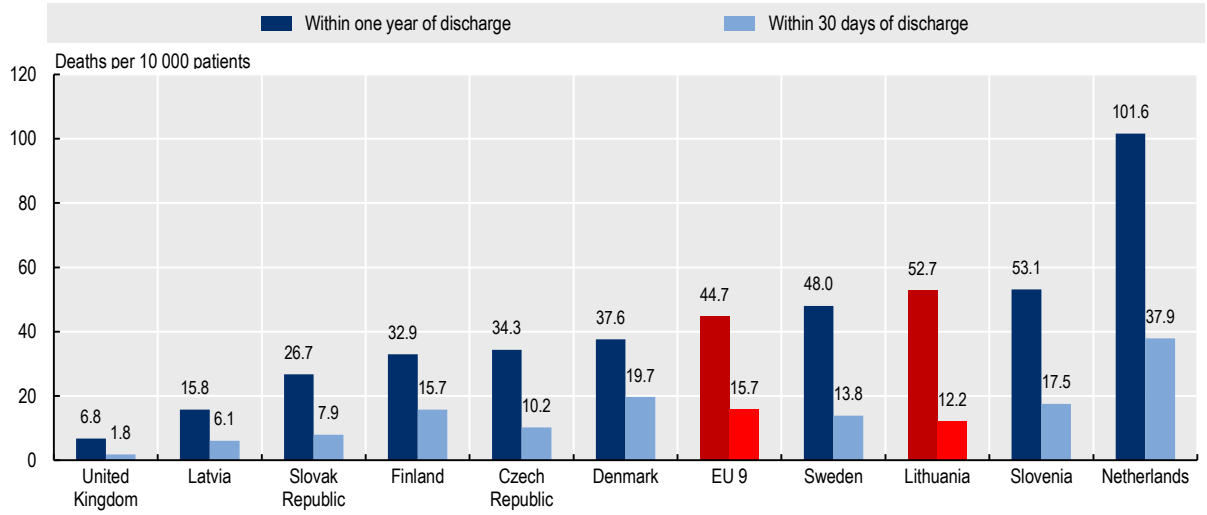
230. The period of time following discharge from hospital is characterised by acute suicide risk, and it is therefore critically important that the transition from hospital to community-based care is managed carefully. That requires not only strong community-based services, but also significant coordination between care providers to ensure the continuity of care. The rate of suicide after discharge can therefore provide some indication of the quality of community-based care and/or the strength of the mechanisms in place to ensure coordination between care providers (OECD, 2021[4]).

231. Lithuania has one of the highest rates of suicide within one year of discharge from hospital amongst the European countries able to submit data (Figure 4.7). In the ten countries able to submit data, on average 45 patients with a psychiatric disorder per 10 000 commit suicide within a year of being discharged from hospital. The rate in Lithuania was significantly above the EU9 average in 2017, at 52.7 patients per 10 000. Slovenia and the Netherlands show higher suicide rates within a year of discharge from hospital (Figure 4.7).

232. As outlined in Chapter 2, Lithuanian mental health experts have highlighted significant challenges with respect to care coordination between inpatient and outpatient mental health care providers. These challenges may go some way to explaining the high rate of death by suicide within one year of discharge in Lithuania.

Figure 4.7. Lithuania has one of the highest rates of post-discharge suicide among European countries which were able to submit data on this measure

Suicide following hospitalisation for a psychiatric disorder, within 30 days and one year of discharge, 2017 or nearest year



Note: [1] Three-year average. Age-sex standardised rate per 10 000 patients. Suicide following hospitalisation for a psychiatric disorder, within 30 days and one year of discharge, 2017 or nearest year.
Source: Adapted from (OECD, 2021[4])

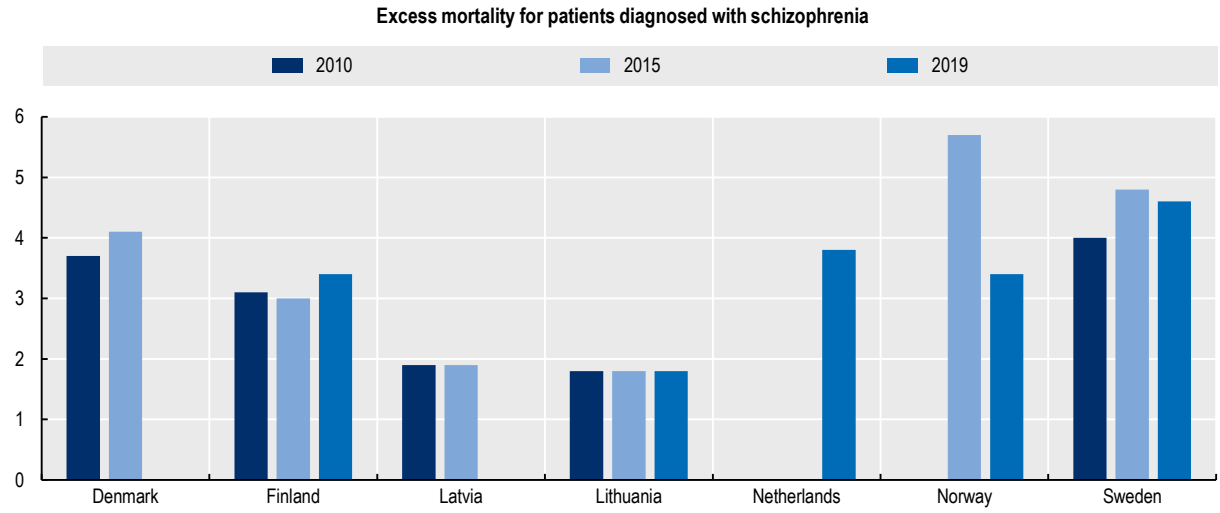
233. The rate of patients who died by suicide within 30 days of discharge from hospital is somewhat lower in Lithuania than the EU9 average. In 2017, 15.7 patients per 10 000 in the European countries for which data was available died by suicide within 30 days of being discharged from hospital, compared to 12.1 per 10 0000 in Lithuania (Figure 4.8).

Excess mortality

234. The OECD Health Care Quality Outcome (HCQO) indicators include two indicators on excess mortality, for people with schizophrenia and bipolar disorder. 'Excess mortality' is the difference in the mortality rate for those with a recorded diagnosed disorder compared to the mortality rate of the general population. If the 'excess' is greater than one, people with mental health disorders face a greater risk of death than the general population (OECD, 2021[4]). Although Lithuania records the lowest rate of excess mortality for people with schizophrenia in EU countries for which data is available (Figure 4.8), persons with schizophrenia nonetheless have a higher mortality rate than the general population. In 2019, the excess mortality rate in Lithuania was 1.8. Recording of 'excess mortality' can also be influenced by the completeness of information on diagnoses; if diagnoses of severe mental illness are underestimated, excess mortality rates are likely to appear lower than they are in reality.

Figure 4.8. Rate of excess mortality for people with schizophrenia

Excess mortality for patients with schizophrenia, 2010, 2015 and 2019

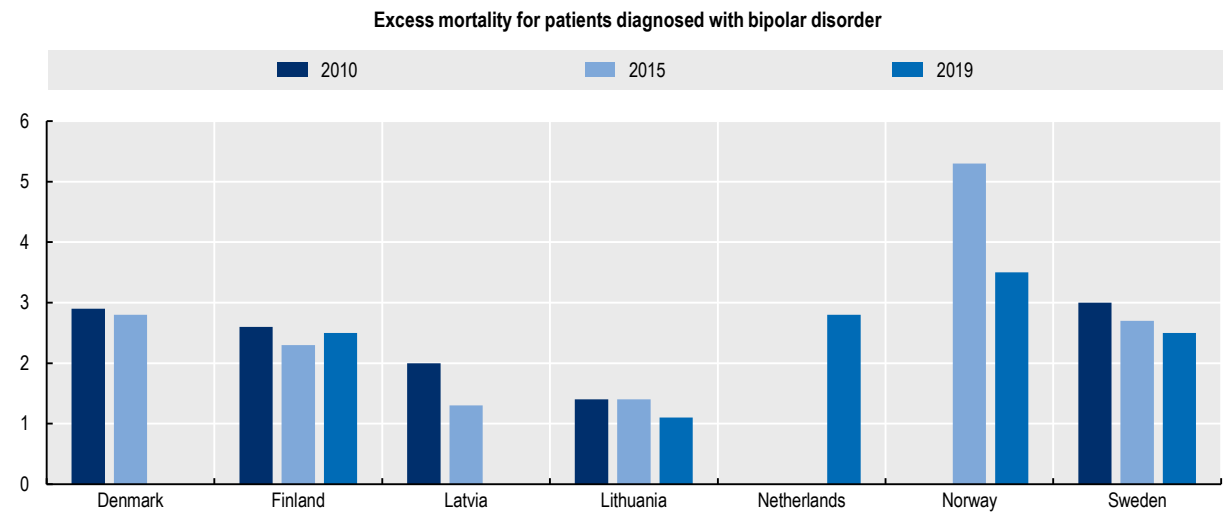


Source: (OECD, 2021[47])

235. Additionally, Lithuania records the lowest rate of excess mortality for people with bipolar disorder in European countries for which data is available (Figure 4.9). In 2019, the rate of excess mortality for people with diagnosed bipolar disorder in Lithuania was 1.1. Again, recording of 'excess mortality' can also be influenced by the completeness of information on diagnoses; if diagnoses of severe mental illness are underestimated, excess mortality rates are likely to appear lower than they are in reality.

Figure 4.9. Rate of excess mortality for people with bipolar disorder

Excess mortality for patients with bipolar disorder, 2010, 2015 and 2019



Source: (OECD, 2021[47])

5 Conclusion

Introduction

236. The Government of Lithuania has made the transition to community-based mental health care a policy priority. Over the last two decades, significant efforts have been made to increase the role of primary care providers in mental health as well as transitioning a substantial part of institutionalised psychiatric and substance abuse services into community-focused systems of care. At present, 116 mental health centres serve as a first point of contact for most people with a mental health condition, mainly consisting of multidisciplinary teams, including psychiatrists, psychologists, mental health nurses, and social workers (OECD, 2018[29]). Alongside the expansion of primary mental health care centres, significant legislative reforms have been enacted over the past decade to ensure the quality, accessibility and continuity of mental health care, and efforts have been made to leverage the payment system for mental health care to improve care quality.

237. Considerable progress has been made. Lithuania's suicide rate has decreased significantly over the past decade, and diagnoses gaps between urban and rural areas have been shrinking. Yet, Lithuania still has the highest suicide rate in the European Union, and increased rates of diagnoses will likely continue to put upward pressure on the mental health care system. Alternatives to medication-based treatment remain largely inaccessible to large parts of the population, and the health care system remains geared toward hospital care. Continued efforts are required for the Government to realise its ambition to deliver high-quality, person-centred care in the community. The preliminary recommendations outlined below aim to build on and expand these efforts.

Areas for Improvement

Stigma

238. Significant stigma around mental illness persists within Lithuania, with these views deeply entrenched and extensively held. This stigma is often associated with practices of the Soviet regime where mental illness and treatment were used as political tools of repression, with stigma of mental illness and psychiatry seemingly embedded in past practices (Doblytė, 2021[27]). Yet formal stigmatisation remains in specific official restrictions against certain professions and activities for people who are registered as having a mental health condition. Informal stigmatisation by the general public also remains for those who utilise mental health services (Puras et al., 2004[36]). Stigma remains a barrier to the take-up of mental health care for many Lithuanians, with some foregoing care on learning of formal stigmatisation measures (Doblytė, 2021[27]). High rates of suicide and comparatively low rates of diagnosis amongst men and people living in rural areas may also indicate a diagnosis and treatment gap which is larger for these groups, potentially driven in part by stigma.

Funding & Resourcing

239. Funding for mental health care is relatively low, and remains geared towards hospital care. Lithuania spends less on mental health care as a proportion of total government health spending than the OECD average, and spending on mental health care as a proportion of total health expenditure has been declining. Inpatient services absorb almost 60% of all mental health funding in the health care sector, and Lithuania still has one of the highest ratios of hospital beds per 1 000 population in the European Union.

240. Workforce shortages and significant geographical imbalances in the distribution of the primary mental health care workforce also constrain the quality and accessibility of mental health care. To strengthen community-based care, it is critical that community-based services are appropriately funded and resourced.

Primary Mental Health Care Centres & Workforce

241. The extensive network of primary mental health care centres across Lithuania is a strength, but cannot be fully utilised until centres are fully equipped with necessary workforce specialities including psychiatrists, mental health nurses, psychologists and social workers. In addition, ensuring adequate provision of these specialists' expertise to ensure accessibility to mental health care services is critical. A 2017 review by the Lithuanian National Audit Office found, for instance, that in 31% of surveyed mental health care centres, experts worked less than five hours per day (National Audit Office, 2017[31]).

242. Recent investment contained within the Government of Lithuania's COVID-19 Action Plan to increase the number of psychologists in primary mental health care centres, in order to reduce the burgeoning patient to psychologist ratios is to be welcomed (Ministry of Health of the Republic of Lithuania, 2020[10]).

Care Pathways

243. High rates of onward referral amongst GPs means that there is a danger of overcrowding at primary mental health care centres by patients with various levels of need and severity. Funding, resource and skills shortages in outpatient settings constrain the type of care that can be delivered in the community. There is a lack of systems capacity for the provision of psychotherapeutic services. Low levels of funding, workforce shortages, as well as overcrowding of some primary mental health care centres mean that individual and group psychotherapy, provided for under legislation, is seldom provided. Consequently, there is a heavy reliance on medication-based treatment (Puras et al., 2004[36]).

244. Funding and resource limitations also constrain the complexity of care that can be delivered in community-based settings: skills and funding shortages can lead to the referral of patients to inpatient care which could potentially be seen in community-based settings if they were adequately funded and resourced relative to demand. High rates of admissions to inpatient care may indicate a reliance on hospital-based care as part of routine care, and signal a need to further strengthen community-based services.

Coordination & Accountability

245. Poor coordination across sectors, institutions and specialists is recognised as a major issue. There are two main pinch points: between GPs and mental health specialists, and between hospital and outpatient care. There is also little coordination between Public Health Bureaus and primary mental health care providers.

246. Research indicates a low level of collaboration between GPs with mental health care teams for the provision of mental health care services, and a lack of coordination with social workers (Jaruseviciene et al., 2014[35]).

247. Coordination between hospital and outpatient care is also insufficient. While legislative measures have been enacted to improve communication across health care settings, low levels of funding constrain their implementation in practice. Incentive structures may also hinder care coordination: while primary mental health care centres are financially incentivised to avoid hospitalisations, hospitals receive funding based on hospitalisations (per bed day, or by diagnosis-related groups). If volume caps are not designed and monitored appropriately, there is therefore a danger that existing incentive structures conflict, and hinder care coordination. Coordination between health care and social care providers is also insufficient, and greater efforts are required to build bridges between health care and social care providers (OECD Interviews, 2021).

Care Quality

Quality and outcomes

248. Based on the limited number of quality and outcomes indicators available in Lithuania, and compared to other countries able to report similar indicators, Lithuania's mental health system performance appears to be middling. Particular attention needs to be paid to coordination of care, and in particular post-discharge care and follow-up. Additionally, heavy reliance on medication-based care, poor patient-provider relationships and insufficient support on discharge from hospital continue to affect service users' perceptions of the quality of their care (OECD Interviews, 2021).

249. Lithuania currently employs a narrow indicator on the quality of mental health care tied to a performance incentive payment in primary care settings. While implementation of the incentive-based measure has been followed by some improvement in the rate of avoidable hospitalisations for those with schizophrenia, consideration should be given to the expansion of quality and outcome improvement mechanisms in Lithuania, particularly in a manner that encourages and facilitates greater user voice. A particularly important – and possibly straightforward – starting point would be routine collection and reporting of a key set of indicators to track quality and outcomes in Lithuania.

Workforce and care-delivery standards

250. The regulations and guidelines surrounding the activities of mental health professionals in Lithuania are currently incomplete (OECD, 2018[29]). A 2017 review by the National Audit Office noted that a lack of national guidance on the scope of psychologists' services had led 35% of surveyed primary mental health care centres to determine their own (limited) number of free psychological consultations (National Audit Office, 2017[31]).

251. Additionally, standardised psychological assessment instruments are currently unavailable, with considerable implications for care quality. A review conducted by the National Audit Office in 2017 found that more than half (58%) of surveyed medical establishments were unable to ensure quality psychological services, with this challenge attributed to a lack of properly adapted assessment methods (National Audit Office, 2017[31]). Standardised psychological assessment instruments which have been properly adapted and tested within the Lithuanian context are critical to ensure care quality, but funding for the adaptation of such instruments has not been available (OECD Interviews, 2021). Ensuring adequate guidance and tools for professionals will be critical to ensuring the provision of high-quality mental health care.

Preliminary Recommendations

Promote good mental health, and reduce stigma

1) Remove/repeal remaining forms of formal stigmatisation as a matter of priority, and ensure efforts to redress informal stigmatisation are continued and monitored.

2) Continue existing efforts and consider new ways to improve mental health literacy across the general population, and across health care providers and front line actors. Improving mental health literacy can be considered a key part of reducing deaths by suicide.

Ensure that mental health resources and system capacity meet population mental health needs

3) Ensure that overall levels of funding are sufficient to meet population needs, and deliver high-quality mental health care.

4) Increase capacity in the system to deliver psychotherapies through a step-wise approach. Consideration could be given to implementing in-person (including in group settings) and online talking therapies delivered by therapists, social workers, psychologists and mental health nurses.

5) Tackle key areas of service provision where there are acute shortages, in particular child and adolescent services and alcohol and substance abuse services.

6) Ensure additional investments are made in both the primary care system and the primary mental health care workforce. Consideration could be given to the introduction of additional measures to build workforce capacity where it is most needed, to improve accessibility outside major cities.

7) Provide additional training for General Practitioners to increase the capacity of the primary care system to recognise, treat and manage common mental health disorders.

Clarify clinical care pathways

8) Clarify the roles and responsibilities of different levels of care providers and develop corresponding treatment guidelines grounded in established best practice in mental health care. Ensure adequate funding and resources to ensure providers are able to deliver on their defined responsibilities.

9) Ensure incentive structures are aligned with care delivery pathways and clinical guidelines. Incentive structures should be designed to ensure robust transitions between inpatient and outpatient mental health care services to improve patient outcomes.

Promote and incentivise high-quality evidence-based care

10) Expand the collection and use of quality and outcome indicators. Without expanding existing data capacity, Lithuania could already make more use of quality and outcome indicators for tracking and setting mental health policy. Consideration should also be given to the introduction of patient experience and outcome measures.

11) Ensure monitoring, oversight and enforcement mechanisms are appropriately designed, funded and resourced to ensure providers meet specified requirements.

12) Ensure adequate guidance is provided for professionals by clarifying professional guidance for psychologists, and ensuring funding for standardised psychological assessment instruments.

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