Mental Health Reforms

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> **MENTAL HEALTH CHALLENGES IN LITHUANIA**

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Contents

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Collective painting during the first open day at Vasaros Psychiatric Hospital, 2004

Editorial

In the fourteenth century, Lithuania was one of the largest countries of Europe, stretching from the Baltic to Ukraine and incorporating Belarus and much of Poland and Russia. For two hundred years it was largely amalgamated with Poland until the 1770's when it was swallowed by its neighbors, mainly the Russian empire. Between the wars, it was a smaller but independent entity until the Soviets and then the Germans and then again the Soviets occupied it from 1940 until March 1990.

By John Bowis and Robert van Voren

Twenty-one years ago, Lithuania was the first Soviet republic to dare to do what virtually nobody ever thought would happen: it reinstated the independence it lost with the first Soviet invasion in 1940 and by doing so, set a process in motion that very much contributed to the disintegration of the Soviet Union the following year. Independence brought an enormous sense of enthusiasm and hope, and the nation set itself the task of reuniting with free and democratic Europe and reforming its outdated Soviet economy and social structures to modern European ones. In the sphere of mental health, this desire to reform was no less strong. An independent Lithuanian Psychiatric Association was formed, a system of mental health centers to be housed in general hospitals was devised, child and adolescent mental health services were overhauled and "Viltis," a parent organization of children with intellectual disabilities, became the largest NGO in the country. It seemed that within a decade or two Lithuania would have shed the dark shades of the totalitarian past.

Teacher and students at Viltis

Global Initiative on Psychiatry was there from the very start. During all these years, our organization invested in mental health reforms in Lithuania, supporting reformers, assisting newly established NGOs, bringing Western expertise and advice, setting up projects with Lithuanian colleagues and step by step helping to transform the mental health landscape. In 2000, we opened a regional office in the Lithuanian capital, Vilnius, which became the region's motor for mental health reform. Projects focused on all the possible areas of mental health: community-based mental health care services, psychogeriatrics, eating disorders, forensic psychiatry and prison mental health, intellectual disability, user and family involvement in mental health – both individual care and treatment decisions and service planning, patient advocacy, mental health economics and developing mental health policy both locally and nationally. The country was an example to others and reformers from many other former Soviet republics as well as from other Eastern and Central European countries came to Lithuania to see what had been accomplished.

In 2004, Lithuania joined the European Union, thereby fulfilling probably its biggest and most improbable dream: it had rejoined Europe within a period of less than fifteen years. However, joining the European Union also meant that reform was no longer seen as a prerequisite to becoming part of the European family and millions of structural funds from the European Union soon found their way into maintaining the old system, rather than investing in innovation. Lithuanians saw their diplomas recognized in Western Europe and, as a result, a mass exodus started which to date has resulted in the emigration of approximately one-fifth of the country's population. Among these have been many doctors and nurses, whose salaries in Lithuania are so low that it is virtually impossible to live off one salary – while much more can be earned working abroad.

The result is a very painful situation, with a country that suffered heavily from the economic recession, a population that has lost many of its brightest and most active citizens to emigration, an increasingly anti-European political climate and a stagnating mental health system, where the process of reform has come to a halt because of a combination of factors: a severe decrease in available funding, a lack of bright young and innovative minds, and a general attitude that further change is no longer necessary.

This edition of Mental Health Reforms is, therefore, an unusual issue. It not only reports on successes, it also very much reports on failures: failures to change the system fundamentally and permanently, a failure to depart fully from the past of a biologically oriented and institutionally based Soviet mental health care system, a failure to continue to take the lead and show other countries in the region how mental health services can be remodeled to the benefit of its users without an abundance of financial means.

We decided, however, that this journal is a very necessary issue,

maybe more than those filled with stories of success and optimism. It functions as a warning that, after twenty years of investment, things can develop in an adverse direction; that investments can fail; that high optimism can eventually come up against reality with sometimes unpleasant consequences. It is also a warning that membership of the European Union in itself is no guarantee that the process of Europeanization will continue. To the contrary: being "in" might be reason enough to stop changing, because it is no longer a condition for being "in."

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GIP Vilnius Celebrates World Mental Health Day 2011

For the third year, GIP/Vilnius joined with the Vilnius City Mental Health Center (Vasaros Clinical Hospital) and the Ministry of Health to celebrate "World Mental Health Day 2011." On October 7 of this year, the event titled "Let's Make Friendship 2011" was held in V. Kudirkos Square in the heart of the city from 12-5 p.m. There were many activities organized in tents and on stage, including a museum of psychiatry. The Mental Health Biblioteca brought many publications on the theme and viewers admired the masterpieces of artists suffering from mental health problems. Young artists created "costumes" of depression, schizophrenia and other mental disorders and one tent allowed visitors to attempt crafts that are used in therapies for patients. Mental health services in other countries were highlighted and medical student volunteer and those working on hot lines for children and youth explained their work. Psychiatrists and psychologists discussed mental health issues and provided consultations. Individuals with intellectual disabilities presented musical performances on stage next to professional musicians and singers.

These events intended to celebrate World Mental Health Day and remind each of us about the essence of good mental health for both individuals and society. In addition, demonstrations of strengths and capabilities of persons with mental disorders facilitated their integration into society – with friendships established among all of us.

Evidence-Based Mental Health Policy in Lithuania

Since an independent Lithuania began democratic reforms in 1990, there have been several attempts to introduce evidence-based mental health policy. The first step was the adoption of the Mental Health Law in 1995. Even though this was an important step, it later appeared to have no significant direct influence on the existing system of psychiatric care.

By Dainius Puras

Another important step was the development of outpatient mental health centers in the level of municipalities, starting in 1995-1997, when the obligatory health insurance system was introduced. At that time, the transformation from the system of outpatient policlinics ("dispensaries") in larger cities into outpatient mental health teams as a part of outpatient general (somatic) policlinics led to some increased funding for outpatient mental health services. This resulted in the addition of a small number of psychologists and social workers to the traditional workforce previously dominated by psychiatrists treating the biomedical component of treatment of psychiatric disorders. In addition, this step had the positive component of de-stigmatization since the location of outpatient psychiatry moved from psychiatric institutions to general medical centers.

However, these changes have not been enough to change the traditional culture of mental health services. Several independent studies, carried out with the help of international foundations (GIP, Open Society Foundation, etc.) from 1998 to 2004, convincingly demonstrated that mental health services continue to be ineffective and that they contribute to the increase of stigma and social exclusion. Although the number of beds in psychiatric hospitals decreased, the number of places in large residential social care homes remained very high. Another problem is a lack of political will to address adequately high rates of suicidal and other self-destructive behavior. Although Lithuania had a highest suicide rate in the world during the last decade of the 20th century and the first decade of the 21st century, no comprehensive suicide prevention strategy with sustainable activities and measurable outcomes was implemented. The only strategic investment during 1995-2005 has been a substantial increase in reimbursements for modern psychotropic medications (antidepressants and antipsychotics) and improvement of the conditions of stay in psychiatric hospitals and residential care homes.

In 2005, a then-new Minister of Health, Zilvinas Padaiga, after the WHO Ministerial Conference on Mental Health in Helsinki, initiated a Task Force for Development of a National Mental Health Strategy. The findings from the aforementioned studies on the poor state of public mental health indicators among the population and ineffective management of mental health services have been used by the Task Force as the analytical part for drawing recommendations for new mental health policy. It was agreed that the main goal was to adopt the policy document, based on modern principles, and not to address the funding issues in that stage. For this reason, Seimas (Lithuanian Parliament) approved the new Mental Health Strategy on April 3, 2007, without any larger debates.

> Lithuania has the highest suicide rate in the world.

The new Lithuanian Mental Health Strategy is very clear about moving to modern principles of mental health care adopted by the WHO in the 2001 World Health Report and by WHO Ministerial Conference in 2005. These principles focus on the following:

- community based services,
- effective programs aimed at mental health promotion and prevention of suicides, violence and other mental health problems,
- deinstitutionalization,
- promotion and protection of human rights in psychiatric institutions, with independent monitoring mechanisms established, and
- mental health policy and services evaluation and research, so that effectiveness of invested resources could be monitored and policy makers could be informed about the situation.

> "No political will has been demonstrated to implement the new Mental Health Policy."

The four years following the adoption of the Mental Health Policy have been marked by vague attempts to implement it. Basically, no political will was demonstrated to implement the main principles of the new policy. To do this, new incentives in funding schemes should be implemented to fill obvious gaps and to reduce existing unbalances in mental health care. However, institutional care, which is overused in Lithuania on the large scale, is likely to be supported again and again as a priority by the Government, even after the adoption of National Mental Health Policy which declares deinstitutionalization as a basic priority. Instead of gradually closing large psychiatric institutions, the Government, in recent years, has allocated substantial amounts of EU Structural Funds to renovate existing residential psychiatric institutions. Also, a huge disproportion of investment in biomedical and psychosocial components within outpatient mental health care remained; thus, municipal mental health centers, officially established as outpatient community-based care teams, have very little to do with modern community-based services. To conclude, out of five obligatory components needed for modern community-based services for severely mentally ill persons, only one component has been and remains adequately funded, and this is reimbursement of psychotropic medications for the patients. The other four components – psychotherapy, psychosocial rehabilitation, vocational rehabilitation and supported housing, are still in their infancy, and there is no intention in the recent plans of policy makers to implement the new mental health policy in a serious way.

Preliminary analysis of the failure to implement the modern principles of public mental health in Lithuania indicates that this has to do with general societal problems in Lithuanian society. There is a high level of intolerance to different vulnerable groups (including mentally ill people) in the general population. Politicians have heard from international organizations about the need to deinstitutionalize mental health services and to liberate mentally ill people and the whole field of psychiatry from outdated stigmatizing institutions, but they never heard about this need from their voters. On the contrary, a large portion of the electorate would like to have less liberal legislation and to isolate people with mental health problems. Other stakeholders, such as professional groups of psychiatrists, the academic sector, and organizations of mental health service users and their relatives tend to lobby for improvement of the existing system and not to basic changes in the culture of services and infrastructure of services. Principles of autonomy and participation of mentally ill people, which have been a driving force in many countries, are not popular and a paternalistic approach still dominates the culture of psychiatric services.

In this situation, it is crucially important to establish a coalition of those organizations and individuals who are willing to facilitate positive changes and to implement the National Mental Health Strategy so that basic principles of modern mental health care can be implemented in Lithuania. This should be the main goal of all organizations working in the field of mental health and committed to humane and evidence–based psychiatry and mental health care for the near future.

> "There is a high level of intolerance to vulnerable groups, including the mentally ill, in the general Lithuanian population."

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Vilnius's Mental Health Plan:
A City that Cares

A working committee to establish a long-term policy for mental health service development in the city of Vilnius was established by Vilnius City Municipality and Global Initiative on Psychiatry in the fall of 2004. The members were Lithuanian and Dutch experts on a wide variety of aspects of mental health care: Maarten Boon, Gintautas Daubaras, Arunas Germanavicius, Christoph Hrachovec, Henriette Kuipers, Dainius Puras, Sigita Radziukynaite, Rasa Laiconiene, Rimanta Rozanskaite, Violeta Toleikiene and Robert van Voren.

By Robert van Voren

Aleksandras Avramenko functioned as secretary of the working committee, Dr. Puras and Dr. Hrachovec were appointed as chairmen. This initiative in Lithuania came after a World Health Organization (WHO) sponsored Ministerial conference where a European Mental Health Declaration and Action Plan for 2005-2010 were endorsed.

The committee concentrated on the whole field of mental health care, for pragmatic reasons excluding forensic psychiatry, addiction disorders, services in jails and police cells and learning disability. However the presented model for strategic developments could also be used as an example for the excluded sections of mental health care. Of course the working committee was convinced about the necessity of collaboration and cooperation with the field mentioned above.

Fulfilling the recommendations of the WHO, the principal criteria of a new servicing model in the field of mental health care include the following:

- service efficiency,
- sustainability,
- orientation towards patient's needs,
- integration into the infrastructure of general city health as well as social and educational services,
- mitigation of negative attitudes concerning mental disorders and raising awareness about research evidence that mental health problems can be effectively tackled if modern approaches are implemented.

The Committee acted on the belief that three overall objectives of any health policy can be equally applied when formulating the objectives of a mental health policy:

1. Improving the health of the population: the policy should clearly set out its objectives for improving the mental health of the population. Ideally, mental health outcome indicators should be used, such as quality of life, mental functioning, disability, morbidity and mortality. In developing countries, however, information systems are generally poorly developed and ministries of health may have to use some process indicators, e.g. access and service utilization.

2. Responding to people's expectations: in mental health this objective can relate to both, respect for persons (human rights, dignity, confidentiality) and client-focused orientation.

> "An explicit mental health policy is an essential and powerful tool for any Ministry of Health."

3. Providing financial protection against the cost of illness and establish a modern system of health care financing.

An explicit mental health policy is an essential and powerful tool for the mental health section in any Ministry of Health. When properly formulated and implemented through plans and programs, a policy can have a significant impact on the mental health of the population concerned. A mental health policy is commonly established within a complex body

of health, welfare and general social policies. The mental health field is affected by many policies, standards and ideologies that are not necessarily directly related to mental health. In order to maximize the positive effects when mental health policy is formulated, it is necessary to consider the social and physical environment in which people live.

The components of mental health services as recommended by the Committee are listed below:

Mental health services integrated into the general health system

- Mental health services in primary care include treatment services and preventive and promotional activities delivered by primary care professionals. Among them, for example, are services provided by general practitioners, nurses and other health staff based in primary care clinics. Primary care services are easily accessible and are generally better accepted than other forms of service delivery by persons with mental health disorders. This is mainly attributable to the reduced stigma associated with seeking help from such services. Training is needed for general practitioners to improve their mental health knowledge.

> "Training is needed for general practitioners to improve their mental health knowledge."

- Mental health services in general hospitals include certain services offered in district general hospitals and academic or central hospitals that form part of the general health system. Such services include psychiatric inpatient wards, psychiatric beds in general wards and emergency departments, and outpatient clinics. There may also be some specialist services, e.g. for children, adolescents and the elderly. These services are provided by specialist mental health professionals such as psychiatrists, psychiatric nurses, social workers, psychologists, and physicians who have received special training in psychiatry. The function of liaison psychiatry should be organized and financed in order to strengthen the collaboration between somatic and psychiatric care.

Community mental health services

Formal community mental health services include community-based rehabilitation services, hospital diversion programs, mobile crisis teams, therapeutic and residential supervised services, home help and support services and services for special populations such as trauma victims, children, adolescents and the elderly. Community mental health services are not based in hospital settings, but need close working links with general hospitals and mental hospitals. They work best if closely linked with primary care services and informal care providers working in the community.

Well-resourced and well-funded community mental health services provide an opportunity for many persons with severe mental disorders to continue living in the community and thus promote community integration. High levels of satisfaction with community mental health services are associated with their accessibility, a reduced level of stigma, and a reduced likelihood of violations of human rights. However, they are sometimes associated with resistance from the communities in which they are placed, and this too needs attention. Private initiatives, already existing in Vilnius, should be formalized. This means that equal possibilities for being financed and accessibility for the public should be established.

Informal community mental health services may be provided by local community members other than general health professionals or dedicated mental health professionals and paraprofessionals. Informal providers are unlikely to form the core of mental health service provision and countries would be ill-advised to depend solely on their services, which, however, can be a useful addition to formal mental health services.

Specialized mental health services

Specialist institutional mental health services are provided by certain outpatient clinics and by certain public or private hospital-based facilities that offer various services in inpatient wards. Among the services are those provided by acute and high security units, units for children and elderly people, and forensic psychiatric units. They meet very specific needs that require institutional settings and a large complement of specialist staff, who have received proper training. Specialist services are usually tertiary referral centers, and, in general, patients who are difficult to treat make up a large proportion of their case-loads.

Dedicated mental hospitals mainly provide long-stay custodial services. In many parts of the world, they are either the only mental health services or remain a substantial component of such services. In many countries, they consume most of the available human and financial resources for mental health. In modern mental health care they play a much smaller, but nevertheless important role in the consecutive chain of mental health services.

Strengthening the role of service users and the non-governmental sector

Patient and family councils can play an important role in reorganizing mental health care from within. We always should realize that patients not only are the real objects of our services, but also are the individual subjects with experiences that can lead to a better understanding of the impact of diseases and treatment.

Nevertheless we know that it can be quite hard to start a functioning system of patient councils and participation. Therefore we advise to search close relations and affiliation with already existing groups in Europe. Non-governmental organizations such as GIP can be of great value in the development of these contacts.

Protection of human rights

Vilnius City Municipality should establish an independent patient advocacy program for clinical settings, daycare, mental health care centers and all other officially acknowledged mental health care providers. This program should be totally independent from the targeted facilities and financed through the municipality and the state. It should offer legal support for individual patients and should monitor the development of the protection of human rights for psychiatric patients. User organizations and non-governmental organizations must be invited to co-operate in this process.

Information and prevention

Information concerning psychiatric diseases and mental health care problems is an important vehicle for destigmatizing and improving the health care services and the mental condition of the population. Social welfare and health care should co-operate in this subject. Basically information should be provided orally and via leaflets. Because of the special problems of Vilnius, one should start with an overall easily accessible view about the possibilities of getting care and treatment. Special attention has to be paid to children and adolescents and to special risk groups. The problem of the huge suicide rates in Lithuania asks for a profound investigation and reconsideration.

Funding

The problems of financing health care, insurances and funding the system during a period of change and reorganization was considered to be beyond the reach and expertise of the working committee. Therefore, it requires the establishment of a taskforce to prepare and present proposals for alternative funding mechanisms for long-term investments in the mental health care sector. Special attention should be paid to issues such as substitution, capital investments and the possibility of long-term financing arrangements.

Service evaluation and scientific assessment

When a country wants to change mental health care facilities, it first should make the right decisions, then implement and next evaluate the course of action. Therefore, it is very important to monitor the developments by a system of service evaluation and scientific assessment. The Center of Social Psychiatry at Vilnius University can play an important role.

> "Patient experiences can lead to a better understanding of the impact of diseases and treatment."

Follow-up

The mental health plan was adopted by Vilnius municipality, among others, thanks to strong support by the then Vilnius mayor, Arturas Zuokas. Unfortunately, due to a combination of factors including his departure as mayor and the financial crisis of 2008, which severely affected Vilnius municipality, the majority of the proposed improvements were scrapped and some of the existing services were curtailed. Still, the mental health plan is used as a reference tool during discussions and negotiations and in that sense the work done is not in vain. When better times come, we hope it will provide the necessary guidelines for the future development of mental health care services in Vilnius.

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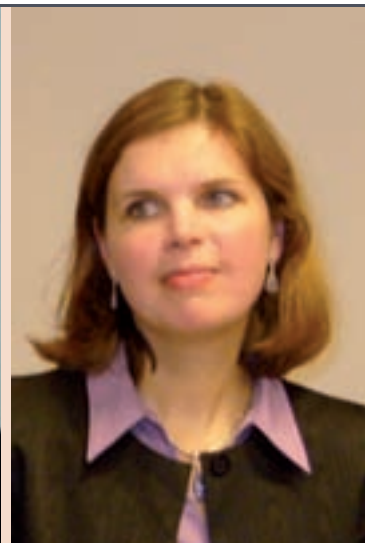
Institutions of Residential Care in Lithuania: Inglorious Past, Vague Perspectives

In the past, big residential care institutions were built with the very best intentions and the belief that individuals with special needs are most efficiently served when they are concentrated in one location. Residential care institutions became part of modern society and integral to the care system and social policy, both based on society's understanding about people with mental disabilities and their needs.



By Eglė Šumskienė and Dovilė Juodkaitė

During this period of time, institutions were broadened, reconstructed, and new ones were built with increased numbers of residents and a variety of services and employees. These changes significantly improved the quality of care; however, they preserved the institutional atmosphere, hierarchical relations between staff and residents, numerous human rights violations and closure to society. These characteristics caused residential care institutions to be placed in the same category as other institutions of disciplinary society: prisons, hospitals, lagers. According to Foucault 1995,[1] the abovementioned institutions are powerful tools of control whose aim is to discipline human behavior. Two Lithuanian authors, Ruskus and Mazeikis 2007,[2] called their isolating function "social capsulization."

During the last decades of the 20th century, residential care was seriously criticized and regarded as a last resort when all other services were proven to be ineffective. It is agreed that care must be individualized and tailored to the needs of a person in care, whereas standardized, universal and "wholesale" provision of services is not efficient and effective. Paradoxically, it is a difficult process to develop community care in Post-Soviet countries even though it better meets the needs of persons in care and is more cost-effective and useful to individuals and the whole society. Various authors identify three main groups of reasons influencing persistence of residential care system:

- structural reasons – general system of social security, ineffective financing, lack of political will;
- external reasons – Western support of residential care institutions in Post-Soviet countries; and
- negative attitudes in society towards residents of social care homes, in particular, and mentally disabled persons in general.

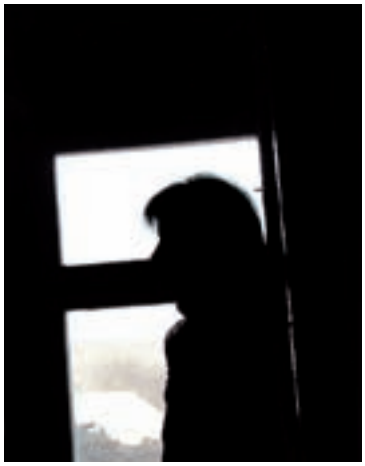
Let's have a closer look at Lithuania and its system of social care for the mentally disabled after twenty years of independence, democracy and commitment to respect human rights. Since the beginning of Lithuanian independence, the in-patient social care institutions inherited from the former Soviet Union prevailed. Great numbers of people with mental disabilities live in these large residential institutions (social care institutions, psychiatric hospitals) which went against the goals of de-institutionalization and modern social care standards, based on the principle of autonomy, consciousness raising, empowerment and emancipation, as well as the right to the least restrictive surrounding.

Prior to entering the European Union, a total of 6,095 people with mental disabilities, or approximately 27.5 per cent of the 22,121 people who declared themselves as having mental disabilities, were living in social care institutions[3]

[1] *Foucault, M. (1995). Discipline and Punish: The Birth of the Prison (A. Sheridan, Trans.). New York: Vintage.*

[2] *J.Ruškus, G.Mažeikis. Neigalumas ir socialinis dalyvavimas. Kritine patirties ir galimybiu Lietuvoje refleksija, Šiauliu universitetas, 2007.*

[3] *According to the 2001 Census.*



The photographs in this article were taken by boys released from Orhei Institution for People with Mental Disabilities

in Lithuania. This group included 5,217 adults in adult facilities and 878 children living in social care institutions for children and young people with mental disabilities. By January 1, 2005, there were 5349 persons (2882 male and 2467 female) and 659 children (373 boys and 286 girls)[4] in state social care homes. For every 10,000 population, there were 15.3 placed in social care homes.[5]

Data by the Department of Statistics of the Government of the Republic of Lithuania disclose further changes in numbers of social care homes as well as numbers of residents. In 2005 and 2006, there were 27 care homes for adults with mental disabilities (including intellectual disabilities), with approximately 5,429 and 5,425 residents respectively. In 2007, there were 30 social care homes with 5,400 residents; in 2008 and 2009, there were 26 social care homes with approximately 5,302 and 5,279 beds respectively. It is notable that there was only a small decrease in numbers in 2009 as compared to 2008. In 2009, there were 708 applications received for residential services in the care homes for adults with mental disabilities, this being 193 applications less than in 2008. Approximately ¾ of those were accommodated in the social care homes, and only 1 in 10 of those received care and support at home or in day centers.

To conclude, this data show only a very minimal decrease and change in numbers of persons with mental disabilities being referred to and receiving services in the long-term in-patient social care institutions during the last 10 years in Lithuania. International practices and trends related to deinstitutionalization provide the arguments that community care is more cost effective than institutional treatment,[6] as well as providing better outcomes, such as quality of life and respect for human rights. Nevertheless, there is still a huge disproportion with regards to funding allocated to the traditional institutional system as opposed to modern community care.

Authors of the report *Wasted Time, Wasted Money, Wasted Lives ... A Wasted Opportunity?* [7] ask why some countries continue to use this funding to perpetuate the long-term institutionalization of people with disabilities, an investment that clearly does not improve their lives although the European Union has allocated the Structural Funds to improve the lives of Europeans? Several Post-Soviet countries, even those poorer than Lithuania, are taking serious steps towards deinstitutionalization. For example, in the beginning of 2011, Moldova announced that in the next 3 years, 136 more persons will move from the Orhei Institution for Persons with Mental Disabilities (Moldova) to the community, thereby benefitting from community services. In addition, new services will be developed such as: 3 Community Homes, 9 Supported Living places, 9 Mobile Teams, 26 Foster Care services, 30 "Respite" services for families providing care for persons with disabilities, 30 Specialized Social services, 48 Educational Support services, and 25 services of Personal Assistance. Furthermore, 90 families will benefit from material support for personal space for children/young people in the process of reintegration into the biological or extended family.[8]

Bulgaria is starting to implement an EC-funded pilot project aimed at developing alternative services for children with disabilities. Establishment of the abovementioned Family Type Placement Centres is an important step considering Bulgaria's long-term political commitment to close large institutions. Another important development towards deinstitutionalization was Bulgaria's political decision to direct the entire European funding (20 million Euro) towards improvement of community services to children and families. The Bulgarian government officially declared that none of the European money will be invested in institutional settings.

Unfortunately, Lithuanian social policy is far from being similarly progressive. In 2009-2010, millions of euros of the EU Operational Program for Promotion of Cohesion were directed to reconstruc-

[4] Even after entering the EU on May, 2004, this number slightly increased, since on 1 July 2004, there were 5344 persons (2865 male and 2479 female) living in social care intitutions for adults with mental disabilities. Data received from Department of Audit and supervision of social establishments, accessed at website http://www.sipad.lt/main/index.php?act=menu&id=57.

[5] This number increased, since data for 1st of January 2004 showed that for 10 000 population there were 14,6 places in social care homes.

[6] David McDaid, GrahamThornicroft. Mental Health II. Balancing Institutional and community-based care. Policy Brief. WHO 2005, page 1.

[7] European Coalition for Community Living, March 2010. Wasted Time, Wasted Money, Wasted Lives ... A Wasted Opportunity? – A Focus Report on how the current use of Structural Funds perpetuates the social exclusion of disabled people in Central and Eastern Europe by failing to support the transition from institutional care to community-based services

[8] http://www.somato.md/index.php?option=com_content&task=view&id=118&Itemid=1&lang=en

tion of residential care institutions although human rights and mental health NGOs reported on severe violations happening in these settings. These organizations initiated public discussion on the future of residential care and promoted the advantages of community care. Such political actions influence public opinion, which currently supports the existing system and the stigmatizing attitude towards mentally disabled people. One-third of Lithuanians believe that the human rights of the disabled received insufficient attention in 2004[9] and that the disabled were thought to be the second most discriminated social group.[10] The situation of the mentally disabled has been notably problematic. Opinion polls have shown that every other Lithuanian would prefer to isolate individuals suffering mental disabilities in institutions caring for mental patients on a regular basis. Sadly, only 30.8% of respondents answered that the above mentioned disabled persons should live in the community, at home, together with people without disabilities, guaranteeing them appropriate social services, thus integrating them into the society and eliminating stigmatizing factors. It has been widely believed that mentally disabled people are dangerous for others and that restrictions on their rights can be justified.[11]

Regrettably, the attitudinal and discriminatory approaches towards people with mental disabilities have not changed at all since 2004, when Lithuania entered the European Union. According to the results of Eurobarometer [2010], there is huge stigma attached to mental health problems in Lithuania. More respondents from Lithuania than any other country felt they would find it difficult talking to someone with a mental health problem (52%).[12] Societal opinion polls in the year 2010 also reveal negative attitudes towards people with intellectual disabilities and mental health problems with this group of people considered to be the second most discriminated group in Lithuania.[13]

In the beginning of the 21st century, Lithuania tried to position itself as an advanced leader of the post-Soviet region successfully implementing integration of disabled persons to the society and developing community care, thus aiming towards deinstitutionalization. The current situation of care for mentally disabled persons in Lithuania can be summarized by adapting Walker's 1997 statement:[14] with the spread of community care and integration of disabled persons into society, we started to believe that mental health reform is moving forward and that Lithuania is a brave and progressive country. But it is enough to take a short look at any of the existing 26 care homes for people with mental disabilities: nicely reconstructed buildings and frightful looks of residents will rather remind you that it is Potemkin's village.

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[9] The Situation of Human Rights in Lithuania and Evaluation of Human Rights Protection System., representative public opinion survey (N = 1,000), conducted by Vilmorus Market Research within the framework of the National Human Rights Action Plan.

[10] How Does the Community Rate the Situation of Human Rights in Lithuania?. Public opinion survey, Human Rights Monitoring Institute, 2004.

[11] Human right in Lithuania. Overview 2004. Human rights Monitoring Institute, Vilnius, 2005.

[12] An average of 22% of EU27 citizens surveyed saying they would find it difficult to speak to a person with a "significant mental disorder". Special Eurobarometer 345 / Wave 73.2 – TNS Opinion & Social, Mental health. Available at http://ec.europa.eu/health/mental_health/docs/ebs_345_en.pdf (last accessed 24.11.2010)

[13] I.Saukiene „The most discriminated are retired people, and the most unfair – courts, Seimas", available at http://www.delfi.lt/news/daily/lithuania/labiausiai-diskriminuojami-pensininkaineteisingiausi-antstoliai-teismas-seimas.d?id=39551833 (last accessed 07.01.2011)

[14] Politicians, from the outset sensitive to the unpopularity of the image of 'water towers and chimney stacks' associated with asylums and institutional care, used the term 'community care' so frequently in the period 1948 1979 that in the public imagination it was thought of as having already been achieved. Walker, A. (1997) 'Community Care: Past, Present and Future', in S. Iliffe and J. Munro (eds) Healthy Choices, Future Options for the NHS. London: Lawrence and Wishart.

The Lessons from Reforming a System of Child and Adolescent Mental Health in Lithuania

I received an email recently asking me to write an article for Mental Health Reforms about Child and Adolescent Mental Health (CAMH) in Lithuania. My colleague also mentioned that the deadline for this job was in one week. That reminded me of the time when I had the pleasure of being a part of the GIP team and I agreed to support GIP again. This article is not a deep and comprehensive analysis of the situation in Lithuanian child and adolescent mental health, but it contains my reflections and thoughts based on experience working in different countries.

By Vytautas Blazys

After regaining independence in 1990, Lithuania inherited the Soviet style psychiatric system and Child and Adolescent Mental Health was a "Two-fold Cinderella" there; psychiatry, as such, was not a priority in Soviet medicine and Child and Adolescent Psychiatry was not a priority in Soviet Psychiatry as a whole. There was no place for Cinderella among her sisters. Pediatricians, Child Cardiologists, Child Pulmonologists and other "ologists" had their clinics in Policlinics (Out–Patient Departments) easily reachable for families; but, as you could guess, Child and Adolescent Mental Health specialists did not have their offices in polyclinics: they were exiled to Psycho-neurological Dispensaries usually located near big psychiatric hospitals. They were based there, because there were no small psychiatric hospitals at all. Nobody wanted to visit these places because everything related to mental health was greatly stigmatized in Soviet society.

After March 1990, some enthusiastic mental health specialists decided to reshape the mental health system in Lithuania. One of the main ideas was to develop Community-Based Mental Health Services instead of treatment in hospitals, and finally Mental Health Centers were established in every administrative region of Lithuania. The same center usually provides services for both adults and children. Mental Health Centers have been functioning for around 15 years now and we could learn some lessons from the development of these Centers.

Lesson No. 1

Usually Community-Based Mental Health Services are at the secondary level and tertiary level of the health systems in other countries, but, in Lithuania, the Centers were created as primary level services. This means that patients and families do not need a referral from their General Practitioner (GP), pediatrician, etc. to access Child Mental Health Specialists. The main idea of this arrangement was to make access to the Services easier for users. At first, we considered this to be a very progressive step, but later on we saw that it did not work very well. Firstly, there was no gate keeper to the services; for this reason, there was quite a long waiting list for some services. This system also created a temptation for clinicians to work for a long time with less complex patients and not provide sufficient support for the most complex patients. Secondly, GPs, pediatricians, etc. were removed from providing support for young people with mental health problems and this had and still has very serious consequences. In general, it is possible to say now that it was a mistake to put CAMHS into the primary level, but it is difficult to move this service to another, for various bureaucratic reasons.

> "The training and role of mental health nurses is key to good child and adolescent mental health services."

Lesson No. 2

Child and Adolescent Mental Health Services were developed in every administrative region of Lithuania, following a tradition that every region should have its own specialists in different areas to provide easier access to the service for families. But the consequences of this design were detrimental to Lith-

uanian CAMHS. Outpatient mental health services are financed by "per capita" rule in Lithuania, as in many other countries; however, this didn't work well for children and adolescents because that population of the catchment area is so small that it is not possible to have a multidisciplinary team for young people since the money coming to the service by the "per capita" rule is not sufficient. In many rural areas of Lithuania, the CAMHS consists only of 0.5 WTE of child and adolescent psychiatrists for this reason. Understandably, this "service" cannot deliver appropriate support for young people.

> "Most professionals are excellent clinicians but they work in an inefficient system."

A small CAMHS with no resources has a negative impact on in-patient child and adolescent departments. Mental health centers are not able to provide proper services for their patients and they are referred for in-patient treatment far from their homes and families - not because they need in-patient treatment, but because there are no out-patient resources in the community. This is not only a clinical or ethical issue, but a serious financial problem also. The in-patient treatment in child and adolescent psychiatry is very expensive and that means that if you do not have an adequate and relatively cheap out-patient treatment option, you must pay much more for in-patient treatment. For those trying to develop CAMHS in their countries, it very important to avoid these mistakes.

Communication with colleagues from outside CAMHS (Social Services, Child Protection agencies, schools, etc.) is an essential part of CAMHS work, but it takes time. Do clinicians have time for this? No, they do not. Why? Simply because senior managers or clerks from the Ministry of Health do not know the specifics of CAMHS work. Thus, it is very important to educate them if one wants to try to develop services for young people in your countries.

As there is a lack of collaboration between mental health and other agencies - social services, schools, etc. - other professionals do not know what CAMHS can or cannot do. This could lead to black and white thinking. Colleagues from these agencies could think that if a child has mental health problems, the CAMHS can do everything and there is no need for their additional involvement. In fact, children and young people with mental health problems need more support than other children. Here is another lesson (**Lesson No. 3**) from the Lithuanian experience – do not blame your colleagues from child protection services and education, but educate them and collaborate with them.

Another issue related to the child and adolescent mental health system in Lithuania is a "psychiatrization" of it. Usually even non-medical treatments - different psychological therapies are delivered only by psychiatrists. But trained nursing staff and/or social workers could deliver many of the evidence based therapies - Cognitive Behavior Therapy, Family Therapy, etc. This could allow for easier access for families to nonmedical ("talking") therapies and it could help save money as well.

Lesson No. 4

So, if you want to have an effective CAMHS, revise the role and training of mental health nurses in your country.

A big surprise for reformers was that not all people in Child and Adolescent Mental Health Services wanted to see changes in the system and this was a significant obstacle. Some professionals felt that they were doing a good job and they did not think they needed to change anything. And they were right to some extent – they were excellent clinicians, but they were placed in an inefficient system.

Lesson No. 5

It is very important not to criticize your colleagues but, rather, criticize the system and try to explain your goals to the colleagues who are doubtful about the reforms.

Almost 20 years have passed since we started reforms in Mental Health in Lithuania. Enthusiastic reformers thought that it would take around five years to achieve the main changes and in 10 years' time, the reform would be fully completed and we would have a new system of Mental Health. Yes, many things have changed dramatically since 1990, but there has been only slight progress in some areas; and there is still a lot to do to improve the system of child and adolescent mental health in Lithuania. And this is another important lesson from our experience – (**Lesson No. 6**) to change the system usually takes more time and resources than expected and you need to have commitment and patience to achieve your goals.

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Interpretation and Implementation of the International Human Rights Standards in Lithuania

Robertas Povilaitis (l) and Dovile Juodkaite (r) at the 10th anniversary of GIP-Vilnius

By Dovilė Juodkaitė

Starting with the adoption of the Universal Declaration of Human Rights in 1948, the United Nations set a strong human rights treaty system which clearly established the legitimacy of international interest in the protection of human rights. With respect to human rights, the sovereignty of the separate states is limited and international supervision is valid for the states that become accountable to international authorities for domestic acts affecting human rights. At the moment, the UN human rights treaty system encompasses nine major treaties.[1]

Every UN member state is a party to one or more of the nine major human rights treaties, thus the universal human rights legal system applies to virtually every child, woman, or man in the world.

Since 1991, when Lithuania regained its independence, there were a lot of changes and democratic reforms carried out in the society. New and amended legislation was adopted that established the basis for a democratic state, as well as guarantees and protection for its citizens. Lithuania became an active member of the United Nations and European Union, and, thus, pursued the main purposes and principles of both of these international organizations - including encouraging respect for human rights and fundamental freedoms for all.

Lithuania has ratified most major international human rights instruments, including those with provisions relating specifically to the rights of people with disabilities.[2] It acceded to the International Covenant on Economic, Social

[1] the Convention on the Elimination of all forms of Racial Discrimination (in force 4 January 1969); the International Covenant on Civil and Political Rights (CCPR) (in force 23 March 1976); the International Covenant on Economic, Social and Cultural Rights (in force 23 March 1976); the Convention on the Elimination of all forms of Discrimination Against Women (in force 3 September 1981); the Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment (in force 26 June 1987); the Convention on the Rights of the Child (in force 2 September 1990); the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (in force 1 July 2003); Convention on the Rights of Persons with Disabilities (in force 3 May 2008); the International Convention for the Protection of all Persons from Enforced Disappearance (in force 23 December 2010).

[2] EUMAP report "Rights of People with Intellectual Disabilities. Access to Education and Employment. Lithuania", Vilnius, 2005.

and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR), both protecting all people against discrimination. Lithuania ratified the Convention on the Rights of the Child, which specifically talks about mentally or physically disabled children and their rights. It has ratified the European Convention on Human Rights (ECHR), as well as the revised European Social Charter, thus becoming bound by its Article 15 on the rights of persons with disabilities. It has also ratified both the UN Convention against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT), as well as the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. In 2010, Lithuania also ratified the UN Convention on the rights of persons with disabilities and its Optional Protocol (CRPD),[3] thus bearing all legal obligations under this Convention.

> "International human rights organizations have, more than once, recommended that Lithuania establish an an independent human rights monitoring mechanism."

Nevertheless, there still remain important international treaties not yet ratified by Lithuania. Although under the obligation with regards to prohibiting any kind of inhuman and degrading treatment or punishment under the UNCAT, Lithuania has not yet acceded to its Optional Protocol of 2002 (OPCAT).[4] This means that Lithuania is not bound by the obligations laid down in OPCAT for creation of independent national mechanisms for the prevention of torture in places where people are deprived of their liberty at the domestic level. OPCAT, for the first time on an international level, established requirements, criteria and standards for the effective national preventative human rights monitoring. Such a mechanism is an innovative element of human rights systems, since currently human rights mechanisms and institutions are more of a reactive nature. OPCAT also very clearly indicates that human rights protection is primarily a national responsibility of states, which should be implemented by the establishment of independent national protection systems.

International organizations responsible for human rights and protection against torture, inhuman and degrading treatment or punishment have more than once recommended that Lithuania establish an independent human rights monitoring mechanism.[5] Nevertheless, Lithuania has not taken these recommendations into account. Successful implementation of the human rights treaty standards depends very much on their accessibility to the victims of human rights abuse. This means both familiarity with the standards and access to remedial mechanisms. According to society's opinion polls, there is still a lack of understanding and awareness about human rights and protection possibilities throughout Lithuania. Society's opinion poll performed in 2010 revealed that 54 percent of respondents have information about their rights. Nevertheless, 48.5 percent of respondents indicated that they didn't know what actions to take if their rights were violated.[6] It is logical that people with disabilities have even less knowledge and awareness about these issues than the general public. Thus, it can be concluded that the human rights situation and national legislation of Lithuania, especially with regards to persons with disabilities, does not totally correspond to international human rights standards. This insufficient compliance is due to the ongoing inappropriate practices of guardianship, involuntary hospitalization and treatment, and legal representation of persons with mental disabilities, etc.

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[3] Law on ratification of UN Convention the Rights of Persons with Disabilities and its Optional Protocol // State news, 2010, No. 67-3350.

[4] Optional Protocol to the Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment of 2002, that entered into force in 2006, after first twenty states' ratifications.

[5] CPT reports to the Lithuanian Government on the visits to Lithuania carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 17 to 24 February 2004 and from 21 to 30 April 2008. Available at: http://www.cpt.coe.int/documents/ltu

[6] Saukiene "The most discriminated are persons of retirement age, the most unfair – court, Seimas," available at: http://www.delfi.lt/news/daily/lithuania/labiausiai-diskriminuojami-pensininkai-neteisingiausi-antstoliai-teismas-seimas.d?id=39551833 (last accessed 04.01.2011).

Lithuanian Psychiatric Association – 1990 Goals vs. the Current Situation

By Dainius Puras

Lithuania experienced amazing times in 1989-1991. The pervasive fear of 50 years of dictatorship disappeared and the entire nation seemed to have wings, willing to reestablish its own country and to build democracy. Needless to say, psychiatry had a lot to rethink and change after being a part of Soviet psychiatry for 50 years. Separation from the All-Union Society of Psychiatrists, Neurologists and Narcologists was not that easy as many leading Lithuanian psychiatrists had been very close to the Moscow school of psychiatry. While many other professional groups (such as, for example, psychologists or architects) in Lithuania separated from Soviet structures quickly and without any hesitation, for Lithuanian psychiatry it took some more time. The First Founding Congress of the Lithuanian Psychiatric Association (LPA), which took place on January 13, 1990, appeared to be unsupported by the majority of psychiatrists in Lithuania (only about 40 professionals attended, or about 10-15 percent), but the basic problem was that the elite of psychiatry (academic leadership and directors of psychiatric hospitals) were reluctant. But political events were developing in 1990 with such enormous speed that after 4 months, on April 7, the Founding Congress of the LPA took place in Vilnius with almost universal attendance of psychiatrists.

I was elected President of the LPA at this Congress. My vision was very clear. We needed to reestablish the reputation of the psychiatric profession through open dialogue with society and with the new government, and to move to develop modern mental health services based on the principles of protecting human rights of mentally ill people and evidence-based mental health policies and services. One of the first tasks of the new Board was to evaluate the extent of political abuse of psychiatry in Lithuania during Soviet years. Although this idea was not accepted by some of the leading psychiatrists, some fragile consensus still was found. During one of the next Congresses, the decision was made by the LPA that political abuse of psychiatry did take place in Lithuania during Soviet rule. Interestingly, this decision was made by voting, as it was impossible to reach consensus. Even more interestingly, the next vote was on whether or not the LPA regrets and apologizes about the facts of political abuse of psychiatry, and the result of this vote was "no."

These first several years of the LPA activities were marked by the spirit of democracy and hot debates, with an open and enthusiastic search for truth and the way to go. However, this spirit started to fade away in the end of the 1990s, and this kind of unexpected regressive development continues through the first decade of the 21st century. It is my subjective view that opportunistic tendencies have dominated the activities of the LPA, with the increasing role of pharmaceutical companies and the lack of will among the psychiatric community of Lithuania to develop the culture of self-regulation so that high ethical standards could become the highest priority for the members of the LPA. During the last congresses of the LPA, there were no open discussions about the most controversial aspects of the psychiatric profession during the period of transition in Lithuania, and the programs of the LPA meetings have been dominated by presentations on effective psychotropic medications.

My interpretation is that the psychiatric profession has decided, at this moment of its development in Lithuania, to take from modern psychiatry only one component, and this is modern psychopharmacotherapy, and not to change the culture of mental health services from the pattern of paternalistic approach to patients and the pattern of psychiatry having power over the other stakeholders. This is why the LPA has not been on the side of human rights activists when the issues of violations of human rights in psychiatric institutions have been raised. Also, the LPA voice is not heard in the current situation when modern principles of mental health care are ignored by the Government and institutional care is strengthened instead of moving to deinstitutionalization policies.

The current situation in the Lithuanian Psychiatric Association does not resemble, in any way, the spirit of the LPA during the first years. This may be not surprising as we watch similar signs of disappointment and nostalgia for the years of communism among a large portion of the population in Lithuania. It is likely that psychiatry is not very different from the society at large; or, to say it in other words, society has the psychiatry that it deserves. Hopefully, both society and psychiatry will have a new stage of progressive development in the nearest future in Lithuania.

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Policy Study on Prevention of Suicide in Lithuania

Introduction: Lithuania's Suicide Crisis

The problem of suicide in Lithuania is a serious and enduring crisis that has not yet been resolved in over 20 years since independence from the Soviet Union. Lithuania is home to the world's highest suicide rate. In 2009, for example, there were 31.5 suicides per every 100,000 people. Lithuania's suicide rate is triple the average of the European Union of 10.1 per 100,000 and twice the average of the region. Every year since the early 1990s, there have been over 1,000 suicides in a country of only 3.4 million, with the suicide rate for men seven times higher than women (58.5 vs. 8.8), especially between 30-49 years of age and living in rural areas. This policy study carried out in 2009-2010 adopted quantitative comparative analysis as well as qualitative analysis from interviews with national experts on mental health policy. Dr. Dainius Puras, ex-Dean of Faculty of Medicine, Vilnius University, former President of Lithuanian Association of Psychiatrists and co-author of Lithuania's 2004 emergency suicide bill, describes the state of suicide in Lithuania: "It's an epidemic," he says. "If it wasn't suicide, but an infectious disease that was killing over 1500 people a year…the government would spend millions…There is a lot of cynical thinking in Eastern Bloc countries, that it is maybe better to let the weak die."[1] However, despite the world's highest suicide rates and clear evidence that the phenomena is relatively new to Lithuanian society, there has been no concerted mental health policy effort to reduce the suicide rate to lower levels over time. Therefore, this article shall examine two questions: Why did suicide emerge as a major problem in Lithuania over the past twenty years and why has the government not done much more to prevent suicides?

By Ramon J. Pebenito Jr. and Arūnas Germanavičius

Trends - 1924-2009

A review of Lithuania's suicide mortality statistics firmly establishes the recent trend of extremely high rates as a new phenomenon emerging from the transition period of the 1990s with no roots in broader Lithuanian history. According to Danute Gailiene, the suicide rate during the Pre-War Independence period was 8 per 100,000. During Soviet occupation the suicide rate increased to 16 per 100,000 in 1962 and later to 36/100,000 in 1984. However, much of the increase is from 1970–1984, during which time the rates grew by 44.6%. With the beginning of the Perestroika period, a sharp decline was observed in 1986, from 36 per 100,000 to 27 per 100,000 by the beginning of Lithuania's regained Independence.[2]

However, from the onset of formal Lithuanian Independence in 1991, and the beginnings of political, social, and, most significantly, economic transition, an explosion in the Lithuanian suicide rate occurred. From about 26 per 100,000 in 1990, suicide rates nearly doubled to about 47 per 100,000 in 1996. Suicide mortality is most prevalent among males, particularly among rural middle-aged to elderly males. The latest Eurostat figures show a steady decline in suicide rates followed from 1995-2007. This ended in 2007 with a suicide rate of 28.4/100,000. From 2007 to 2008, suicide rates increased to 30.1, and the suicide rate increased again for 2009 with a rate of 31.5/100,000. While this rate is smaller than the all-time peak of the mid-1990s, it is still larger than the pre-transition suicide rate of 26/100,000. Moreover, it presents an alarming new trend after years of decline. This new trend is likely related to the ongoing economic crisis, which began in Lithuania in 2007-2008 and persists to this day.

Causal Factors

For an issue as complex as suicide, a number of possible explanations exist. However, scholars in the field of sociology going back to Emile Durkheim and health experts in the present day generally agree that economic and social disruptions usually have an adverse effect upon a society's suicide rates. Lithuania is no exception. Many scholars have observed that Lithuania's difficult socio-economic transition

[1] Webster, Jason. "Lithuania's Suicide Epidemic". Insight News TV. Insight News Television Ltd. 2004. Accessed April 22, 2008 http://www.insightnewstv.com/d74

[2] Gailiene, Danute, "Vicious Circle: Suicides in Lithuania After Independence". Psichologia, 2005. Accessed February 15, 2011 http://www.leidykla.vu.lt/fileadmin/Psichologija/31/7-15.pdf

from living under Soviet occupation in a command economy towards democracy and a market-based economy likely contributed to the massive increase in suicide rates throughout the 1990s transition period.

For example, Eidukiene unambiguously cites the suicide crisis as influenced in large part by "the state of anomie in contemporary society, conditioned by decades of Soviet occupation and the dramatic transition period," adding "the exceptionally high suicide rate is a symptom of society's anomie[...] The period of radical reforms which Lithuanian society is still experiencing is bringing about a crisis of values, together with increasing psychological and social insecurity and feelings of helplessness, and social exclusion."[3] Suicide and other forms of external mortality also increased throughout the former Soviet Union during the 1990s, but not to the extent of Lithuania. What accounts for this variation?

After the fall of the Soviet Union, Lithuania and the other Baltic countries embarked on an extremely rapid, Neo-Liberal economic transition program to move from communism to capitalism. Lithuania, Latvia, and Estonia's "shock therapy" approach was directly contrasted by the more gradual reforms of other post-communist countries, like those in the Caucasus, or neighboring Belarus, Ukraine, or ex-Satellite countries such as Romania and Bulgaria. While these gradual countries favored slower privatization of state-owned enterprises and more deliberate liberalization of trade and price controls, Lithuania and the other Baltic countries adopted a radical and swift transformation that caused considerable social stress, anxiety, and hopelessness among its people. As these reforms were implemented, unemployment and inflation exploded.[4] Lithuania's first independent government was so unpopular as a result of these reforms that, in 1992, they lost a parliamentary election to a party dominated by former communists, led by Mr. Algirdas M. Brazauskas.

Budrauskaite, et al, place the Lithuanian state at the center of its speedy economic transformation: "The government of Lithuania

[3] Lithuanian Human Development Report 1998. State and Human Development. United Nations Development Program, 1998 p. 78

[4] Svejnar, Jan. "Transition Economies: Performance and Challenges." The Journal of Economic Perspectives Vol. 16, No. 1, (Winter, 2002) p. 16

planned to achieve a radical structural change in ownership and a rearrangement of the institutional structure. Priority was given to the adjustment of the legal framework for functioning of a market economy, liberalization of prices, privatization of enterprises and liberalization of trade and external sector."[5] Despite these vast changes in the economy and the new experience of mass unemployment for Lithuanians, no corresponding social outreach programs were developed to facilitate a socially cohesive transformation from the communist system to the intense competition, uncertainty, and instability of emerging capitalism. During the early transition period, many were left vulnerable and felt excluded from the new Lithuania, and inevitably turned to alcohol. The seminal 2009 Lancet article by Stuckler, King, and McKee, "Mass Privatization and the Post-Communist Mortality Crisis: a Cross-National Analysis," helps establish the acute sensitivity that health outcomes in the transition economies of the former Soviet Union and Communist Bloc bear towards macroeconomic transformations.

The Absence of Suicide Prevention Policies

The abject failure of the Lithuanian government to put forth a systematic policy response to the ongoing suicide crisis in the country is directly tied to its failure to comprehensively reform its national health system. In many ways, the Lithuanian health system strongly resembles the defining characteristics of Soviet times: inefficient, corrupt, and organized on the biomedical principles of epidemiological containment of infectious diseases. Germanavicius observes, "Despite sporadic efforts […] the direction of investments remains based on historical principles: emphasis on psychiatric institutions, medications, and social exclusion […] neglect of public health approach, psychosocial interventions, community based approaches, and GP involvement in public health."[6]

Likewise, the role of the general practitioner/family doctor is marginalized in the Lithuanian health system. General practitioners are poorly-paid, under-trained, and often un-incentivized to diagnose and pro-actively help patients who may suffer from mental illnesses like depression, alcoholism, or from physical illnesses such as cardiovascular disorders. Many GPs simply refer their patients to specialists in large hospitals. Lithuania's suicide rate is the world's highest, but it is also among Europe's leaders for external mortality, mortality from heart disease, circulatory illness, and certain forms of detectable cancer. Yet, despite the clear failings of the health system and the potential to reduce avoidable mortality from suicide, heart disease, and cancer using evidence-based interventions at the municipal level, government resources continue to prioritize large institutions, both somatic and psychiatric.

> "Lithuanian reformers and international organizations, including WHO, have long criticized the health system of Lithuania."

In conclusion, suicide prevention in Lithuania is a priority of the highest order. The steps required to lower the suicide rate in the long-term are clear: stronger GP involvement in mental health to detect depression and alcohol, larger public investment in public health and social outreach programs to provide support for vulnerable groups, especially rural men, and an overall systemic transformation towards community-based solutions. However, these recommendations are not new. Reformers in the country as well as international groups like the WHO have long-criticized the health system in Lithuania. The total absence of political will among policymakers to challenge the powerful health system establishment and confront medical elites at the largest institutions has created paralysis at the policy reform level. There can be no long-term solution to the suicide crisis in Lithuania until this political will emerges.

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[5] *Budrauskaite, Aline, Jypara Mamytova, Katarina Mlinareviæ, and Alla Savina. "Trade Policy and Economic Growth: Cases of Belarus and Lithuania." Privredna Kretanja I Ekonomska Politika No. 90 (2002) p. 74-76*

[6] *Germanavicius, Arunas, Dainius Puras. "Case Lithuania: Current Situation and Future Prospects of Mental Health Care Reform." Psychiatrisch centrum Sint-Hiëronymus. 2005. Date accessed: Nov. 3, 2008. http://www.hieronymus.be/documenten/Germanavicius.pdf*

Empowerment Strategy for Mental Health Care Users in Decision Making (Lithuanian Experience)

These authors conceptualize the nature of empowerment as the transformation of mental health care users from a position of slavery (where users have no rights to their own opinions) to an empowered position, where they are treated as respectable partners in the system. This concept includes all aspects of the mental health care system, including rehabilitation, social integration and participation in decision making at all levels. There are two aspects of empowerment – the individual aspect and organizational (institutional) aspect.

By Arūnas Germanavičius and Saulius Pečiulis

The most important factor of individual empowerment is the fulfillment of all personal rights, fixed in national law and strategy of the improvement of the mental health care system. These personal rights include the participation in decision making about treatment of each mental health care user. A major problem in Lithuania is the fulfillment of the right of user to defend him/herself in court when decisions are being made about compulsory treatment (this right is fixed in national law, but almost never works practically).

Institutional aspects of empowerment include working with users organizations. In Lithuania, there are two types of users' organizations:
1) Self-help organizations, which are active in rehabilitation and social integration (patients clubs are counted here); and
2) Patient councils, a more advanced form of organization, which represents the rights of users and is elected by all patients of a mental health care unit. In Vilnius, the mental health care center (Vasaros str. 5, Vilnius) Patient council has five years of experience working with the hospital administration and other professionals. It consists of seven members and meets twice a month. The concept of Patient councils in Lithuania is implemented by consultation of mental health users from the Netherlands. A good first step in user empowerment is the participation of users' representatives on the Board of the hospital. Only an independent Patient council has the real capacity to be heard by professionals and to elaborate on the most qualified proposals for improvement of services at the hospital level and even more – at the level of national policy and international practices. This means that users should be regarded as professionals, should have job descriptions, and receive payments for their expertise. This latest thesis was never implemented in Lithuania and has hardly been acknowledged even in developed democratic health and social care systems.

The Lithuanian experience shows that empowerment of users through the patient council concept is one of the best possible ways of empowering users in participation of decision making. However, local data shows that its implementation is very slow. A study of human rights and conditions of care undertaken by users groups in Lithuania of long term care facilities for severely mentally ill people showed that none of the six institutions had users' councils despite the official legal requirements for such councils in social care homes. ("The Catalogue of Social Services" and "Normatives for Social Care Homes") (Samsanaviciute Zina et al., 2005; internet reference: http://sena.sam.lt/lt/main/news?id=76377). A year later, a human rights monitoring project found that only a very small number of institutions visited do have such Patient councils (internet reference: http://jga.lt/uploads/studijos/zmtesiu_stebejimo_uzdarose_inst_ataskaita.pdf). A plausible relationship was hypothetical between a better quality of care and existence vs. an active role of

> "Sadly, there is still no strategy for Lithuanian mental health services to include users in planning, implementation and monitoring services."

patients in users' councils, but was never proven in a scientific way. It is also important to note that often administrations of such institutions do not understand practically the positive role of users' councils and the concept of users' involvement remains only on paper.

It is regrettable that after 20 years of independence, Lithuanian mental health care services do not have a general strategy for ways that mental health care users could be active partners in planning, implementing and monitoring services. Professionals still maintain very defensive positions about different roles in services by splitting traditionally into service providers and service recipients (Lithuanian Psychiatric Association has deleted patient rights and wellbeing protection from the aims of the statute of this organization). Modern concepts of social psychiatry that emerged in the United States, Western Europe, Australia and other progressive places around the globe, has had almost no influence on mental health services in Lithuania. Only slight and very formal shifts towards users' involvement have been observed (e.g. Ministry of Health/Ministry of Social Welfare and Labor sometimes invites representatives of user organizations during the preparation of some legal documents; some user organizations have been involved in the committee deciding on the list of state-reimbursed medications, but it is frequently manipulated by pharmaceutical companies and professionals). That is why mental health care users' organizations in Lithuania still remain weak, scattered and do not have a strong voice in decision making. We definitely believe that if the Lithuanian users' movement was strong, the usage of European Union structural program finances for modernizing Lithuanian psychiatric hospitals in 2009-2011 would not be allocated for buying ECT (electro-convulsive treatment, so-called electroshocks) machines or for observational video cameras.

We still believe that some of these first positive examples of user involvement and empowerment in Lithuania (users' clubs and councils) might develop into a nationwide consortium or umbrella organization, and a productive movement that could enhance transition of Lithuanian psychiatry towards modern social psychiatric community-based services. Also we hope that this example might be useful for other countries, especially with similar cultural and historical experiences.

Vasaros Hospital before and after the renovation

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This article was never published before. It was written shortly before the death of Dr. Saulius Peciŭlis.

Development of Patient's Person of Trust (POT) Program in Lithuania

The idea of POT position came from the Netherlands where it has been working since 1982. After being modified and adapted for the Lithuanian situation, POT started its activity in Vilnius in 2006, under the coordination of GIP-Vilnius office. POT services are included in the Vilnius City Mental Health Strategy and financed from the Vilnius city council sponsored health program.

By Rūta Juodelytė

Rūta Juodelytė (L) and Klementina Gečaitė (R).

Rūta Juodelytė and Klementina Gečaitė are patients' persons of trust. Email: paciento.patiketinis@gmail.com

The purpose of POT is to create and establish a representative model of mental health service users' rights protection. POT is seeking equal opportunities for persons with mental health problems to integrate into society and contribute to construing a chain of mental healthcare services in Lithuania according to the priorities adopted in National mental health strategy: (1) guarantee of human rights, (2) provision of services that meet patient's needs, (3) encouragement of autonomy and participation, and (4) strengthening of patients, their family members and nongovernmental organizations.

Essential features of the POT position are independence from mental healthcare institutions and the full support of the client in his/her relation with the healthcare institution. The person of trust assists the patient in realizing his/her rights by performing three essential functions of the position: (1) mediation and representation in case of complaints (2) provision of information on patient's rights and (3) identification of the shortcomings in providing mental healthcare service.

During the years of implementation, POT has proved to be successful and necessary for both – mental health service users and in-patient and out-patient mental health service providers in seeking mental healthcare services of better quality and respectful for human rights. For more information please contact paciento.patiketinis@gmail.com or call +370 5 2715760.

> Persons of trust have been successful for users and providers in seeking a quality mental health care system with respect for human rights.

Primary Mental Health Care in Lithuania

Since 1996, 80 community mental health centers have been established in Lithuania that work at the community medicine level and are controlled by the municipality. Psychiatrists are the key people at these centers. On January 1, 2006, there were 224 psychiatrists, 110 medical psychologists, 160 clinical social workers, and 220 mental health nurses working in these centers. The population of Lithuania is approximately 3.5 million in 10 districts and 60 municipalities.

By Eugenijus Mikaliūnas

The goals of these centers are as follows:

A. To educate families as to how to live with the patients;
B. To prepare the community to accept the patient, thereby reducing the stigma in the community; and
C. For psychiatrists to establish the modes of operation for this new strategy.

If these goals could be accomplished, the treatment results would increase. The main tasks for the psychiatrist working in a community based mental health center in Lithuania are as follows:

A. To diagnose mental disorders;
B. To prescribe drugs (if necessary);
C. To consult with the families of patients;
D. To provide instructions and consultation with the psychologists, nurses or social workers related to the treatment; and
E. To provide strategies for prevention of mental disorders.

The center psychologists do the psychological diagnostic work and provide psychological assistance to the patients, as ordered by the psychiatrists.

The benefit of this growth of the mental health center movement is evident:

- The quality of services improved as provided by teams of mental health specialists.
- The disease diagnostics improved and were quicker; treatment and rehabilitation also improved.
- There are expanded possibilities to get consultation not only from psychiatrists, but also from medical psychologists, clinical social workers, mental health nurses, and, in some cases, from psychotherapists and rehabilitation specialists.
- Psycho-neurological dispensaries didn't do follow-up care; no one provides follow up care.
- There is a positive influence over patients and staff on stigma reduction.
- There is close contact with the family doctor in the team. In the future, such work will be fundamental and work closely with day hospitals, rehabilitation centers, patient's societies, clubs, patient's families clubs, vocational rehabilitation centers and other community services.
- The result of such work is that the number of beds will decrease in psychiatric institutions.

The positive aspects of this system are:

- People can consult with a psychiatrist without waiting for a referral from the general practitioner, thereby decreasing stigma and avoiding delay in treatment;
- Psychiatrists diagnose diseases more accurately and faster than other professionals.

The mental health centers are progressive; but, also, substantially expensive compared with services extended by the family doctor.

> "Mental health centers are progressive but substantially more expensive than the services of the family doctor."

The pro-capita financing system for primary mental health care relates to the costs based on the number of individuals living in a particular catchment area, rather than on the volume or content of service. The

benefit of the pro-capita financing system is that the entire Lithuanian population, without exceptions, can access mental health services in an emergency situation and those individuals with health insurance have the possibility of accessing a wide variety of ambulatory services. On the other hand, the disadvantage is that this financial system may discourage a higher quality and quantity of work.

In addition to treatment issues, psychiatrists in primary mental health care in Lithuania are responsible for ensuring public safety (e.g., issuing permissions and health certificates for fitness to drive a car, own a weapon, etc.) and prevention of mental disorders. In Lithuania, both the family doctor and mental health center psychiatrists are responsible for these work tasks. All information about an individual's health history received from the family doctor and treatment institutions is stored at the work place of the specialist. In the future, it would be better to gather this information and prophylactic health control would be easier by establishing e-health projects. In the future, specialists from public health offices should be working on the prevention of mental disorders.

This work is certainly needed; one suggestion is that the mental health center coordinates the work but that public health officials would do the actual work.

Some primary mental health care centers are legally and financially independent, but the majority are dependent on polyclinics. This independence question depends on the intentions and initiative. It is likely, in my opinion, that the situation will remain the same as it is at present because those who are in favor of independent mental health centers have already eastablished them, while those who don't want the independence will prefer the status quo. If a change is to be made, the persons with the interest would be responsible for implementing this change.

The next steps of this strategy are:

- To establish rehabilitation day outpatient departments (centers) near these mental health centers, where the multidisciplinary team would give psychosocial rehabilitation services;
- Psychiatrists, working with the team, will prescribe not only psycho-pharmacological treatment, but also alternative methods of treatment in order to evaluate their effectiveness.

> Day rehabilitation outpatient centers should be established near mental health centers.

There are about 400 psychiatrists in Lithuania, half of them working at the community based Mental Health Centers and the other half at inpatient services. Thus, there is a balance; and every service, at the time of state transformation, developed its field in accordance with available reserves and finance. In Europe, psychiatrists with equal professional preparedness gather different experiences, depending on whether one works in a wealthy or developing country, whether in outpatient or inpatient services.

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Primary Care Systems in Lithuania: the Role of Psychiatrists

Lithuania has witnessed a substantial increase in community mental health care centers over the years. This has served as a good stimulus for the move from predominantly in-patient mental health care of past years.

By Robertas Bunevicius

However, this move has created two parallel primary care systems, one for general medicine and another for mental health, thus segregating psychiatry from general medicine at the primary care level. The system limits the involvement of primary care (family) doctors in mental health and causes the status of psychiatrists to be vague. If they are working in primary mental health centers, they may be treated as primary care physicians; if they are working in secondary or tertiary level facilities, they are treated as specialists. A significant percentage of psychiatrists serve as managers of the primary mental health centers rather than working as psychiatrists.

The costs of the provision of primary care are constant and strongly dependent on the population living in a particular catchment rather than on the volume or content of services. This does simplify the financial administration of primary health care but it does not stimulate an increase of quality and quantity of services provided.

While public safety and prevention is not a direct responsibility of the psychiatrist, who is overqualified for such activities, these specialists may provide considerable professional expertise in these fields. Public health centers and public safety institutions should provide such services but could call on the specialists when needed.

I would suggest a deeper integration of community medicine and mental health care where mental health services were provided by community health care centers along with general medical services. These centers should include psychiatric nurses and psychologists and psychiatrists could serve as consultants. It would be the responsibility of municipalities to implement such changes but the respective laws would need to be changed.

We have not achieved integration of psychiatry to general medicine nor at the primary care, secondary or tertiary levels. Forensic psychiatry maintains close ties with Eastern counterparts instead of moving forward towards modern Western psychiatry.

> "A deeper integration of community medicine and mental health care is needed."

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In Memoriam

SAULIUS PEČIULIS
(1960-2010)

"When your roof is falling down – the sky opens to you." With such sayings, one of the famous Lithuanian mental health care users, Saulius Pečiulis, was constantly cheering people around him. He fought stigma, acknowledging that "stigma begins in the hospital, when other mental health care users are treating you like jail inmates."

In his famous book, Ten Secrets to a Successful Life for People with Mental Problems (2002, Vilnius), which is also translated into English and Russian, he emphasized that the role of the psychiatric professional is not merely as a treatment provider, but they "should be occupied ... with the education of users as personalities and their moral training."

Saulius was one of the great dreamers about mental health reform in Lithuania; he also practically implemented his ideas in his role as president of Vilnius "Kulgrinda" users club, established in 1994.

From 2005 until his death, S.Pečiulis worked as senior researcher at the Clinic of Psychiatry, Vilnius University. His PhD in social sciences (economy) from Moscow State Lomonosov University gave him the perspective of a researcher with a user's background, able to contribute greatly to the European Union project "EMILIA" ("Empowerment of mental health care users through education, support and action," Framework 6, Life Long Learning). Together with other users and professional researchers of the Vilnius Clinic at Vasaros 5, he co-authored "Training Program for Suicide Prevention for Mental Health Users" – first of such users-led training programs. I remember his very fragile and, at the same time, very flexible and strong attitude towards participants when he led the course giving examples of his personal breakdown due to psychosis, his long path to recovery with periods of hope and hopelessness, sometimes thinking about suicide. Saulius's attitude that all types of religions prohibit suicide was very helpful not only for him, but also for other users who received inspiration to live for life.

He was a great lecturer and it was great satisfaction to hear and watch him during his lectures. One of the first great public international appearances of Saulius was in 2002 during the World Psychiatric Association congress in Yokohama (Japan), when he debated psychiatric reform towards community mental health with Prof. T. Tomov and Dr. D. Puras. Later, together with the prominent user from the United States, Mr. Joel Slack, they together made the "Respect Seminars" in Lithuania for mental health care users in 2004. Saulius was inspired by Joel's arguments on stigma: "Stigma is social death ... Just as stigma begins with ourselves, it must end with ourselves." S.Pečiulis writes about stigma – as a phenomenon which begins with other users in a psychiatric hospital as they relate to a newly admitted inmate. These ideas are based on his own experience and should be very seriously regarded as an argument for creating "First Psychosis Services," thus stopping hospitalizing young patients together with long term patients in acute psychiatric wards.

Saulius Pečiulis was not only an active and productive user. He was at the beginning of the Sajudis movement (Lithuania liberation organization from SSSR, established in 1988), very active politically, later an economic adviser for First Prime Minister and woman of Independent Lithuania - Ms. Prunskiene. He also established the Lithuanian Stock Exchange and some other very important economic foundations of newly re-created state.

Saulius Pečiulis's work and activities are inevitable parts of the positive development of Lithuanian modern history and social psychiatry moving towards a modern system of care. The only thing he wished – that it would go much faster!

Dr. Arunas Germanavicius

In Memoriam

MELVIN SABSHIN
(1925-2011)

To capture Melvin Sabshin in a short obituary is almost a *contradictio in termine*, yet one thing is absolutely clear: those who knew Melvin Sabshin invariably remember his imposing stature, his supreme intellect and his analytic and ever questioning mind, as well as the typical broad smile on his face and the big cigar stuck in the corner of his mouth.

Melvin Sabshin, former Medical Director of the American Psychiatric Association (APA), passed away on June 4, 2011. He had his roots in Russia, which may explain his keen interest in the issue of Soviet political abuse of psychiatry in the 1970s and 1980s. At the beginning of the twentieth century, his parents emigrated from an area that is now in Belarus, fleeing from anti-Semitism under the Tsar, and were socialist activists before and after their emigration. Born in 1925, Sabshin grew up in New York, being a brilliant student and graduating in 1940 from High School shortly after having turned fourteen years of age. Then, at the young age of 14, after active lobbying by his mother, he was admitted to the University of Florida, from which he graduated in 1943 at the age of seventeen.

In 1944, Melvin Sabshin entered Tulane University in New Orleans, Louisiana, after having spent one year in the US Army as a volunteer. Here he became politically active in the civil rights movement, defending equal rights for blacks (for instance by refusing to enforce separation between white and colored at the blood bank at Charity Hospital in New Orleans) and eventually even joining the American Communist Party, a fact he kept concealed until I interviewed him for the first time in February 2009. It was a typical Melvin Sabshin situation: I had to find out myself, but when I deducted this from a sequence of hints he made in the course of the interview and asked whether he had been a member only in spirit or also factually, he was visibly pleased that I had caught his hints, and answered with the usual big grin on his face: "You could say: both."

His membership, which he ended in the early 1950s when he became disenchanted with the political course of the party, haunted him well into the 1970s when he was already at the APA. His FBI-file is 400 pages thick and documents the intense scrutiny by the FBI, his dishonorable discharge from the US Air Force as being "politically unreliable," the interrogations by the FBI in the late 1950s and the fact that he was not allowed to join government commissions even when being Medical Director of the APA because of this political past.

In spite of FBI resistance, he became Director of the Psychiatric and Psychosomatic Institute of Michael Reese Hospital (IPP) and later also Acting Dean of the Medical School of the University of Illinois. Here he met his second wife, Edith Goldfarb, a trained psychoanalyst like himself, who became his constant and loving companion until her death in 1992. Edith's death left him deeply depressed and disoriented, until he met and married Marion Bennathan in 2000, with whom he spent the rest of his life living mostly in London, and who cared for him with much love and affection until his death.

In 1974, Melvin Sabshin moved from Chicago to Washington D.C., after having been appointed Medical Director of the American Psychiatric Association (APA). Under his 23-years of leadership, the APA would become the most powerful psychiatric empire in the world. During his tenure as Medical Director, Sabshin became, in fact, the intellectual leader of the psychiatric profession in the United States. During his tenure, among many other accomplishments, he was instrumental in developing one of the largest psychiatric publishing houses, (American Psychiatric Press) and was instrumental in developing and promoting one of the leading classifications of mental disorders, the Diagnostic and Statistical Manual (DSM); DSM-IV is dedicated to him as a sign of his involvement: *"To Melvin Sabshin, a man for all seasons."*

During his time at the helm of the organization, the APA became probably the most revered organization in international psychiatry, with Ellen Mercer directing the Office of International Affairs and greatly expanding the APA's international network, e.g. developing links with China. Many older psychiatrists worldwide remember this period as the heydays of the APA, when APA Annual Meetings were considered the most interesting international events in world psychiatry.

From 1983-1989 Melvin Sabshin also functioned as a member of the Executive Committee of the World Psychiatric Association (WPA), the main psychiatric body that unites psychiatric associations around the globe. Here he showed his unique diplomatic skills, meandering through the minefield of, on one hand, supporting the fight against political abuse of psychiatry in the USSR (the reason why I met him for the first time in the early 1980s), on the other hand the realities of being on the board of a global organization including those who did not support his position vis-à-vis the USSR, and the challenge to promote improved mental health care worldwide. Typically of him, he befriended both those who vehemently fought Soviet psychiatric abuse and, at the same time, the East German member on the same WPA executive, Prof. Jochen Neumann, with whom he remained close friends until his death. He was instrumental in finding the final compromise in 1989, which led to the return of the Soviets to the WPA from which they had been forced to leave in 1983, without giving up his ethical stand and his support for human rights.

During the last years of his life, physical ailments increasingly impaired his ability to move around and participate in professional life as actively as he would have liked. However, his mind was unaffected, and when needed, he would gather all his strength and dominate the discussions. In 2008 he published his memoirs, *"Changing American Psychiatry,"* and during the subsequent two years, we met frequently while working on my book *"Cold War in Psychiatry"* in which he figures as one of the two main characters (the other being his friend Jochen Neumann). He often left me wondering who determined the course of the long interviews. In fact, he quickly made the project to a large degree his own, all the time pushing me to dig deeper and to find better answers to difficult questions. It was an exhilarating period that unfortunately came to an end when the book was finished.

The last time we physically met was during the presentation of the book in October 2010. Frail, hardly able to walk, exhausted, he gathered all his strength during the presentation, quickly taking the lead and turning the discussion to his favorite subject – the DSM classification, in which he strongly believed and which, in his view, had been one of the important tools in curbing and finally ending the political abuse of psychiatry in the USSR.

Melvin Sabshin is survived by his wife, Marion; his son James Sabshin, M.D., a neurosurgeon; four granddaughters, two of whom are psychiatrists, and by many friends all over the globe. He truly was a unique personality.

Robert van Voren
This obituary was earlier published in The Psychiatrist, September 2011

Russian Summaries

By Elena Mozhaeva

Редакционная статья
Джон Боуис и Роберт ван Ворен

Этот выпуск Mental Health Reform отличается от других. В нем отражены не только успехи, но и неудачи в реформировании системы психического здоровья в Литве. В частности, речь идет о сохраняющемся доминировании биологического подхода и акценте на стационарах, недостаточном учете интересов пациентов, о консервативной позиции Литовской психиатрической ассоциации и т.д. Пусть этот номер послужит предостережением: как оказалось, после двадцати лет вложений в реформирование дела могут пойти в обратном направлении, оптимизм созидательности может столкнуться с жесткой реальностью, подчас с неблагоприятными последствиями. Пусть это будет предупреждением о том, что членство в Евросоюзе само по себе не гарантирует процесса дальнейшей европеизации страны.

Доказательная политика в области психического здоровья в Литве
Дайниус Пурас

С началом в Литве в 1991 демократических реформ, в стране неоднократно предпринимались попытки введения доказательной политики в области психического здоровья. Так, был принят Закон о психическом здоровье, создана сеть муниципальных центров психического здоровья, принята новая национальная стратегия психического здоровья с акцентом на службах на основе сообществ, эффективных программах развития психического здоровья, профилактики суицидов, насилия и пр., деинституциализации, продвижении и охране прав человека в психиатрических заведениях, мониторинге работы служб и т.д. Вместе с тем, политической воли в отношении следования этим принципам не наблюдается. Приоритетом правительства остается институциональная помощь. Большие средства вкладываются в ремонт крупных психиатрических больниц, огромные диспропорции существуют в финансировании биомедицинского и психосоциального компонентов в системе внебольничной помощи, фактически адекватно финансируется лишь психофармакотерапия. В обществе высок уровень нетерпимости к уязвимым группам, и значительная часть электората хотела бы убрать психически больных ‘’с глаз долой”. Принципы автономии и удержания психически больных в сообществе не пользуются популярностью, а в культуре психиатрических служб продолжает доминировать патернализм. Для изменения ситуации представляется необходимым создать коалицию сил, заинтересованных в реализации Национальной стратегии психического здоровья.

План Вильнюса в области охраны психического здоровья: Небезразличный город.
Роберт ван Ворен

Осенью 2004 муниципалитет Вильнюса и Глобальная инициатива в психиатрии (ГИП) создали рабочую комиссию по разработке долговременной политики развития служб психического здоровья. В нее вошли литовские и нидерландские эксперты, представляющие самые разные аспекты проблемы. С учетом рекомендаций ВОЗ, была разработана модель стратегического развития, которая представлена в статье. Этот план был утвержден муниципалитетом Вильнюса, но потом, в силу ряда факторов, большинство запланированных шагов были отменены, а некоторые из уже существующих служб подсокращены. Но план не потерял своей ценности, и на него продолжают ссылаться в дискуссиях и переговорах. Возможно, его черед придет в будущем.

Учреждения интернатного типа в Литве: бесславное прошлое, неясное будущее
Эгле Шумскиене и Довиле Юодкайте

Учреждения интернатного типа заслуженно обвиняют в выполнении функции ‘’социальной капсулизации” и ставят в один ряд с тюрьмами, больницами и лагерями. Литва унаследовала систему ухода за инвалидами по психическому здоровью от Советского Союза. К сожалению, литовская социальная политика оказалась не очень прогрессивной и больше ориентировалась на поддержание существующего положения, чем на деинституциализацию и интеграцию в условиях помощи на основе сообщества. Присоединение

к Евросоюзу не повлекло за собой прекращения дискриминации инвалидов по психическому заболеванию в населении. Сейчас в стране существует 26 интернатов для психохроников: здания недавно реконструированы, но достаточно взглянуть в испуганные лица обитателей, чтобы понять – это всего лишь очередная ''потемкинская" деревня.

Уроки реформирования системы психического здоровья детей и подростков в Литве

Витаутас Блазис

Доставшаяся Литве в наследство от СССР система психического здоровья детей и подростков была ''дважды Золушкой" - и среди психиатров и в общей медицине. Для нее не было места в поликлиниках, легко доступных населению. Ее помещали под крыло ПНД или крупных психиатрических больниц. После 1990 в Литве появились центры психического здоровья на основе сообществ (ЦПЗС), которые обслуживают как взрослых, так и детей. Опыт их работы позволяет извлечь некоторые уроки. Так, было ошибкой создание ЦПЗС в первом эшелоне помощи -это привело к длинным листам ожидания, избыточным затратам на простые случаи и недостатку поддержки сложных пациентов. Существующая система финансирования не позволяет создать в ЦПЗС мультидисциплинарные бригады. Ощущается недостаток сотрудничества ЦПЗС с коллегами из служб защиты детей и системы образования. Не используются в полной мере возможности психиатрических медсестер в проведении семейной и когнитивно-поведенческой терапии. Некоторые врачи не видят необходимости в реформировании системы: сами они - отличные клиницисты, но помещены при этом в неэффективную систему. Поэтому важно критиковать не коллег, а систему, и пытаться разъяснить цели сомневающимся. И последнее: для изменения системы обычно требуется больше времени и ресурсов, чем изначально предполагалось, и, кроме того, нужны преданность делу и терпение в достижении целей.

Интерпретация и соблюдение международных стандартов прав человека в Литве

Довиле Юодкайте

После получения независимости в 1991 Литва ратифицировала большинство основных международных инструментов прав человека, в т.ч. относящихся к правам инвалидов. Но на сегодняшний день, ситуация с правами человека и национальное законодательство Литвы, особенно в части людей с ограниченными возможностями, не полностью соответствуют международным стандартам, так как продолжаются нарушения в области опекунства, недобровольной госпитализации и лечения, законного представительства инвалидов по психическому заболеванию.

Литовская психиатрическая ассоциация – цели 90-х и нынешняя ситуация

Дайниус Пурас

Отделение в прошлом от Всесоюзного общества психиатров оказалось нелегким, так как ведущие литовские были тесно связаны с ''московской" школой. Первые годы деятельности ЛПА были отмечены духом демократии и горячими дебатами, но потом энтузиазм 90-х сменила регрессия с доминированием оппортунистических тенденций, усилением роли фармкомпаний и нежеланием самих психиатров развивать культуру саморегулирования. Складывается впечатление, что психиатрическая профессия решила взять из современной психиатрии лишь один компонент – современную психофармакотерапию – и не менять культуру служб психического здоровья и не уходить от патерналистского подхода. В целом, психиатрия не очень отличается от общества в целом, т.е. общество имеет ту психиатрию, которую заслуживает. Хочется надеяться, что и общество, и психиатрия в ближайшем будущем войдут в новую фазу прогрессивного развития.

Исследование политики превенции суицидов в Литве

Рамон Дж. Пебенито (мл.) и Арунас Германавичус

Показатель суицидов в Литве – один из самых высоких в мире. Многие ученые связывают его с трудностями социально-экономического перехода от Советской оккупации к демократии и рыночной экономике, особенно в странах Прибалтики. ''Шоковая терапия" в Литве, Латвии и Эстонии сильно отличалась от постепенных реформ в других пост-социалистических странах. В Прибалтике начались радикальные и быстрые перемены, и они стали причиной значительного социального стресса, тревоги и чувства безнадежности в населении с неизбежным ростом алкоголизации. Система здравоохранения при этом сохраняет худшие черты советской: она неэффективна, коррумпирована, организована на биологических принципах эпидемиологического сдерживания инфекционных болезней. Плюс полное отсутствие политической воли поднять проблемы и потребовать изменений у могущественного истеблишмента здравоохранения и медицинской элиты. Никакого долговременного разрешения кризиса с суицидами в Литве быть не может без появления данной политической воли.

Стратегия усиления пользователей служб психического здоровья в части принятия решений (Литовский опыт)

Арунас Германавичус и Сайлиус Печулис

Авторы рассматривают природу усиления как трансформацию потребителя помощи в сфере психического здоровья и его переход с положения раба (с отсутствием права на свое мнение) в положение ‘’усиления”, когда к нему относятся в системе как к уважаемому партнеру. Данная концепция включает в себя все аспекты системы оказания помощи, в т.ч. реабилитацию, социальную интеграцию и участие в принятии решений на всех уровнях. Выделены два аспекта усиления: индивидуальный, т.е. реализация все личных прав и их фиксация в национальном законодательстве и стратегии развития системы помощи, и организационный (институциональный), представленный организациями самопомощи и советами пациентов. К сожалению, данная концепция реализуется очень медленно. В Литве после 20 лет независимости все еще нет общей стратегии превращения потребителей помощи в партнеров по планированию, соучастию в работе и мониторингу служб психического здоровья. Профессионалы продолжают защищать свои позиции и не хотят изменения ролей в системе.

Развитие в Литве программы доверенных лиц пациентов

Рюта Юоделите

Идея доверенных лиц пациентов (ДЛП) пришла из Нидерландов, где ДЛП работает с 1982 года. Эту программу несколько изменили и адаптировали к условиям Литвы, и она была впервые запущена в Вильнюсе в 2006. ДЛП независимы от служб психического здоровья и выполняют функции посредников и представления интересов пациентов в случае жалоб на условия содержания или терапии, обеспечения информации о правах пациентов, выявления недостатков в работе служб психического здоровья. Опыт ДЛП оказался успешным как в стационарных, так и в амбулаторных заведениях и способствовал повышению качества оказания помощи и уважению прав человека в отношении пациентов.

Первичная помощь в сфере психического здоровья в Литве

Эугениус Микаулинас

С 1996 года в Литве было создано 80 центров психического здоровья на основе сообщества (ЦПЗС), подчиненных муниципалитетам. Основными целями ЦПЗС являются: (1) обучение семей, имеющих психически больных; (2) подготовка сообщества к принятию пациента и снижение стигмы в обществе; (3) утверждение нового способа действий для психиатров в рамках данной стратегии. Система ЦПЗС имеет много преимуществ в силу приближенности к пациенту, связей с врачами общей практики и наличия мультидисциплинарных бригад, осуществляющих вмешательства. На ЦПЗС также возложена обязанность выдачи разрешений и справок о допуске к управлению транспортными средствами и владению оружием.

По причине подушевого принципа финансирования система ЦНПЗ оказывается заметно дороже, по сравнению с услугами домашних врачей. Большинство центров являются самостоятельными в юридическом и финансовом смысле заведениями, но большинство действует при поликлиниках. На будущее планируется создание при центрах реабилитационных дневных стационаров, а также назначение психиатрами не только фармакотерапии, но и других видов лечения.

Системы первичной помощи в Литве: роль психиатров

Робертас Буневичус

Развитие в новой Литве системы помощи на основе сообщества в виде ЦПНЗ стало хорошим стимулом к отходу от доминировавшего в прошлом стационарного лечения. С другой стороны, создание ЦПНЗ привело к формированию двух параллельных систем первичной помощи – одной для общей медицины и другой для психического здоровья, т.е. психиатрия оказалась отделена от общей медицины в первом эшелоне помощи. Это привело к размыванию статуса психиатра в ЦПНЗ, который нередко оказывается в роли врача общей практики. Центры также должны в большей мере использовать возможности психиатрических медсестер и психологов, оставив за психиатрами функцию консультанта.

Памяти ушедших

Сайлиус Печулис (1960-2010)

Мелвин Сабшин (1925-2011)

Other themes addressed by Global Initiative on Psychiatry to be covered in future issues of Mental Health **Reforms:**

- **Community Mental Health Care**
- **Mental Health and Human Rights**
- **User Involvement in Mental Health Services**
- **Substance Abuse Prevention**

Global Initiative on Psychiatry

Global Initiative on Psychiatry (GIP) is a federation of international not-for-profit organizations for the promotion of humane, ethical and effective mental health care worldwide. The federation is registered in Hilversum, The Netherlands, and works closely with its federation members in Bulgaria, Georgia, Lithuania, The Netherlands, the United Kingdom and the United States, and a country office in Tajikistan, as well as with numerous NGOs, governmental and international organizations.

In addition to being a major contributor to improved mental health care systems in Central and Eastern Europe and the Newly Independent States (CCEE/NIS), GIP also works in other regions of the world such as Africa, Indochina and the Indian sub-continent. In all regions our goal is to empower people and help build improved and sustainable mental health services that are not dependent on continued external support.

Photography

The photographs in this issue were taken by the staff of GIP, authors of the articles, or other parties. The individuals portrayed were aware that their photographs might be published.

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