

STRENGTHENING COMMUNITY-BASED MENTAL HEALTH CARE IN LITHUANIA

RECOMMENDATIONS REPORT



Strengthening community-based mental health care in Lithuania: recommendations report

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Executive summary

Significant steps have already been taken to strengthen community-based mental health care in Lithuania, but further efforts are needed to ensure that they meet current and future needs. While service provision has been expanded considerably in recent years, almost one in three Lithuanians with mental distress reported unmet needs for mental health care in 2016, and care provision remains primarily geared toward hospital-based care (Wijker, Sillitti and Hewlett, 2022). This report sets out recommendations developed as part of an EU-funded project focussed primarily on care for people with severe mental illness, with the aim of reducing reliance on inpatient care for people with severe mental illness, and promoting person-centred and recovery-oriented care¹:

- 1) Given the current heavy reliance on inpatient care, challenges with care coordination, and gaps in care quality, it is recommended that Lithuania develop comprehensive **care pathways and clinical care guidelines grounded in established best-practice in mental health care**, setting out responsibilities for different levels of care providers and mechanisms for coordination, such as referral pathways. Given resource constraints, an iterative approach to the development of care pathways/clinical guidelines is recommended, prioritising development by potential impact.
- 2) In light of ongoing challenges with care coordination, and particularly post-discharge care and follow up, Lithuania should **strengthen care planning** by making more comprehensive use of written care plans and ensuring that those tasked with assessing and addressing service users' needs have appropriate training, guidance and support to do so. Lithuania should also **ensure citizens have access to a named care coordinator** at critical junctures such as the transition from hospital to community care, and should consider the provision of a named care coordinator for people with high needs.
- 3) Given Lithuania's current heavy reliance on medication-based care, and limited recourse to alternative treatments, Lithuania should invest in **scaling up access to talking therapies**. Given considerable resource constraints, it is recommended that Lithuania first expands access to those already in contact with the treatment system, piloting a talking therapy offer for people with moderate mental illness in the existing care structure, as a first step to expanding access to talking therapies for all Lithuanians.
- 4) To better meet the complex care needs of people living with severe mental illness in the community, recommendations are set out for the Lithuanian government's pilot of **Assertive community treatment (ACT)**, focussed on ensuring an approach that enables these teams to be the primary providers, rather than coordinators, of care.

¹ These recommendations are elaborated in further detail throughout this report.

- 5) Lithuania should **broaden mechanisms to monitor and improve care quality and outcomes**, starting by defining and monitoring a core set of quality and outcome indicators. Lithuania should then expand the levers available to improve care quality and outcomes, for example by reporting on quality and outcomes data in a way that enables constructive comparisons across regions and over time, initiating or supporting quality improvement bodies or projects, and/or strengthening scrutiny and assurance mechanisms.

These recommendations build on the significant efforts that have already been made to scale up access to high-quality mental health care, and implementing them will help to strengthen care provision as Lithuania continues on its ambitious reform to improve mental health and mental health care for Lithuanians.

Introduction

Background and context

1. Lithuania has embarked on an ambitious reform programme to strengthen community-based mental health care. Significant steps have been taken to improve services; over 100 multi-disciplinary mental health care centres have been established across Lithuania, the legislative framework for mental health care has been strengthened, and suicide prevention procedures have been developed. It is clear that progress has been made. Over the past ten years the suicide rate has fallen, the rate of avoidable hospitalisations for people with schizophrenia has fallen, many more people are accessing mental health care, and urban-rural gaps in diagnostic rates have narrowed. Yet, there is much more to do.

2. Further efforts are needed to strengthen community-based mental health care services to ensure they meet current and future needs. First, because needs are high. More than one in six Lithuanians experienced a mental health problem in 2016, and diagnoses for mental health conditions have close to doubled over the past two decades.² It is likely that increased diagnostic rates will continue to put upward pressure on the mental health system. Second, because there are significant gaps in Lithuania's capacity to meet those needs. Almost one in three Lithuanians with mental distress (30%) reported unmet needs for mental health care in 2016, and service users report difficulties accessing appropriate mental health support. There remain formal restrictions on social and economic participation for people diagnosed with a mental health condition, which serve as a barrier to help-seeking.

3. Further efforts are also needed to ensure that people are able to access high-quality care at the right time, and in the right place. The mental health care system remains hospital-centric, with inpatient services absorbing almost 60% of mental health funding in the health sector. Within community (outpatient) settings, the range of treatment options remains limited: there is a lack of capacity to deliver psychological therapies, and a heavy reliance on medication-based care. Coordination within and across sectors is also a significant challenge. Care pathways are not yet clearly defined, and there are significant challenges with post-discharge care and follow up. More work is also needed to monitor and ensure the quality of mental health care, to ensure that quantitative gains in accessibility translate to qualitative improvements in people's lives (Wijker, Sillitti and Hewlett, 2022). Against this backdrop, the Lithuanian Ministry of Health continues its ambitious reform programme.

This report

4. This report sets out recommendations to strengthen community-based mental health care in Lithuania, developed as part of an EU-funded project focussed on care for people with severe mental

² Diagnoses for all mental and behavioural disorders increased by approximately 80% in the period between 2001 and 2019 (this figure includes dementia)

illness. The recommendations in this report are focused on five policy priority areas identified by the Lithuanian government, in line with its national mental health reform. The five best practice areas include:

- the development of care pathways/clinical care guidelines,
- care coordination,
- scaling up access to talking therapies,
- assertive community treatment (ACT), and
- measuring and improving care quality and outcomes.³

5. The recommendations in this report have also been shaped by a number of contextual factors and policy priorities, namely that – alongside a goal to reduce inpatient care – there is a desire to shift the delivery of mental health care away from a predominantly biomedical approach. The shift from institutional to community care has often represented a cultural shift in approaches to care – beyond merely a technical shift in the location of care - toward a more person-centred and recovery-oriented approach. Approaches to promoting person-centredness and recovery-oriented practice are consequently a constant theme throughout this report.

³ The five best practice areas were selected by the Lithuanian Ministry of Health, in consultation with the OECD. The selection was guided by the priority areas for reform identified through the OECD's assessment of the provision of community-based mental health care in Lithuania (Wijker, Sillitti and Hewlett, 2022).

1 Care Pathways and Clinical Care Guidelines

Introduction

6. Comprehensive care pathways and clinical care guidelines can help drive mental health system improvement. Defining a clear treatment pathway, guideline and care standard that is grounded in evidence-based practice can promote high-quality care by defining the treatments and interventions that service users should receive, setting a benchmark for what care should be delivered, and making any gaps between best practice and care delivery more apparent. Care guidelines in particular are widely used across OECD countries to promote care quality by disseminating and implementing evidence-based practice (Hewlett & Moran, 2014).

7. There is currently little clinical guidance available in Lithuania, and the roles and responsibilities of different care providers in the treatment of severe mental illness are not clearly defined. OECD's review of the provision of community-based mental health care in Lithuania highlighted a heavy reliance on inpatient care, challenges with care coordination, and gaps in care quality. Clinical care guidelines are limited in terms of their breadth and depth, and Lithuanian care providers have expressed a desire for their development. For example, survey research conducted with Lithuanian General Practitioners (GPs) suggested that the development of clinical guidelines and clarity over the roles of different providers could help to improve the identification and treatment of mental health issues in primary care (Jaruseviciene, Sauliune, Jarusevicius, & Lazarus, 2014). Lithuanian mental health experts interviewed by the OECD for the purposes of this project in 2021 similarly indicated a desire for greater clinical guidance in the treatment of mental health conditions.

8. The development of comprehensive care pathways in Lithuania holds significant potential to support the transition to community-based care, and to drive care quality. The development of care pathways and clinical care guidelines provides one concrete mechanism to agree and define clear treatment pathways which rely less heavily on inpatient care, to agree and define mechanisms for coordination, and provide clinical guidance that can help to improve the quality of care. In the context of a community-based care transition, the process of defining care pathways also provides an invaluable opportunity for stakeholders to come together to agree on a vision for the future of the mental health system.

Box 1.1. Defining and differentiating care pathways and clinical care guidelines

The terms used to describe care pathways and clinical care guidelines vary across countries.

Typically, clinical care guidelines are service provider-focused, setting out best practice for delivering care. In this paper, the term **clinical care guidelines** is used to refer to guidelines that set out evidence-based recommendations for the provision of mental health care. Clinical care guidelines are typically focused on specific mental health conditions, though there are also thematic guidelines on key mental health concepts and practices, such as recovery, or care coordination.

Care pathways are used to provide guidance on service users' 'progression' through the mental health system. In this paper, the term **care pathways** is used to describe pathways that set out the goals, organisation, provision, coordination and evaluation of care for specific groups of service users, such as people with a specific mental health condition, or people with a specific service need.

In practice, some countries provide treatment guidance that consolidates elements of both. Some clinical care guidelines provide some guidance on the level of care where certain treatments or interventions should be provided, for instance.

Source: (Schrijvers, Hoom, & Huiskes, 2012); (National Institute for Health and Care Excellence, 2012)

Care pathways and clinical care guidelines in Europe: best practices and innovative uses⁴

9. Care guidelines are widely used across OECD countries to drive care quality by disseminating evidence-based practice. Many countries have well-established clinical care guidelines for the treatment of a range of mental health conditions. They are typically focused on specific mental health conditions, but there are also thematic guidelines on key mental health concepts and practices, such as recovery, or service user experience. Clinical care guidelines are typically more common for the most prevalent and/or severe mental health conditions.

10. There seems to be a high degree of commonality across countries in the primary treatment recommendations made for mental health conditions, suggesting some scope to adapt international guidelines to the Lithuanian context. An international comparison of the use of evidence-based clinical guidelines for eating disorders in Australia, New Zealand, Germany, the Netherlands, Spain, the United Kingdom and the United States highlighted strong commonalities across countries in main treatment approaches, but showed that there are large differences amongst additional recommendations on evidence-based treatments (Hilbert, Hoek, & Schmidt, 2017). A 2011 comparison of clinical care guidelines for schizophrenia in New Zealand, the United Kingdom (England), the United States and Germany similarly noted a high degree of commonality in evidence-based treatment recommendations, though noted some lack of clarity or divergence in areas where evidence was newly emerging (for example, new types of treatments/medications), or where evidence remained lacking (for example, the duration of certain

⁴ OECD reviewed a sample of care pathways/clinical care guidelines for the treatment of schizophrenia in adults across selected countries, as one example of clinical guidance for the treatment of severe mental health conditions. Schizophrenia is used as a 'sample' condition to enable a constructive comparison of care pathways and clinical care guidelines for severe mental illness across countries. There are typically separate guidelines for the treatment of schizophrenia in adults, and children and adolescents. The discussion in this section relates to clinical guidance for adults.

treatments) (Gaebel, Riesbeck, & Wobrock, 2011). Some countries have developed approaches to clearly demarcate where treatment recommendations are based on limited or weak evidence, for example in Denmark where a traffic light colour-coding system signals the strength of the evidence for each recommendation.

11. Care pathways and clinical care guidelines can be used to guide service providers and service users through the mental health system. The breadth of guidance, what is included in the package of guidance, differs across countries. All of the selected countries have clinical care guidelines for the treatment of schizophrenia at a minimum, while some countries have well-established care pathways. Both pathways and guidelines often include accompanying guidance, such as quality standards, or guidance for implementation.

12. Similarly, care pathways and guidelines can be a useful tool to demarcate responsibilities for the delivery of mental health care, and for coordination between care settings. Countries differ in the extent to which they use guidelines to establish expectations about which provider should deliver which components of care. They generally do not specify providers of care (though there are some exceptions), but some do specify the level of care in which treatments and interventions should be delivered. Some countries also use care pathways/clinical guidance to set out mechanisms for coordination. In Finland, for instance, guidelines set out clear referral pathways between providers, and also provide recommendations on mechanisms to ensure effective coordination (such as establishing joint meetings of inpatient and outpatient providers when a service user is being discharged from hospital to community-based care).

13. Care guidelines should be used as one basis for the development of care standards. Measurable care standards based on clinical guidance provide one mechanism by which to understand the extent to which the care that is being delivered is evidence-based, and in line with best practice. Defining measurable care standards can help make gaps between best practice and care delivery more apparent and can help to identify opportunities for improvement. Countries use different approaches to measure the extent to which care is delivered in line with clinical guidance, and in line with best practice. For example:

- In the United Kingdom (England), the clinical care guideline for schizophrenia is accompanied by a number of measurable quality statements, together with structure, process and outcome indicators that service providers can use to guide or evaluate care delivery; and
- In Denmark, there are separate clinical care registries for a number of mental health conditions (such as depression and schizophrenia) that contain a range of indicators intended to measure the extent to which care delivery is aligned to clinical guidance.

These are discussed in further detail in Section 5 (Quality and Outcomes), which discusses approaches to measuring and improving care quality.

14. Care standards can also help to promote care quality by establishing key timelines for treatment, such as maximum waiting times. These are particularly critical given the importance of early identification and intervention. In the United Kingdom (England), for instance, the care pathway for schizophrenia and psychosis is accompanied by a care standard which outlines a maximum two-week waiting time from referral to treatment for early intervention of psychosis. Data from NHS England suggests that introduction of the waiting times standard was followed by an increase in the proportion of people starting treatment within 2 weeks, from 65% in 2015 to 76% in 2018 (NICE, 2019).

15. Care pathways and clinical guidelines can also be used as a tool to promote recovery-oriented practice by:

- setting clear expectations about the involvement of service users and their social networks in decisions about their treatment, and

- defining a holistic set of health and social interventions oriented around medical, social and personal understandings of recovery. For example, some care pathways/clinical guidelines set out recommendations for a range of social interventions in addition to medical treatments and interventions, helping to ensure a focus beyond (just) symptom alleviation. In Finland and the Netherlands, for instance, care guidelines for schizophrenia contain recommendations related to housing and supported employment.

For example, in almost all of the care guidelines reviewed by the OECD for the purposes of this work, there are clear expectations about the engagement of service users in the development of a care plan, while other guidelines go even further and set clear expectations about the engagement of their social networks, including service user's family, carers and loved ones (Table 1.1).

Table 1.1. Countries set clear expectations about service user involvement in decisions about their treatment, and pathways often recommend both social and clinical interventions

	Service user involvement ¹		Social interventions ²	
	Service user	Social network	Supported employment	Housing
Denmark ³	X	X	x	x
England	✓	Carers ⁴	✓	x
Finland	x	x	✓	✓
Germany	✓	Family, close confidants	✓	x
Netherlands	✓	Family, loved ones ⁴	✓	✓
Scotland	✓	Family, carers	x	x

Note: ¹ Refers to involvement in treatment decisions only. A number of countries separately recommend specific interventions for service users' social networks, such as family intervention. ² Recovery is a broad concept, the definition and experience of which can differ from person-to-person. There are a broad range of health and social interventions which may be necessary or useful to aide one's 'recovery'. Supported employment and housing are considered here to provide a cursory comparison of the recovery-orientation of care pathways and clinical care guidelines. However, broader forms of support might of course be necessary or desirable to facilitate recovery. ³ In Denmark, the clinical care guideline for schizophrenia does not set expectations about service user involvement, but does provide guidance to practitioners to support the involvement of service users in decisions about their care (such as decision aids which practitioners can use to discuss the potential benefits and risks of treatment with service users) ⁴ If the service user agrees.

Source: (Sundhedsstyrelsen, 2015); (National Institute for Health and Care Excellence, 2021); (Käypä hoito, 2020); (Deutsche Gesellschaft für Psychiatrie und Psychotherapie, 2019); (GGZ Standaarden, 2017); (Scottish Intercollegiate Guidelines Network, 2013).

16. Making care pathways and guidelines available to both service providers and service users could also help to promote person-centeredness by increasing transparency about the treatments and interventions to which service users are entitled. In some countries, such as the United Kingdom (England), the care pathway is explicitly oriented towards providers, service users and their support networks, whilst in other countries, such as Denmark and Germany, clinical care guidelines are oriented exclusively toward service providers. In other countries, such as Finland, the Netherlands and United Kingdom (Scotland), the care pathway is oriented somewhat more strongly to service providers, but separate and/or shortened versions of the guidance are also made available for service users.

17. Care pathways and clinical care guidelines should be as accessible and user-friendly as possible to facilitate their use in practice. Service providers in the Netherlands, for instance, have suggested that clinical care guidelines that were too long and difficult to navigate were rarely used in practice (OECD Virtual Expert Workshop - Lithuania, 2022). Additionally, the behavioural economics literature suggests that reducing the effort and complexity associated with a behaviour will make it more likely for that behaviour to be enacted (Behavioural Insights Team, 2015). Breaking down complex information into manageable 'chunks', and visualising information, can help to make it easier to process, understand and retain (Gobet, et al., 2001); (Eppler & Platts, 2009).

18. Finally, it must of course be noted that developing care pathways and more clearly defining responsibilities for care is not, in and of itself, a panacea – it will be critical to ensure that adequate resources and funding are available to ensure that providers are able to deliver on their defined accountabilities.

Recommendations – developing care pathways in Lithuania: an iterative approach

19. As outlined earlier in this section, there is significant potential for the development of care pathways and clinical care guidelines to drive mental health systems improvement in Lithuania, particularly given the heavy reliance on inpatient care, challenges with respect to care coordination, the limited availability of clinical guidance and known gaps with respect to the quality and outcomes of care. Well-defined care pathways could help to address some of these challenges and – in the context of a community care transition – could provide a valuable opportunity for stakeholders to come together to agree a vision for the mental health system.

20. Given the current state of development, and in light of resource constraints, an iterative approach to the development of care pathways and clinical care guidelines is recommended. The recommendations are as follows:

- a) **Clarify the roles and responsibilities of different levels of care providers and develop corresponding clinical care guidelines grounded in established best practice in mental health care.** Consideration should be given to ensuring that these set out the responsibilities of different levels of care providers, set out mechanisms for coordination, and are accompanied by relevant, measurable care standards.
- b) **Given resource constraints, prioritise the development of clinical care guidelines by potential impact** (for example, having regard to prevalence, resource demands and burden caused by the condition). There are two potential ways forward:
 - i. Given one of the foremost policy priorities of Lithuania's ongoing reform remains to reduce inpatient hospital use, and that service users with schizophrenia currently represent the group most frequently using hospital services, consideration could be given to starting with the development of a care guideline for schizophrenia, building on the set of practice guidance which already exists;⁵
 - ii. Alternatively, given there are currently few clinical care guidelines in Lithuania and that the process of developing these is not well-established, consideration could be given to starting with the development of a 'smaller', more contained pathway (at least in terms of the number of potential groups that would need to be involved) to test and iterate the approach. Consideration could be given to starting with a guidelines for eating disorders. Care for this group may involve comparatively fewer experts and groups than for schizophrenia.

⁵ The Description of the Procedure for Outpatient Treatment of Schizophrenia, Schizotypic and Delusional Disorders With Compensating Drugs (Order No. V-733, 2012) sets out guidance on the diagnosis of schizophrenia in outpatient settings, and outpatient treatment with medication. Lithuania could consider building on (and replacing) this procedure with a comprehensive treatment pathway and corresponding clinical care guideline for schizophrenia. This process would involve clarifying the roles and responsibilities of different levels of care providers, developing a corresponding guideline grounded in evidence-based treatments and interventions for schizophrenia, and developing accompanying care standards aligned to policy priority areas and areas of clinical significance.

- c) **Given resource constraints, take a pragmatic approach to the development of guidelines, and consider adapting international guidelines to the Lithuanian context.**
- d) **Once a clear patient path has been agreed, a pilot of the patient pathway should be conducted** before the approach is scaled up nationally.
- e) **Longer-term, consideration should be given to the development of comprehensive cross-sectoral health and social care pathways** that also set out mechanisms for cooperation between sectors.

2 Care Coordination

Introduction

21. Ensuring an integrated approach to assessing and addressing a wide range of service users' needs can be challenging – particularly for those with high and varied needs. Community care transitions can bring a new level of complexity to that challenge. While shifting mental health care from hospital to community-based care settings has the potential to improve the quality and accessibility of care, it can also raise challenges with respect to care coordination (OECD, 2021). As the network of care providers expands and becomes more complex, it becomes more challenging to coordinate care between multiple care providers to meet a diverse set of patient needs, and to ensure that patients do not drop out of touch with services at critical junctures.

22. Poor care coordination is associated with a range of poor health and social outcomes, such as increased risk of suicide and homelessness (OECD, 2021). Research also suggests that – when done well – effective care coordination can improve the quality and outcomes of care, and can contribute to a range of positive outcomes such as enhancements in care continuity, reductions in clinical symptoms and unmet needs, improvements in quality of life, and improvements in patient satisfaction (Tyler, Wright, & Waring, 2019); (Isaacs, Beauchamp, Sutton, & Kocaali, 2019); (Jones, Hannigan, Coffey, & Simpson, 2018). As mental health systems grow more complex, countries are increasingly searching for innovative and effective approaches to improve care coordination, configure service delivery around the needs of service users, and ensure that service users do not drop out at critical junctures.

23. Care coordination in Lithuania, as in other EU countries, is recognised as a major challenge. Interviews with service users and mental health experts highlight significant challenges around care coordination, and quality and outcomes data points to gaps in care continuity, particularly in the transition from hospital to community services. For example, Lithuania's somewhat high rate of repeat admissions to inpatient care, and high rate of suicide following discharge from inpatient settings, could point to challenges around coordination of care following discharge and/or in community settings more generally (Wijker, Sillitti and Hewlett, 2022). During OECD interviews conducted for the purposes of this project, several care providers and experts by experience echoed these challenges, suggesting that many patients are discharged from inpatient care without a care plan, recommendations, medication, or information about the support available to them (OECD Interviews, 2021). Improving care coordination will be critical to strengthening community-based mental health care in Lithuania.⁶

⁶ The focus of this section and the corresponding recommendations are predominantly, though not exclusively, on care coordination in the transition from hospital to community services.

Care coordination in Europe: approaches, opportunities, and challenges

24. The process of clarifying and defining clinical care pathways – including to clarify the roles and responsibilities of different levels of care providers – provides one mechanism by which to promote effective care coordination. The process of defining clinical care pathways should be used as an opportunity to set out mechanisms for coordination between different levels of care providers, and the process of doing so should also help to identify and pinch points that may need to be addressed. Section 1 deals specifically with the development of care pathways.

25. Beyond care pathways, a broad range of care coordination approaches have been trialled across OECD countries. While the ambition of coordinated and integrated care is a common one, the functions of care coordinators (what is being coordinated) and the goals of care coordinators (the challenges that care coordination is trying to address) vary considerably. Some care coordination approaches focus on specific care settings or critical junctures, such as improving the continuity of care in the transition from hospital to the community, whilst other models focus on coordinating care for specific patient groups, such as those with severe mental illness, or complex care needs. Some care coordination models also share features akin to case management (see Box 2.1).

Box 2.1. Defining and differentiating care coordination and case management

Care coordination and case management

Defining care coordination and case management is challenging because the functions, goals and activities of care coordinators and case managers vary and are not always clearly delineated, and the terms care coordination and case management are sometimes conflated or used interchangeably.

In this paper, **care coordination** refers to the process of identifying and assessing an individual's care needs, and coordinating and/or facilitating the provision of appropriate care services to meet those needs. It refers to a range of approaches to ensuring the provision of continuous and integrated care across settings.

The term 'case management' is contested, due to the pejorative implication that people with mental health conditions are 'cases' that require managing. Keeping this caveat in mind, what are generally referred to as '**case management**' services involve the co-ordination, integration and allocation of individualised care to meet a wide range of patient needs. There are a number of notable case management models, such as brokerage case management, intensive case management, and assertive community treatment (ACT). ACT is discussed in further detail in Section 4.

Service providers can have named care coordinators who are accountable for coordinating and/or integrating care across professionals, teams or sectors without necessarily adopting a named case management approach. Case management programmes often appoint a named care coordinator to provide individualised support to service users.

Care Plans

Care plans are individual plans for the care and treatment of service users. Care plans can facilitate care coordination by ensuring that everyone involved in a service user's care is provided information about the service user's needs, goals and treatments.

Source: (Hewlett & Moran, 2014); (Jones, Hannigan, Coffey, & Simpson, 2018); (Department of Health Western Australia) (Brophy, Hodges, Halloran, Grigg, & Swift, 2014); (Sonola, Thiel, & Kodner, 2013); (Isaacs, Beauchamp, Sutton, & Kocaali, 2019).

26. Two commonly-used approaches to improve care coordination across OECD countries are the use of named care coordinators, and written care plans. Peer support also has the potential to improve coordination (or at least engagement with services), and is becoming increasingly popular across OECD countries as a recovery-oriented service that has the potential to improve patient well-being, reduce relapse and decrease the burden on formal acute mental health services (Valenstein & Pfeiffer, 2018, cited in (OECD, 2021).

Care plans

27. Personal mental health care plans are one practical tool that can be used to facilitate care coordination, and ensure that service users' treatment meets their needs. Care plans can facilitate care coordination by ensuring that everyone involved in a service user's treatment is aware of the treatment that they should be receiving. Written care plans are also a useful tool for – and important record of – the care planning process that sits behind them. Effective care planning can help to ensure that service users' needs are comprehensively assessed and addressed, and that interventions are tailored to service user's needs and preferences. The collaborative development of a care plan between practitioner and service user also provides one avenue by which to ensure shared decision-making in mental health care.

28. Personal mental health care plans are used in most OECD countries (at least in some settings), and the majority of OECD countries require or strongly recommend service users' involvement in the development of care plans (OECD, 2021). Requirements and recommendations for the development of a care plan can vary depending on the care setting, the severity of illness, and the complexity of service users' care needs. While care plans tend to be more common for individuals with severe mental illness or complex health and social care needs, some countries recommend or require that a care plan is developed for all service users (Hewlett & Moran, 2014). In the United Kingdom (Scotland), for instance, all patients are entitled to a personalised recovery or care plan (Mental Welfare Commission for Scotland, 2019).

29. While a growing number of countries produce care plans in mental health care, research suggests that care plans are not always used to their full potential. For example, in many countries user involvement is required but does not always happen in practice (OECD, 2021). Research from several different countries has also found significant gaps between policy and practice in care planning. In Australia and the United Kingdom (Scotland and England), for instance, a number of different reviews with service users have found that care plans are not always developed in practice, and that where they are, service users are not always involved in their development (Brophy, Hodges, Halloran, Grigg, & Swift, 2014); (Mental Welfare Commission for Scotland, 2019); (Jones, Hannigan, Coffey, & Simpson, 2018). Consideration should therefore be given to levers that could prove useful to bridge the gap between policy and practice in care planning.

30. Countries have used different approaches to bridge the gap between policy and practice in care planning, for example by reducing the administrative burden associated with developing a care plan, or by providing guidelines or training for providers on their use. For example:

- In the United Kingdom (Scotland), the Mental Welfare Commission has developed a good practice guide for the development of care plans (Mental Welfare Commission for Scotland, 2019)
- In Australia, practice standards for clinical care providers have been developed with the aim of increasing informal carers' participation in care planning (Jones, Hannigan, Coffey, & Simpson, 2018)
- England has trialled attaching individual performance targets to the completion of care plans. However, it is worthwhile to keep in mind that qualitative research with care coordinators suggests it led some coordinators to perceive care planning as a 'chore' rather than a critical component of therapeutic care (Jones, Hannigan, Coffey, & Simpson, 2018)

31. Ultimately, while a range of levers can be utilised to encourage care planning, what is perhaps most critical is to ensure that those tasked with developing a care plan have the skills, resources and capacity required to do so.

Named care coordinators

32. Another commonly used approach to facilitating care coordination is the use of named care coordinators. Who performs the role of care coordinator varies across and within countries, and can vary depending on the care setting. Some care coordinators focus on specific care settings or critical junctures, whilst in other models care coordinators focus on coordinating care for specific patient groups. In Finland for instance, several health centres use a 'depression nurse' model. A physician conducts an assessment, develops a care plan, and then refers the patient to a nurse. The nurse plans, coordinates, implements and evaluates the treatment and medication set out in the care plan (Patana, 2014). In Norway and Denmark, GPs play a critical role in coordinating care. In Norway, for instance, GPs are considered the primary health contact for people with mild-to-moderate conditions, and sometimes also play a role in managing and coordinating care for some people with severe mental illnesses (OECD, 2014).

33. Several European countries designate named care coordinators in the transition from hospital to the community, which is a period of peak suicide risk, and a juncture where service users can drop out of contact with treatment. The European Psychiatric Association promotes the use of care coordinators (or at least, 'transition managers') for mental health service users being discharged from hospital on the basis that specific elements of case management – transition managers and timely communication between inpatient and outpatient providers – may have a positive impact on health and social outcomes such as quality of life and symptom severity (Gaebel, et al., 2020). Several European countries adopt this approach. In the United Kingdom (England) for instance, discharge coordinators are required to develop a written care plan collaboratively with service users being discharged from hospital (National Institute for Health and Care Excellence, 2016). In Denmark, transitional care is managed by a team of professionals (sometimes referred to as 'the patient's team'). Named coordinators from both inpatient and outpatient settings are jointly responsible for coordinating transitional care arrangements for service users being discharged from hospital (OECD Virtual Expert Workshop - Lithuania, 2022).

34. Finally, who performs the role of care coordinator can also vary depending on the needs of service users. Coordinating care for people with severe mental illness or complex care needs can be particularly challenging due to the complexity of needs and the range of services that require coordinating. Several countries have developed specific care coordination models – often tied to packages of support - for people with severe mental illness or complex care needs. For example in the United Kingdom (England and Scotland), the Care Programme Approach was an approach to coordinating care for people with mental health conditions, and complex care needs. In the CPA, care needs were comprehensively assessed and addressed in a written care plan, with service users allocated a named care coordinator and their care plan regularly reviewed (OECD, 2021). A number of evaluations of the CPA pointed to its potential to help keep service users in contact with the mental health system.⁷ Targeting more intensive and comprehensive care coordination packages to people with complex care needs can help facilitate manageable caseloads for

⁷ The United Kingdom (England) has recently signalled a shift away from the Care Programme Approach toward a more universal approach to care coordination that requires all service users in need of community mental health care to be assigned a named key worker (rather than a care coordinator) to assess and address service users' needs. The new approach – set out in detail in NHS England's Position Statement – also emphasises a multidisciplinary and team-based approach to addressing service users' needs, including through lived experience (peer support) roles (NHS England, 2021^[32])

care coordinators, and enable them sufficient time to build strong relationships across networks of professionals, teams and sectors (Sonola, Thiel, & Kodner, 2013).

35. Beyond ensuring that service users have access to a named care coordinator, it is also important to ensure that care coordinators are well-equipped to deliver on their role. Having a named care coordinator role in and of itself not enough to overcome structural barriers to coordination. There are a common set of factors that are often described as critical enablers of – or barriers to – effective care coordination, which typically fall within four key dimensions:

- People and culture – ensuring that care coordinators are adequately prepared for their roles, and that there are mechanisms in place to foster collaboration across settings (and across sectors, where care coordinators are tasked with cross-sectoral coordination)
- Accountabilities – ensuring that the roles and responsibilities of care coordinators are clearly defined, that coordinators have adequate authority to perform their roles, and that the boundaries of their role are well-understood by everyone involved in a service user's care
- Process – ensuring that there are supportive processes in place to lower the administrative burdens faced by care coordination (such as clear referral pathways and processes, or agreed mechanisms for coordination in critical junctures such as the transition from inpatient to outpatient care); and
- Information systems – ensuring appropriate mechanisms for information sharing between settings and sectors.

36. Evaluations of a range of mental health care coordination interventions in the United Kingdom, Denmark, the United States and Australia have highlighted challenges in the implementation of care coordination initiatives, suggesting that – in the absence of these supportive structures - care coordinators can face significant challenges manoeuvring complex systems and processes (Tyler, Wright, & Waring, 2019); (Hannigan, Simpson, Coffey, Barlow, & Jones, 2018); (Jones, Hannigan, Coffey, & Simpson, 2018).

Peer support

37. Peer support is increasingly popular as a recovery-oriented service that has the potential to improve engagement with services, improve patient well-being, reduce relapse and decrease the burden on formal acute mental health services (Valenstein & Pfeiffer, 2018, cited in (OECD, 2021). Peer support can take many forms. While peer support was initially premised on the idea of voluntary effort, it has led to the development of professional, funded positions in mental health care (OECD, 2021).

38. Peer support has been shown to be valuable and valued. An evaluation of peer support workers in Ireland found that all surveyed service users found peer support beneficial to their recovery (OECD, 2021) Peer support has also been suggested to decrease stigma within services. Evaluations of peer support pilots in both Sweden and the United Kingdom have highlighted the potential of peer support workers to contribute to cultural change amongst the mental health workforce, with staff reporting that peer supporters helped to reduce prejudice and change their perspectives with regard to mental ill-health (Swedish Partnership for Mental Health, 2018). These findings are consistent with the findings of the 2022 Lancet Commission on ending stigma and discrimination in mental health, which suggests that the most effective way to reduce stigma is to increase social contact between people with and without experience of mental health conditions (Thornicroft, et al., 2022).

39. While research on the cost-effectiveness of peer support remains nascent, a limited set of evidence suggests that peer support for people with severe mental illnesses can be cost-effective. An analysis of six studies conducted by researchers at the London School of Economics in 2014 suggested that peer support could help generate cost reductions in mental health care related to reduced inpatient use, and

fewer/shorter readmissions. Averaging the value of bed-days saved per peer support worker across the six studies, researchers suggested a potential return on investment of £4.76 for every £1 invested (Knapp, et al., 2014). A more recent (2016) and more conservative estimate by the National Institute for Care Excellence (NICE) in the United Kingdom (England) on the cost-effectiveness of peer support vs. treatment-as-usual recommended that group-based peer-delivered self-management training be considered for people being discharged from hospital as part of recovery planning (see **Error! Reference source not found.**). It is worthwhile noting, of course, that the effectiveness and cost-effectiveness of peer support will inevitably be driven in part by the type of peer support employed.

40. In the context of care coordination, peer support is potentially promising as a recovery-oriented approach to facilitating engagement with services. For example, the European Psychiatric Association recommends that people with lived experience of mental ill-health be included in teams for the community-based treatment of people with severe mental illness, on the basis that peer support may improve engagement with treatment (Gaebel, et al., 2020). Several countries, such as Canada and the United Kingdom (England) also recommend and/or use peer support specifically to strengthen the transition from hospital to community services (see **Error! Reference source not found.**).

41. If Lithuania were to actively promote peer support, one important consideration would be to ensure that peer support workers – and the teams that they will work in – are adequately prepared. A 2021 review of strategies to address peer support implementation challenges suggested that organisational commitment and preparation, effective recruitment and strong training and supervision for peer support workers is critical to the successful and sustainable implementation of peer support (Zeng & McNamara, 2021).

Recommendations

- 1) **Strengthen care planning by making more and better use of written care plans.** Ensure requirements and recommendations for the development of a care plan incorporate best practice, for example that care plans should be developed collaboratively with service users, and in consultation with the service user's carer or representative where the service user provides consent to do so. Ensure that everyone involved in service user's care is able to understand and use the care plan, including by building literacy around care plans, and by making sure the care plan is written in an accessible way.
- 2) **Ensure those tasked with assessing and addressing service users' needs in a written care plan have appropriate training, guidance, and support to do so.**
- 3) **Consider developing and iterating a template for best practice care plans in Lithuania** in collaboration with service user representatives and groups.
- 4) **Ensure service users have access to a named care coordinator in critical junctures, such as the transition from hospital to the community.** Ensure that supportive structures are in place so that care coordinators can deliver on their roles. Longer-term, consideration could also be given to implementing a specific care coordination programme for people with high needs, with service users provided access to a named care coordinator to comprehensively assess and address their needs in a written care plan.
- 5) **Consider promoting peer support in service delivery** to encourage person-centred care, and potentially improve engagement with treatment.
- 6) **Implement quality and outcome measures to provide an insight into the quality and effectiveness of care coordination and care planning.** Concrete suggestions for quality and outcome indicators are contained in Section 5 on quality and outcomes. Consideration could also be given to the introduction of qualitative monitoring alongside such indicators to provide insights

into the quality of the care plan and care planning process (i.e., ensuring there is some oversight to ensure that care plans are high-quality, developed in consultation with service users and regularly reviewed, beyond measuring simply whether or not a care plan exists).

- 7) **Address stigma and promote good mental health.** Stigma remains one of the most significant barriers to help-seeking and could play some role in service users dropping out of care in the transition from hospital to community. To improve outcomes for service users, measures to address stigma and promote good mental health should be bolstered. Formal modes of stigmatisation should be repealed as a matter of priority.

3 Scaling up Access to Talking Therapies

Introduction

42. Talking therapies are an effective and evidence-based intervention for a range of mental health conditions, from high prevalence disorders such as depression and anxiety, to conditions such as eating disorders, obsessive compulsive disorder, bipolar disorder and schizophrenia (OECD, 2021). Yet, psychological therapies remain inaccessible for many Lithuanians. The OECD's report on the provision of community-based mental health care in Lithuania highlighted a lack of systems capacity for the provision of talking therapies, and a heavy reliance on medication-based care (Wijker, Sillitti and Hewlett, 2022).

43. Increasing access to talking therapies is one way in which Lithuania could better look to meet mental health needs and improve care quality. Given that there is currently a heavy reliance on medication and little recourse to alternative treatments, it could also help to provide greater choice in treatment and deliver care that is more in line with service users' preferences. Psychological therapies have come to be well-recognised as an important tool for increasing treatment availability, improving recovery rates, offering choice and quality of treatment, and closing the treatment gap for common mental health conditions. Investment in evidence-based therapies is not just important from the perspective of an ethical imperative to close the treatment gap, but also hold potential to save health systems - and national economies - money in the medium to long-term.

44. While countries may need to make additional investments in scaling up access to talking therapies, there is a strong and persuasive argument that expanding access to psychological therapies, particularly for mild to moderate conditions, is cost-effective in the medium to long term. In the United Kingdom (England), France and Canada, the case for expansion has been made in part based on economic evaluations which suggest that the economic benefits of providing talking therapies in terms of improved employment outcomes and reductions in sickness benefits would outweigh the economic costs of providing them, such that scaling up access to talking therapies would eventually 'pay for itself' (Layard, Clark, Knapp, & Mayraz, 2007); (Dezetter & Briffault, 2016); (Vasiliadis, Dezetter, Latimer, Drapeau, & Lesage, 2017); (Knapp, Martin; Wong, Gloria, 2020).

45. While improving access to talking therapies could help close the treatment gap for mental health conditions, countries face common challenges ensuring appropriate resources are available to do so. While there are strong arguments that investments in scaling up access to talking therapies are cost-efficient in the medium to long term, increasing access nonetheless demands significant commitment and investment of resources.

Approaches to improving access to talking therapies

46. One way in which countries have sought to improve access to talking therapies is by adopting a stepped care approach to care delivery. Stepped care for mild-to-moderate mental health conditions has

been supported as a cost-effective approach with good outcomes by a wide range of clinical guidelines. In stepped care approaches, treatment starts with low intensity interventions, for example bibliographic self-help and multimedia self-help, and then rises in intensity in line with responsiveness to treatment and symptom severity, including for example one-to-one psychological therapy delivered by a specialist (Hewlett & Moran, 2014). The stepped care approach means that treatment intensity is scaled to need. This can reduce pressure on more specialised services by improving availability of low-intensity interventions.

Low-threshold interventions for people with mental distress

47. While many countries may need to invest to increase access to services, many people experiencing mental distress would benefit from low-threshold support such as internet and phone-based information and support, bibliographic self-help, guided self-help, community support. Low-intensity interventions such as bibliographic and guided self-help, peer support groups, and a range of new internet-based interventions can be effectively implemented with low costs, especially when backed with support from primary carers. For example, Australia has developed the [Beyond Blue website](#), which provides self-help material and easy-to-understand information around mental health and care. Information is provided both for people experiencing mental distress and for people whose loved ones are experiencing mental ill-health.

48. Some countries have invested in large-scale training programmes to facilitate the provision of more expansive low-threshold support. Finland, for instance, has sought to expand access to low-threshold support for people with mental distress through its 'Therapies to the Frontline' programme by providing training to practitioners (such as nurses, social workers, and school social workers) to deliver brief interpersonal counselling (3-8 sessions) to adolescents with symptoms of depression in primary care, including in schools (OECD Study Visit to Finland – Lithuania 2022). The government provided 53 million euros of funding in 2020-2021 to municipalities to roll out the programme for adolescents, and municipalities were provided discretion to select which professionals should be trained, based on three criteria, namely that professionals:

- are likely to reach adolescents with low threshold needs in their roles;
- are interested in taking part in the training; and
- had sufficient basic knowledge and skills needed to provide the interventions (Linnaranta, 2022).

In practice, professionals trained were primarily nurses, and some social workers (including school social workers).

Scaling up access to talking therapies for people with mild-to-moderate mental health conditions

49. Efforts to scale-up access to talking therapies include stand-alone schemes such as the Increasing Access to Psychological Therapies (IAPT) programme in the United Kingdom (England), as well as trials to reimburse talking therapies in France, and approaches to provide common behavioural therapies in primary care such as reimbursing practitioners and general practitioners to provide cognitive behavioural therapy (CBT), as is done in Norway (Hewlett & Moran, 2014).

50. In several countries – such as Finland and the United Kingdom (England) – the expansion of talking therapies has been supported by training programmes designed to upskill non-psychologists (such as nurses and social workers) to be able to deliver interventions. Given resource and skills constraints remain one of the primary challenges to increasing access, upskilling workers – for example by training nurses to be able to deliver lower-threshold interventions – could serve as a tool to expand access to treatment

(getting more people access to interventions) and as a tool to improve care quality for those already in contact with the treatment system (by reducing pressure on more specialised workers such as psychologists and psychiatrists, providing them greater capacity to deliver highly specialised interventions for those with more severe needs).

51. Both England's IAPT and Finland's Therapies to the Frontline programmes also stand out for incorporating routine outcome monitoring in service delivery. In Finland, all professionals were trained to use one nationally-accepted outcome measure – Patient Health Questionnaire (PHQ-9) for depressive symptoms – to measure the efficacy of treatment from intake to post-treatment. (OECD Study Visit to Finland – Lithuania 2022). In addition to one nationally defined measure for routine outcome monitoring, regular supervision and support were flagged as a critical success factor for the programme, and strong supervision structures were a dedicated focus of the training programme. Social workers had one dedicated contact in their care setting who they could meet with regularly, for instance, and had regular meetings with a supervisor (e.g. a psychiatrist) (OECD Study Visit to Finland – Lithuania 2022).

52. The United Kingdom (England)'s Increasing Access to Psychological Therapies programme similarly places considerable emphasis on training, supervision, and routine outcome monitoring – but was established instead as a stand-alone structure. IAPT also stands out for systematically including only therapies assessed as effective by the National Institute of Care Excellence (NICE), and for the use of a stepped-care model with lower intensity services delivered by a specifically trained non-psychologist workforce – notably by 'psychological well-being practitioners'.

53. While there is a strong argument that evidence-based psychological therapies are cost-effective in the medium to long-term, for many countries significant investments such as the one demanded by IAPT are not feasible (OECD, 2021). For other countries, it may be more realistic to extend care from an existing base. As outlined earlier in this section, for instance, some countries have sought to extend access from primary care, or to scale up access by reimbursing talking therapies.

Scaling up access to talking therapies for people with severe mental illness

54. Talking therapies are a critical component of the care pathway for the treatment of severe mental illnesses such as schizophrenia across many countries. In the United Kingdom (England), Denmark, Finland and the Netherlands, for instance, talking therapies such as CBT are recommended for patients with psychosis and/or schizophrenia (National Institute for Health and Care Excellence, 2021); (Sundhedsstyrelsen, 2015); (Käypä hoito, 2020); (GGZ Standaarden, 2017). Psychological therapies are increasingly also being used in acute care settings as a compliment to medication-based treatment.

55. Yet, scaling up access to talking therapies for people with severe mental illness is challenging for many countries, given the resources required to deliver these highly specialised types of therapies. Funding challenges and workforce shortages – in terms of workforce numbers and skills – are persistent in many countries and represent a particular challenge in Lithuania. While expanding capacity for low-threshold therapies can help divert demand away from the highly specialised workforce required to deliver these types of therapies – and in principle free up more of their time to deliver them – to effectively meet the demand for care, it is likely that countries will still need to invest in the care workforce. In both the Netherlands and the United Kingdom (England), for instance, efforts to increase access to psychological therapies for people with severe mental illness have involved:

- Upskilling the existing workforce, for example by providing training for non-psychologists to be able to deliver talking therapies to people with mild-to-moderate conditions, in principle leaving workers with highly specialised skills more time to spend providing talking therapies to people with SMI; and

- Investing in the workforce, including by investing in education and recruitment of those with highly specialised skillsets.

Recommendations - avenues to improve access to talking therapies in Lithuania

56. **Ensure access to appropriate mental health care for the whole of the population**, including by increasing capacity to deliver talking therapies for all segments of the population. Given significant resource constraints, a pragmatic way forward would be to start small and iterate.

57. As a starting point, Lithuania should look to **scale up access to talking therapies for people already in contact with the mental health care system**, for example people with moderate depression and anxiety.

58. To do so, Lithuania could develop a talking therapies offer within its existing care structure by **piloting a moderate mental illness team in primary mental health care centres**.

59. Longer-term, if the pilot proves successful, in principle people with SMI could be referred to the same structure, but this would require additional investments in resources and training.

60. Lithuania should **consider monitoring access to talking therapies as part of national performance indicators, for example by measuring access, waiting times and/or resources** (e.g. numbers with competences/skills to deliver, or FTE employed). Quality and outcome measures related to psychological therapies are discussed in further detail in Section 5 on Quality and Outcomes.

4 Assertive Community Treatment

Introduction

61. Experiences of severe mental ill-health can be very difficult to manage, both for those who experience them, and from a service delivery perspective. People living with severe mental illness are at particular risk of experiencing persistent symptoms and more frequent episodes and are, therefore, more likely to require access to more intensive forms of support, and experience fluctuations in their mental health and care needs. Engagement in and adherence to treatment can also be incredibly difficult to manage (Hewlett & Moran, 2014).

62. Meeting these needs in the community can be challenging. While the transition from hospital to community-based settings can improve the quality and accessibility of care, the shift from institutional to community care poses particular challenges for people with severe mental illness, who might historically have made more use of intensive hospital-based services, and who may face challenges utilising 'standard' outpatient services. In a number of countries, for instance, 'standard' outpatient services tend to exclude service users after a certain level of non-attendance, despite the fact that negative and positive symptoms can make it challenging for service users to keep appointments.

63. Several different outpatient care models have been developed to meet these challenges, and to provide a congruent approach to meeting the complex care needs of people with severe mental illness in community-based care settings (OECD, 2021). Case management and variants of case management such as Assertive Community Treatment have been widely trialled across OECD countries as one such approach (see Box 4.1).

64. Lithuania committed to piloting ACT from the beginning of 2023 to improve community-based care for adults with severe mental illness, and to reduce reliance on hospital care. This section sets out the OECD's recommendations with respect to the implementation of a pilot of ACT in Lithuania, with reference to OECD's analysis of the provision of community-based care in Lithuania (Wijker, Sillitti and Hewlett, 2022), evidence on the effectiveness and cost-effectiveness of ACT, and critical enablers for the successful implementation of ACT identified through the OECD's review of best practices (April 2022).

Box 4.1. Community care models: case management, assertive community treatment and intensive case management

Case management has become somewhat of an umbrella term to refer to a wide range of practices based on the simple principle that a case manager – or case managers – take a comprehensive and individualised approach to assessing and addressing citizens' needs. Case management models typically aim to improve outcomes, maintain engagement with services, and reduce hospitalisation (and therefore healthcare costs) (Dieterich, Irving, Park, & Marshall, 2010).

Case management

In this paper, following Dietrich et al. (2010), '**Case Management**' (**CM**) refers to a range of typically non-intensive case management services where one person – a case manager – is responsible for managing community-based care for a defined group of citizens. Case managers are typically responsible for assessing the needs of citizens, developing a care plan, ensuring that the care plan is implemented, and maintaining contact with the citizen.

Assertive community treatment

'**Assertive Community Treatment (ACT)**' is an intensive clinical case management model that emphasises a multi-disciplinary and team-based case management approach to meeting the needs of citizens. ACT teams are characterised by low and shared case-loads, regular contact with citizens, a focus on 'in-vivo' care (the provision of care at home or in the community, rather than an office), daily meetings and 'assertive' methods, in that service providers take a proactive approach to engaging and maintaining citizens in treatment. ACT teams typically aim to be the primary providers – rather than coordinators – of clinical care, and focus on improving outcomes and promoting independent living by delivering care and psycho-education as close as possible to the service user. Alongside these elements, some of the key components of ACT are:

- A focus on improving both social and clinical functioning, for example in social relationships and employment
- The development and periodic review of a comprehensive care plan
- The provision of continuous care across care settings, and over time; and
- The provision of direct support with management of symptoms (and often a focus on medication management).

Low caseloads are designed to facilitate the provision of intensive support – particularly in response to crisis – to avoid admission to inpatient care where possible (Kent & Burns, 2005).

Intensive case management

Intensive case management evolved from assertive community treatment and case management (OECD, 2021). The term '**Intensive Case Management**' (**ICM**) is typically used to refer to case management services with small caseloads (e.g. caseloads <20) and 'intensive' (high-intensity) services. The terms ICM and ACT are sometimes used interchangeably, but are typically distinguished where ICM does not employ one of the key features of ACT (Dieterich, Irving, Park, & Marshall, 2010); (Simpson, Miller & Bowers, 2003).

Source: (Simpson, 2003); (Dieterich, Irving, Park, & Marshall, 2010); (Kent & Burns, 2005)

Assertive Community Treatment: evidence and innovations

65. Assertive Community Treatment (ACT) has been trialled or implemented in several European countries, including the United Kingdom (England), Denmark, Finland, Norway, Sweden, Switzerland and - very recently - Greece (albeit in a hybrid form) (Peritogiannis & Tsoli, 2021).

66. ACT practices vary across Europe, highlighting the critical importance of adapting ACT to local contexts. While core components of ACT are well-established in the literature (see Box 4.1), the OECD's review of best practices in community-based care highlighted that the implementation of ACT has varied across countries due to national context (such as population density), system-specific features and resource constraints. For example, the stated aims, target group and catchment area, staff composition and working hours of ACT teams vary across countries.

*There is evidence that ACT can be effective, but it is mixed*⁸

67. Available evidence suggests that:

- a) **There is moderately good evidence that ACT improves engagement and satisfaction with services – at least for so long as citizens use those services**
- b) **There is evidence that ACT can improve symptoms and social functioning, at least for so long as citizens are using ACT services**⁹
- c) **While there is mixed evidence on the impact of ACT on hospital use in Europe, ACT appears more effective in reducing hospital use when hospital use is high.** Several reviews have sought to identify the 'critical ingredients' of ACT (Bond & Drake, 2015); (Dieterich, et al., 2017). Both reviews concluded that ICM is most effective at reducing hospitalisation in contexts with high baseline rates of hospitalisation.¹⁰ While not directly equivalent to ACT (as the review also included non-ACT ICM interventions), these findings have been taken to mean that ACT appears most effective in reducing hospital use when hospital use is high (Burns, Tom, 2010); (Thoegersen, Morthorst, & Nordentoft, 2019).
- d) **The structural and organisational features of ACT appear to play some role in reducing hospitalisation.** The systematic reviews and meta-regressions outlined above also assessed the relationship between fidelity to components of the ACT model, and reductions in hospital use, with the findings suggesting that interventions are most effective in reducing time in hospital when organised in accordance with the structure and organisation sub-scales of the ACT model (Burns, et al., 2007); (Dieterich, et al., 2017).. Authors in both systematic reviews found an association between fidelity to the 'organisation and structure' sub-scale and hospital use, namely whether teams:
 - Are the primary source of care for patients
 - Are situated away from the hospital

⁸This review focused primarily, though not exclusively, on the impact of ACT on hospital use, given the Lithuanian Ministry of Health's focus on reducing hospital use

⁹ It will nonetheless be important to monitor the results of the pilot and adjust accordingly as needed, as evidence for some countries has been mixed

¹⁰ High level of hospitalisation were defined as about 6 days per month in the past 2 years (in the most recent systematic review, with 0.2 days per month gained out of hospital by every day increase in hospital per month in the preceding two years) (Dieterich, et al., 2017)

- Meet daily
 - Share responsibility for caseloads
 - Are available 24 hours per day (if access to the team is triaged through a community team, interventions receive a lower fidelity score)
 - Have a team leader who is also a case manager; and
 - Offer unlimited time for services.¹¹
- d) **On the other hand, very low caseloads and specific staffing configurations do not appear to have a discernible impact on rates of hospitalisation.**

68. To summarise, it would seem that adherence to some of the specific methods of ACT are more important than others in terms of reducing hospital use. The finding that strict adherence to some of ACT model's more expensive features – very low caseloads and specific staffing requirements – is not associated with reductions of hospital use is of particular relevance for the Lithuanian context given known resource constraints.

69. However, the suggestion that team size is not associated with reductions in hospital use should not be taken to mean that the size of the team does not matter at all. For example, if teams are providing services for the most 'severely ill,' or those with highest needs, and case managers anticipate visiting service users several times a week (for example in line with a 'pure' ACT approach), individual caseloads would likely need to be lower than if teams are providing services to people with a broader spectrum of needs (for example all people with severe mental illness, as is done in some Dutch FACT teams, where there may be less people who require high intensity services). As a point of reference:

- **ACT** – in the pure ACT model caseloads are 1:10 (though in practice this can be closer to <1:15), with very intensive services provided only to the most 'severely' ill, and these low caseloads facilitating this very intensive form of support. The total team case load could run around 60-100, for instance, with care for all of those service users managed on the ACT 'board'
- **ICM** – in ICM more generally, caseloads are <1:20 - these are typically service models explicitly based on ACT but could also include other forms of ICM which don't necessarily share all of the features of ACT, and could be slightly less 'intensive' at least in terms of the time required by staff per service user
- **FACT** – the recommended caseload is 1:25, meaning a total team size of, for example, 220-250. Only a fraction (e.g. 20-30) will require daily care and attention and be 'on the board'. I.e., the caseload can be higher because some service users will require less intensive support.

While the evidence does not provide a straightforward 'answer' on optimal caseloads, one practical approach could be to look at the needs mix of the service users that are intended to be included in ACT teams, and adjust caseloads accordingly.

¹¹ The authors of the fidelity scale have suggested a number of factors that can increase fidelity on this sub-scale, and might therefore increase the likelihood of reducing hospitalisation. These are outlined in further detail in Chapter Annex B

Service providers have also highlighted several challenges with the ACT model, and new variants of ACT are emerging to meet those challenges

70. While the evidence base sheds some light on the ‘critical ingredients’ of ACT and ICM, service providers have also begun to shed light on some of the strengths and challenges of the ACT model. Service providers in several countries have raised two common challenges with ACT, namely:

- a) **It can be challenging to upscale or downscale care in line with service users’ needs, and some mechanism is required to accommodate fluctuations in the intensity of needs.** Service providers have highlighted that a rigid separation between ‘standard’ community care and ACT services posed challenges in circumstances where symptoms worsened, leading to a need for admission and a higher reliance on inpatient care. This challenge works both ways:
- In terms of ‘upscaling’ care from community teams - for example in community mental health teams utilising case management approaches, where citizens required care more than weekly, managers faced challenges with caseloads; and
 - In terms of ‘downscaling’ care from ACT teams to less intensive forms of support – service providers in a number of countries have raised challenges both in terms of determining the optimal time to transition service users to less intensive services and in terms of managing the transition.

Service providers in Denmark and the Netherlands have suggested that some mechanism to accommodate fluctuations in needs is necessary, and co-location or integration between ACT and community mental health teams has been explored in part to address this challenge (OECD Study Visit to Denmark – Lithuania 2022 and virtual Study Visit to Netherlands – Lithuania 2022).

- b) **Service providers in some countries have found ACT not to be particularly well-suited to rural areas because the number of users who require intensive mental health services is too low – i.e. there is no “critical mass”** (Bond & Drake, 2015). In the Netherlands, some providers reported that it was not possible to implement full ACT teams in rural areas given low population numbers. In particular, service providers envisaged challenges implementing ACT teams that would cover several rural areas given how much travel time would be required, and that there would be challenges with care continuity (van Veldhuizen, 2007). There appears to be a consensus emerging in the literature that ACT is not particularly well-suited to – or at least challenging to implement in – rural areas (Burns, Tom, 2010).

71. Variants of ACT such as flexible assertive community treatment (FACT) have emerged in part to address these challenges. Both ACT and FACT are characterised by a multi-disciplinary, team-based approach to care with low caseloads and intensive support, but FACT effectively merges ICM and ACT (see Box 4.2).

Box 4.2. Flexible Assertive Community Treatment (FACT)

FACT teams effectively 'merge' ACT and ICM teams, so that any citizen in a FACT team receives either ACT (the most intensive services) or ICM (slightly less intensive services), depending on their needs. FACT emerged in the Netherlands and, in the Dutch model, 7-8 individual case managers working in multi-disciplinary FACT teams work with caseloads of around 20 patients who are receiving either 'regular' (ICM) or 'intensive' (ACT) care:

- Most citizens with severe mental illness (SMI) receive regular care from an individual case manager (estimated to be 80% of those with SMI in the Netherlands). The citizen's individual case manager will visit 2 – 4 times per month and is responsible for needs-led care planning
- Citizens experiencing a worsening of their symptoms receive intensive care (ACT) via a team-based approach (estimated to be 20% of those with SMI in the Netherlands) – if a citizen on any individual case managers' caseloads experiences a worsening of their symptoms – or is at risk of relapse or readmission – citizens are placed on the 'FACT board,' and case management is conducted by the team. The citizen keeps their 'primary' case manager but can meet with representatives of the whole team.

Source: (van Veldhuizen, 2007); OECD Study Visit to Denmark – Lithuania 2022; OECD Study Visit to the Netherlands (virtual) – Lithuania 2022

72. The Dutch model has inspired the development of FACT in several European countries. FACT has become increasingly popular over the past two decades, with a number of European countries – Denmark, the Netherlands, Sweden and Norway, for instance – shifting to the delivery of FACT to varying degrees (Odden, et al., 2019); (Svensson, Hansson, Markström, & Lexén, 2017) in some cases replacing ACT, and in other cases supplementing ACT teams.

73. However, while FACT teams are now operating in a number of countries, evidence on their effectiveness, and cost-effectiveness remains limited, in part due to its recent implementation (Norlander & Nordén, 2015); (Veldhuizen, Delespaul, Kroon, & Mulder, 2015).

The Lithuanian context: key considerations

74. In a nutshell, evidence on the effectiveness of ACT on reducing hospital use is mixed, though there is relatively good evidence that ACT improves engagement in, and satisfaction with services. ACT appears most likely to be effective when targeted to people with high baseline rates of hospitalisation, and when care is organised in line with the 'organisation and structure' sub-scale of the ACT model (though the organisation of care seems to be less important than baseline rates of hospitalisation). ACT appears not to be particularly well-suited to rural areas, and consideration needs to be given to the interaction between ACT and lower-threshold services (i.e. how fluctuations in intensity of needs will be managed and how the interaction of services will be managed).

75. OECD's review of the provision of community-based mental health care in Lithuania noted a heavy reliance on inpatient care with a relatively high rate of beds, high number of admissions, and a somewhat high rate of repeat admissions (Wijker, Sillitti and Hewlett, 2022). At a very surface level, therefore, it seems that ACT targeted to people with high hospital use and organised in accordance with the organisational sub-scale of the ACT fidelity scale could reduce hospital use in Lithuania. ACT could also improve engagement in and satisfaction with treatment in Lithuania. These strengths are significant, and not to be under-stated.

76. However, there are several significant challenges with respect to the implementation of ACT or variants of ACT in Lithuania:

- a) **ACT is a resource intensive service, and there are significant (financial and human) resource constraints in Lithuania.** There are significant resource constraints, with low levels of spending on mental health care (as a share of total health spending), and persistent workforce constraints – suggesting that a high-cost and high-intensity service such as ACT may be challenging to implement. Careful consideration of a low-cost approach to implementation might therefore be warranted.
- b) **ACT is predominantly a mobile service that is not well-suited to sparsely populated areas.** Lithuania is a country with a relatively small population and relatively low (and declining) population density, making the design and implementation of ACT challenging.
- c) **Lithuania has made significant investments in the delivery of an expansive network of multi-disciplinary primary mental health care centres across the country, but these are resource constrained. There is a strong argument to be made for expansion from this base, and a risk that ACT diverts resources away from these centres, or means that there are duplications in service provision.** These multi-disciplinary centres currently deliver the bulk of community care for people with severe mental illness, but lack of capacity leads to referral to inpatient care where community care could likely treat if they were sufficiently resourced and funded to do so (Wijker, Sillitti and Hewlett, 2022). There are two implications relevant to the decision on ACT:
 - a. Given known resource constraints, the significant investment that has been made in the PMHC structure, that the organisational features of ACT appear to contribute to reductions in hospital use, and that it is unclear whether ACT continues to offer benefits over and above well-resourced and high-functioning CMHTs, it should be carefully considered whether it would be more useful, more effective, more cost effective, and/or better from a long-term strategic perspective to strengthen PMHCs to be able to deliver intensive forms of support organised in line with the components of ACT for which there is better evidence (that is, co-locating or integrating ACT teams into PMHCs), rather than developing a separate ACT structure. This question is particularly pertinent given PMHCs are already in principle configured to deliver multidisciplinary care, and configured to be able to deliver some of the core aspects of ACT, such as outreach¹²; and
 - b. Irrespective of that decision, given a growing consensus in the literature that it would be neither recovery-oriented nor cost-effective for citizens to access ACT indefinitely Lithuania will, in any event, need to strengthen the capacity of these centres to ensure a sustainable and congruent approach for the long-term community care of people with severe mental illness. In the absence of such an approach, there is a high risk that people who ‘graduate’ ACT are ‘graduated’ to services that do not have the capacity to provide the necessary support, sustaining a heavy reliance on hospital care or a ‘revolving door’ to hospital services.

In the context of the upcoming pilot, these decision points should be weighed carefully. A short-term pilot could well find positive impacts on hospital use and other outcomes, but that should not be taken to mean that those outcomes will be sustained when citizens are ‘graduated’ to less-

¹² Lithuanian legislation already caters for the reimbursement of home visits by both psychiatrists and mental health nurses (Order No. V-943, 2005) albeit for people with a disability (people where a need for ‘permanent care’ has been identified).

intensive services, and it should not be taken to mean that similar outcomes could not be delivered by high-functioning – and likely lower-cost – CMHTs (lower cost in terms of higher case loads, fewer staff or fewer visits, for instance). This is a difficult decision, as the answer is not immediately clear based on the available evidence; and

- d) **Additionally, there are significant challenges with care coordination, particularly in the transition from hospital to community care.** The implication in the current context is that particular attention would need to be paid to the discharge from ACT to less intensive community services. Given current evidence suggests that it may be beneficial for ACT services to be located away from hospital, and given there are significant challenges with care coordination, consideration should be given to co-location of ACT services with the services that will deliver the bulk of care to the target group in the long-term (likely PMHCs given that is where the bulk of community care for people with severe mental illness is currently delivered).

Recommendations

77. It is clear from the discussion above that there is no easy or perfect solution to the implementation of a pilot of ACT in Lithuania. Considering the available evidence and the Lithuanian context, on balance:

- a) **Consideration should be given to the long-term development of services in Lithuania**, and the appropriate balance of investment in ACT services and less intensive community-based services.
- b) **For the pilot of ACT**, it would be important that:
- ACT is targeted to those with histories of high hospital use
 - ACT teams work in catchment areas which enable them to be the primary providers (rather than brokers) of care
 - ACT teams are organisationally anchored in PMHCs, either as separate teams based out of PMHCs (in areas assessed as having the highest need) or by strengthening the outreach and assertive case management capacity of existing teams. Co-location or integration could help to prevent and address coordination challenges in Lithuania.
 - ACT teams could enter into co-operation agreements with municipalities to support the provision of integrated medical and social services for those who need them, particularly given reports from care providers that there is a need to build bridges between medical and social support in Lithuania (Wijker, Sillitti and Hewlett, 2022). This could enable the integrated delivery of mental health and employment support, for instance (as is the case in Denmark, where municipal employment officers can provide consultative services, albeit on a part-time basis).
 - An effective or alternate approach to the delivery of ACT is explored for rural areas.

5 Quality and Outcomes

Introduction

78. Quality and outcome measures are critical to understanding and improving the quality of mental health care, and to driving mental health systems performance. They provide important insights into whether care provided makes a meaningful difference to the lives of those who access it, and whether care is an effective use of resources.

79. Yet, the quality and outcomes of care have proven challenging for many OECD countries, both to measure and improve (OECD, 2021). Lithuania is no exception in this regard. OECD's review of the provision of community-based mental health care in Lithuania highlighted that greater focus is required to monitor and improve care quality, given:

- a) There are few quality and outcome measures in use in Lithuania that could provide insight into the quality, accessibility and efficacy of the care that is provided, or the impact of ongoing mental health reforms. There is currently one national-level quality indicator for mental health care, namely a quality indicator for primary mental health care centres on the rate of avoidable hospitalisation for service users with schizophrenia. This quality indicator is attached to an upside-only financial incentive – a 'pay-for-performance measure' – whereby primary mental health care centres can receive additional compensation for 'good performance' on this indicator.¹³ While introduction of the measure has been followed by some improvement in the reported rate of avoidable hospitalisation, the breadth and depth of quality measures should be expanded to provide a meaningful insight into care delivery, and to help identify opportunities for improvement;
- b) Quality and outcomes data points to gaps in care quality, and interviews with service users highlight limits to how person-centred the system currently is; and
- c) There are currently few service improvement mechanisms in place, and few mechanisms to enable service users to inform and evaluate mental health policy, practice and evaluation.

80. Given gaps in the tools available to understand and improve the quality of mental health care, OECD's review recommended that more use be made of quality and outcome indicators to set, track and evaluate mental health policy and care delivery. The focus of this section is on providing concrete suggestions for doing so.

¹³ A full explanation of the pay-for-performance measure is set out in the [OECD Health Working Paper on the provision of community-based mental health care in Lithuania](#) (2022)

Measuring care quality and outcomes: what to measure, and how to use data to drive improvement

81. Given a historic gap in the availability and comparability of meaningful mental health data, there has been increasing focus on defining and measuring mental health and mental health systems performance at international and national levels.

International measures of quality and outcomes

There are a range of internationally-defined and internationally-comparable indicators of care quality and outcomes for mental health care:

1) OECD's Health Care Quality and Outcomes indicators

The OECD's Health Care Quality and Outcomes (HCQO) data set contains mental health indicators with respect to patient safety and care quality, including indicators on:

- In-patient suicide among patients diagnosed with a mental disorder
- Suicide within 30 days and 1 year after discharge for patients diagnosed with a mental disorder (two separate indicators); and
- Excess mortality for patients diagnosed with schizophrenia and bipolar disorder (two separate indicators).

Lithuania already provides data on every indicator except the indicator on in-patient suicide, where data has not been available since 2020.

2) A New Benchmark for Mental Health Systems performance indicators

In 2021, the OECD published *A New Benchmark for Mental Health Systems*, setting out a framework to define and assess mental health system performance. The indicators were developed through a broad and participatory process with international mental health experts, including a full data feasibility exercise. The framework sets out six key principles for understanding mental health systems improvement, recognising that a high-performing mental health system:

- Focuses on the person who is experiencing mental ill-health
- Has accessible, high-quality mental health services
- Takes an integrated, multi-sectoral approach
- Prevents mental illness and promotes mental wellbeing
- Has strong leadership and good governance
- Is future-focused and innovative.

The Benchmark sets out a series of performance indicators in line with each performance domain. In addition to the HCQO indicators outlined above, this includes indicators on:

- The use of care plans in mental health care (whether care plans involve service users and carers or representatives)
- Patient-reported outcomes of mental health care and patient-reported experiences of mental health care (including the share of people with a mental health problem who reported being treated with courtesy and respect by doctors and nurses during hospitalisation)
- Repeat admissions to inpatient care (3 or more times in 1 year, %)

- Coercion in mental health care (absolute number of patients placed in seclusion or restraint per annum)
- The share of service users who receive a follow-up after discharge within nationally mandates or recommended timelines; and
- The availability of talking therapies (whether primary care providers provide talking therapies).

3) **OECD Council Recommendation on Integrated Mental Health, Skills and Work Policy**

The OECD Council Recommendation on Integrated Mental Health, Skills and Work Policy – to which all OECD countries are adherents - recommends that countries measure employment and educational outcomes of people with a mental health condition in national quality frameworks.

Employment and educational rates of people with mental distress were reported in *A New Benchmark for Mental Health system*, including data for Lithuania.

4) **Patient-reported outcome and experience measures**

Since publication of *A New Benchmark for Mental Health System*, the OECD has been supporting countries to pilot patient-reported outcome and experience measures (PROMs and PREMs) for mental health care, to provide internationally comparable insights into service user's experiences and outcomes of care. PROMs and PREMs could be used as a tool for self-management, can facilitate clinical dialogue to support shared decision-making and patient-centred care, and provide a concrete tool to incorporate service user voice in evaluating and planning mental health policy and service delivery, with the ultimate goal of improving the quality and efficacy of care.

Lithuania does not currently routinely collect or report on patient-reported outcome and experience indicators.

National measures of care quality and outcomes

82. At a national level, an increasing number of indicators are used across OECD countries to measure the quality and outcomes of mental health care. While mental health system indicators have long been limited to 'inputs' such as numbers of hospital beds or service contacts, there is growing recognition that a broader set of quality and outcome indicators are necessary to provide a meaningful measure of whether or not care is effective and high-quality. The indicators operationalised to measure quality and outcomes vary across OECD countries, in part due to:

- national alignment to strategic and priority policy areas / areas of clinical importance
- variations in data capacity and availability; and
- variations in measures and standards of clinical care quality.

83. Lithuania already has rich sources of administrative data which could be better used to track and inform policy and service delivery. Without expanding existing data capacity, Lithuania could already make more use of quality and outcome indicators to set and track mental health policy. Lithuanian mental health experts have previously convened working groups to research, agree and pilot a range of quality and outcome indicators that could be implemented using existing administrative data. The working group developed a framework of quality indicators covering a range of quality domains, including measures on the use and length of use of medication, the availability of psychotherapy, patient employment outcomes, and communication between providers, amongst others, most of which could be disaggregated by age, gender, geography (urban/rural) and diagnosis (OECD Interviews, 2021). Of particular relevance some of the priority areas discussed in this report, the group identified:

- Indicators on the continuity of care following discharge from hospital, including those considered to be at high risk of suicide (e.g. % of service users who visit a mental health centre within 30 days of being discharged from hospital, % who continue outpatient care for a designated period of time following discharge from hospital) – of particular interest in the Lithuanian context given known challenges with care coordination;
- Indicators providing insight into the range of treatments and interventions available to - or at least accessed by - service users (e.g. % of service users with various mental health conditions who receive only medication at mental health care centres) – of particular interest in the Lithuanian context given the heavy reliance on medication-based care and the limited availability of psychotherapeutic care; and
- Indicators on the continuity of treatment (e.g. clinical indicators on the % of service users with depression who continue antidepressant treatment for a certain period following first contact).

84. A set of quality and outcome indicators should be agreed in consultation with key stakeholders, and routine collection and reporting of these indicators to track quality and outcomes across regions and over time would be beneficial. When agreeing quality and outcome indicators, it will also be important to consider how quality data could and might be used to facilitate service improvement, and how national, clinical and individual-level measures of care quality can be aligned to ensure they pull in the same direction. An approach to doing so is outlined in further detail below.

85. Data availability and data quality will undoubtedly guide the initial set of indicators agreed to monitor quality and outcomes, so consideration should be given to adopting a pragmatic and iterative approach. Such an approach could involve agreeing a set of indicators that are pragmatic (i.e. making best use of the data that is already available) and aspirational (i.e. indicators that should be collected but are not yet available within existing data collections). Countries can and do take such a pragmatic and iterative approach to improving mental health data. In the United Kingdom (Scotland) for instance, the Quality Indicator Profile (QIP) was developed through extensive stakeholder consultation that formed agreement on a set of ‘pragmatic’ and ‘ambitious’ indicators – consolidating data that was already being collected, and setting out goals to commence new data collections on a range of indicators. Roll-out of the QIP was staggered accordingly, with measurement and reporting beginning on the indicators for which data was already available, while government bodies and service providers now work together to advance collection of the uncollected/uncollectable indicators (OECD Study Visit to Scotland – Virtual - Lithuania 2022).

86. National, provider-level and individual-level measures of quality and outcomes should be aligned so that they pull in the same direction. How countries approach this alignment varies (see Table 5.1).

Table 5.1. National, clinical, and patient-reported measures of quality and outcomes in selected countries

	England	Denmark	Finland	Scotland
National-level measures of care quality and outcomes <i>(cross-cutting ‘system’ metrics)</i>	NHS Mental Health Performance Dashboard	Danish Health Care Quality Goals	National Mental Health Strategy	Quality Indicator Profile for Mental Health
Clinical measures of care quality and outcomes <i>(aligned to condition or thematic area)</i>	Care standards (embedded in guidelines)	Clinical quality databases (based on guidelines)	Quality of care register for nonaffective psychotic disorders	Guidelines only – under development
<i>Example</i>				
Patient-reported experience and outcome measures	PREMs (via Community Mental Health Survey, Care Quality Commission)	PROMs (nested in clinical quality registries for	-	Indicator on quality of life, in Health and Care Experience Survey

Note: The reviewed countries were selected by the Lithuanian Ministry of Health, in consultation with the OECD team

Improving care quality and outcomes

87. Quality and outcomes data can be used to support mental health systems improvement. There are a range of levers that can be attached to quality and outcomes data to drive improvement, though it is important to ensure that the focus remains on establishing a culture of continuous improvement. That is, quality and outcome measures should include:

- Safety and quality measures which set a minimum acceptable standard of care; and
- Quality and outcome measures over and above this ‘minimum’ acceptable standard, where the focus is not on ‘punishing’ providers for failing to meet a particular target, but fostering a culture of continuous improvement by identifying opportunities for improvement, identifying and sharing best practices, and proactively collaborating to improve the quality and outcomes of care.

88. Bearing this in mind, there are a range of levers that countries attach to quality and outcome measures to drive mental health systems performance and improve care quality.

- a) Transparency and benchmarking – making quality and outcome data publicly available can serve as an accountability tool and can help to drive care quality, particularly where it is published in a manner that enables constructive comparisons of performance across regions and/or providers. In England and Denmark, for instance, performance data is regularly made available at a regional level (NHS England, 2022); (Danish Ministry of Health, 2018)
- b) Quality improvement bodies and projects – quality and outcome measures can help to identify opportunities for improvement and areas of best practice, which can inform quality improvement projects at national, organisational and professional levels. In Denmark, for instance, professional boards for clinical quality registries analyse clinical data, which can help identify areas for improvement.
- c) Governance mechanisms to improve care quality – in a number of countries, there are national and sub-national governance forums to monitor care quality and safety, and drive improvement. For example in Denmark, there are ‘adverse learning events’ – forums supported by regional management information – where regional representatives gather to discuss adverse events which impact mental health outcomes related to topics such as medication, clinical samples, care and treatment and coordination. The focus is explicitly on learning, rather than punishment, to encourage a collaborative approach to driving improvement.
- d) Financial incentives – countries have trialled aligning quality and outcome measures to financial incentives. In United Kingdom (England), for instance, there is a Quality and Outcomes Framework (QoF) which serves as a pay-for-performance scheme for GPs. NICE has recommended that the QoF includes an indicator on the percentage of patients with certain severe mental health conditions who have a comprehensive care plan documented on record in the preceding 12 months, with the involvement of the service user and their family or carers (NICE, NICE Quality and Outcomes Framework indicator). However, evidence on the use of incentives in health care, and mental health, is mixed (OECD, 2016).
- e) Alignment to scrutiny and assurance – aligning measures of care quality to monitoring and evaluation systems can help to ensure the delivery of high-quality, evidence-based care. Regional and provider-level quality and outcome measures can be aligned to regulatory structures by setting a standard against which care quality can be assessed, either through planned inspections or by

serving as a prompt for unplanned inspections (for instance, where data suggests that there are significant gaps between what is expected and what is delivered). In the United Kingdom (England), for instance, the Health Care Quality Commission assesses care providers against the care quality standards set out in care pathways, with assessments influencing provider ratings.

89. In addition to these ‘top-down’ levers to manage and improve care quality, efforts should also be made to encourage, facilitate and promote bottom-up/local and user-led improvement, for example by:

- Encouraging local and community-led improvement efforts. In Scotland, for instance, the Scottish Recovery Network – with funding from the central government – works with lived experience groups to evaluate and improve service delivery
- Ensuring that there are mechanisms at a clinical level for service users to understand the progress and outcomes of care, which can help to inform patient-provider conversations; and
- Establishing mechanisms to elevate service user voice, for example through patient-reported experience and outcome measures that can help to inform patient-provider conversations, policy and service delivery.

Challenges and opportunities in the Lithuanian context

90. There are a number of significant strengths to the expanded use of quality and outcome measurement and monitoring in Lithuania:

- a. Firstly, Lithuania already has rich sources of data which could be utilised to monitor the quality of care, and drive service improvement.
- b. Secondly, the OECD’s interviews highlighted a real desire amongst both care providers and service users to improve the mechanisms available to measure and monitor care quality. Lithuania’s ongoing reform provides an invaluable opportunity to capitalise on that momentum and advance the approach to quality management (and ultimately – make a meaningful difference to people’s experiences of mental health care).
- c. Thirdly, given known limits to how person-centred the system currently is, the use of patient-reported experience and outcome measures may help to elevate service user voice, and promote person-centeredness in mental health care.
- d. Finally, given the significant changes being planned to mental health care policy and practice in Lithuania as part of the ongoing national reform, quality and outcome data could provide an invaluable systems governance tool to ensure that reforms are delivering their intended benefits (and to monitor for potential unintended consequences). The development of a national ‘dashboard’ or equivalent could help policymakers and practitioners measure and monitor delivery against strategic plans, could provide valuable insights on the efficacy and cost effectiveness of reforms, and could also help to promote transparency. Reporting of a key set of indicators over time and across regions would be particularly beneficial.

91. Nevertheless, a number of potential challenges would need to be considered:

- a. Firstly, attention would be warranted to ensuring the quality and reliability of the underlying data. There are certain measures of service provision where data is currently self-reported, and limited assurance is conducted (for example, workforce numbers). Additional measures may be warranted to assure the quality and veracity of the data informing assessments of quality and outcomes. A pragmatic way forward may be to adopt an iterative process (starting with what is already available and improving, or starting in areas where data quality is more certain).

- b. A second, and related challenge, would be to ensure there are appropriate mechanisms in place to ensure that data is recorded accurately, particularly given known resource and time constraints amongst service providers. Consideration could be given to appropriate training and/or guidance on data entry once a set of quality and outcome indicators are defined.
- c. Thirdly, due consideration would need to be given to governance and resourcing (and specifically, which organisation would be accountable for collecting and analysing the data). Currently, there is no obvious organisation in Lithuania to take on such a role. Given limited resources, one possibly straight-forward approach would be to make greater use of existing data, and/or to compile what is already available at the provider level and at the central level in a harmonised way (as is done by Public Health Scotland, for instance).
- d. Additionally, adequate care would need to be taken to ensure sensitive handling of data from both an ethical and legal perspective (particularly given ongoing restrictions for those with a registered mental health condition).
- e. Finally, there is a risk of 'feedback fatigue' if quality and outcomes data is collected without appropriate mechanisms to act on feedback. Collecting feedback without acting on it can prompt disengagement amongst service users.

Avenues to improve measurement and management of care quality in Lithuania: potential ways forward

92. Given resource constraints in Lithuania, and the potential cost and complexity of new data collection(s), a pragmatic and iterative approach to improving quality and outcomes data would be prudent. A particularly important – and possibly straightforward given existing data availability – starting point would be routine collection and reporting of a key set of indicators to track quality and outcomes in Lithuania. Ideally, such indicators would be available at a sub-national level, to enable constructive comparison between regions.

93. Given resource constraints, an iterative approach to quality improvement would also be prudent. As a starting point, Lithuania could begin to drive a culture of improvement by:

- Periodically reporting on a key set of indicators – for example, via a mental health dashboard – if possible, reporting data across regions and over time. The frequency with which key indicators are reported will of course be driven by resource constraints.
- Agreeing on comprehensive care standards - as clinical care guidelines and accompanying care standards are developed, these indicators could be nested in overarching quality goals, and accompanying reporting (see chapter 1); and
- Implementing patient-reported experience and outcome measures for mental health care to elevate service user voice, and using the output to help inform policy and practice.

Consideration should also be given to encouraging bottom-up improvement by supporting (financially and/or logistically) the development of service user organisations in Lithuania which could help to inform policy and practice.

Recommendations

- 1) **Agree a set of key quality principles/goals**, in consultation with a broad set of stakeholders.
- 2) **Agree a key set of quality and outcome indicators aligned to each goal/principle**, in consultation with a broad set of stakeholders (potentially in the context of agreeing a broader set of

mental health performance indicators). Goals and indicators should build on and complement patient safety requirements that set a minimum acceptable standard of care.

- 3) Specifically related to quality and outcomes, Lithuania could consider including implementing:
- a) International measures of quality and outcomes, to enable constructive cross-country comparisons:
 - OECD's HCQO indicators – in-patient suicide, suicide within 30 days and 1 year of discharge, and excess mortality
 - Repeat admissions to inpatient care (3 or more times in 1 year, %)
 - The share of service users followed up within nationally mandated or recommended timelines following discharge from hospital
 - Coercion in mental health care (absolute number of patients placed in seclusion or restraint per annum); and
 - Patient-reported outcome and experience measures (PROMS and PREMs, discussed separately below).
 - b) National-level measures of care quality and outcomes, in line with policy priority areas:
 - Care continuity
 - Balance of treatment (medical and psychosocial)
 - Care coordination / planning
 - Waiting time standards; and
 - Compliance with care standards.

Setting a national-level goal on compliance with care standards provides one practical approach by which to ensure that national (cross-cutting) and clinical measures of quality are aligned, and to ensure the sustainability of the framework. Given the recommendation in section 1 of this report that Lithuania take an iterative approach to the development of guidelines and care standards, a national indicator on compliance with care standards would effectively bring any future standards into the national framework without a need to update the entire framework.

- 3) **Given resource constraints, take an iterative approach to expanding quality and outcome indicators.** Prioritise making best possible use of data which is already available. Consideration could also be given to agreeing an ambition for a limited set of uncollected/uncollectable indicators, and phasing implementation (i.e., beginning to report on the indicators already available, and working with stakeholders to develop the uncollected/uncollectable indicators).
- 4) **Pilot patient-reported outcome and experience measures (PROMs and PREMs) for mental health care.** A pilot of PROMs and PREMs should be conducted to test and iterate feasibility in the Lithuanian context before considering scaling up the approach more broadly.
- 5) **Broaden mechanisms to improve care quality and outcomes,** using an iterative approach:
 - a) Regularly report on a key set of indicators to track quality and outcomes, ideally across regions and over time; and
 - b) In the medium to longer-term, broaden the levers available to improve care quality and outcomes.