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Towards a holistic approach to children's rights in Lithuanian mental health policy: a case study

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Summary

A holistic approach to children's right to health requires that a disorder-oriented approach and a health promoting perspective are considered equal priorities. However, the mental health policy in many countries is still oriented towards the biomedical treatment of disorders rather than preventive and promotional measures. In this paper we argue that a successful implementation of a health-promoting approach can be achieved through sustainable investment in sectoral cooperation, capacity-building and political will. Using the example of Lithuanian mental health policy, we show how the shortcomings affecting each determinant impede progress in prioritizing a health promotion perspective and thus a holistic approach to children's right to health. Our findings suggest that the application of a holistic approach in Lithuania might face many challenges and obstacles, such as a high number of vulnerable children, the quality of child and family support services, and the still minimal and fragmented interest of policy makers in improving children's mental health.

children's rights/child mental health/holistic approach to healthcare/health policies in Lithuania

Recently, the European Union region has recognized that adoption of a life-course approach and substantial investment in child healthcare are some of the preconditions for advancing universal health coverage. Although the life-course approach is based on the longitudinal view, it is much more than that. The World Health Organization (WHO) [1] notes that it is based on the recognition that adult health and illness are rooted in health and experiences in previous stages of the life-course and it systematically reflects economic, social, environmental, biomedical and other relevant factors that influence health.

From the perspective of children's rights the life-cycle approach suggests looking at the right to health as consisting of two main elements: the right to survival and the right to holistic development. The right to survival mainly relates to the prevention of child mortality, whereas the right to holistic development covers not only physical and mental health but also a broad spectrum of rights such as civil, cultural, economic, social and political rights, and freedoms enjoyed by citizens [2]. Such spectrum of rights requires meaningful participation at all levels of society's organization, involving children, families and communities. The right to holistic development also requires that a disorder-oriented approach and a health-promoting perspective concerning practices, policies and the infrastructure have to be considered as equal priorities and thus treatment of disorders on the one hand, and their prevention and the promotion of physical and mental health on the other hand, have to go together and to be well balanced. However, in many states childhood policies, including child mental health policies, are still oriented

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towards the treatment of disorders rather than preventive and promotional measures. Furthermore, child-oriented services tend to be stigmatized, which leads to social exclusion.

The application of a holistic approach to children's development sheds light on some elements which are important in determining progress: low number of risk factors, empowerment of families, funding priorities and political will. Children's health, and especially mental health, is affected by various factors among which the economic, social and family conditions play a significant role. Empowering families and communities is closely linked to sectoral cooperation because empowerment policies and practices challenge traditional barriers between health, education, social welfare and other sectors [3].

The WHO [4] in 2013 established that public expenditure on mental health is usually very low in low- and middle-income countries, with a large proportion of these funds going to in-patient care, especially psychiatric hospitals and other in-patient and residential facilities. The availability of sufficient resources is a necessary but not a sufficient condition for promoting children's mental health. As the WHO notes elsewhere [5], the inefficient and inequitable use of resources is one of the strongest impediments of progress because 'at a conservative estimate, 20–40% of health resources are being wasted'. Thus, failure to put the holistic approach into practice may be linked not just to financial obstacles, but may be mostly due to prevailing attitudes among stakeholders that are not in line with this approach. There are many practical examples of how 'mind shifts' can make a considerable difference.

Based on a review of the existing literature and examples of the Lithuanian mental health policy we argue that the road to the application of a holistic approach to children's rights might be particularly difficult for the states with 'inherited' systemic problems in the promotion of children's right to development because of a high number of risk factors, lack of professional parenting support, pre-determined funding priorities and lack of political will.

This article is divided into five parts. We begin by presenting the risk factors for mental health disorders in children in Lithuania, such as children in social risk families, the problem of violence in the family and loss of parental care, particularly in relation to mental health. Next, we reflect on parenting skills promotion in Lithuania. We then analyze the roots of Lithuanian mental health policy and discuss the question of healthcare budget, followed by overall conclusions.

RISK FACTORS FOR CHILDREN'S MENTAL HEALTH DISORDERS IN LITHUANIA

An extensive body of research examines risk factors for children's mental health problems. The WHO [6] acknowledges that home-/family-related conditions, such as socioeconomic status of the family, maltreatment in the family, parental absence or rejection, are important risk factors for the child's development.

Social risk families

According to government statistics [7], in 2014 the number of social risk families in Lithuania was near 10 000 and around 20 000 children were growing up in such families [8]. As shown in the UK [9], a multi-agency strategy is needed to provide adequate mental health support to children from social risk families. One of the main tasks of the social sector is to ensure affordable and high-quality day-care centers for children from social risk families [10]. In Lithuania, day care is the main service offered to children growing up in vulnerable families. However, day care centers are able to deliver services to just 25% of those in need. In practice the percentage is even lower, because the majority of municipal day-care centers are accessible only to about 10% of pupils [11]. But accessibility is just one part of the problem. Despite the official commitment to the provision of high-quality, comprehensive (i.e. social, educational, psychological, mediation) services to children and families, the quality of services offered by day-care centers remains one of the biggest concerns, for several reasons. The data [11] show that on average one social worker works with 30 families and children, whereas the established practice recommends one social worker for 12–15

children. Lack of psychological help is another big concern because in some cases day-care centers do not offer any (day-care center in Kaunas), or there is one psychologist for 300 families and children (day-care center in Klaipėda).

The problems with accessibility and quality of psychological therapies at day-care centers raise serious doubts about such issues as timely diagnosis of children's mental health problems, continuity of services and treatment of more complex mental health disorders.

VIOLENCE AGAINST CHILDREN IN THE FAMILY

The problem of violence against children in Lithuania is one of the biggest concerns repeatedly emphasized by the United Nations (UN). The UN Committee on the Rights of the Child (CRC) [12] notes that there is an increase in cases of child abuse, particularly in families with parents who are unemployed, abuse alcohol or live in poverty, as well as of children living in care institutions. The European Council [13] calls for a prohibition of corporal punishment of children in law and in practice. As at November 2015, 29 states (out of 47) have achieved prohibition in all settings, including the home. Latvia and Estonia also belong to this group. Meanwhile in Lithuania corporal punishment is still not legally prohibited in the home, in alternative care settings and in all forms of day-care settings (but it is prohibited in day care which forms part of the education system) [13]. The inaction of Lithuanian authorities does not raise serious concerns because surveys show that more than 50% of Lithuanian parents thought that corporal punishment could always or sometimes be used to discipline children [14].

There are no comprehensive statistical data about children suffering from physical or psychological abuse in their family environment and this is a common problem for many countries. Some fragmented attempts to survey the situation in Lithuania were made by civil society organizations. In 2008, Save the Children conducted a survey of more than 1000 children in Lithuania between 10 and 15 years of age about their family environment. The survey showed that almost 50% experienced physical punishment in the family environment, and 5% stated that they were constantly subject to psychical punishment [15].

Lithuania belongs to the group of 12 countries from the 41 European region countries that routinely provide official statistics on child maltreatment based on cases of acts of violence against children officially recorded by child protection agencies [16]. The data from the past 5 years (2010–2014) show that on average more than 1350 children per year experienced an act of violence in Lithuania. Physical violence prevailed over psychological violence by about 100 cases each year, except 2014 when reported acts of psychological violence prevailed by 75 cases. About a third of violence cases occurred in the family environment (violence by parents, stepparents, adoptive family and foster family).

As noted by the WHO [16], severe abuse can lead to homicide and it is estimated that for every child death, there are between 150 and 2400 substantiated cases of physical abuse. The studies report a relatively high prevalence of severe physical abuse in post-communist countries [17]. Statistical data from the past 4 years show that in Lithuania the number of child suicides (9–19 years old) varies from 22 to 44 per year [18].

Deprivation of parental care

In Lithuania, where the number of children is almost 533 000, 2% are deprived of parental care and more than a third of these children are in institutional care (over 3800 children) [19]. Only in 2014 almost 2000 children lost parental care. According to the State Child Rights Protection and Adoption Service [20], in 2014 58.7% of children who lost parental care in Lithuania remained in foster families, almost 36.8% were placed in institutions and 4.6% were moved to social families. UN *Guidelines for the Alternative Care of Children* clearly note that deinstitutionalization should be the ultimate goal of each state [21]. The use of residential care should be limited to specific cases and can be justified only if it plays a constructive role. However, restrictions to placing a child in residential care are strictly limited to children under the age of 3, who should be rehoused in family-based settings. These restrictions are based on the 'attachment theory', developed more than 50 years ago and

emphasizing the importance of primary care for normal child development [22]. Instead of intimacy and continuity of relations with parents (or substitute parents), children in institutional care are exposed to a lack of individualized emotional attachment. Research on various domains of child development finds that institutionalized children have significant developmental deficits [23]. Damaging physiological effects of institutionalization have been shown, for instance, in terms of general physical development of children in institutions as well as in terms of the development of the central nervous system [23].

In 2014, a group of researchers [24] conducted a survey aiming to compare children's emotional and social well-being in foster families, social families and institutions. The survey questioned 358 children growing up in foster families, 179 from social families and 343 from institutions. The results showed that the Realization of Children's Rights Index (RCRI), covering children's privacy, protection, participation and support, is higher in the family environment than in institutional care. In addition, the researchers found that 45% of children in institutional care experienced bullying, compared with 21% in the family environment. Based on the study correlation between the form of care and bullying, it might be concluded that institutional care is a source of social discrimination. The results also showed that the vast majority of children (89%) would prefer family environment over institutional care.

Lithuania took some steps in achieving international standards in children's mental healthcare. The government approved the Plan of Transfer of the Functions of the Founder of State Childcare Institutions to Municipalities and the Plan of the Optimization of the Network of Childcare Institutions, both in 2007. The latter plan establishes two stages of optimization: the first stage in 2008–2010, transfer of the functions of the founder of state childcare institutions to municipalities; and the second stage in 2011–2015, reduction of the number of places in childcare institutions and optimization of the organization of the activities of childcare. It was stated that by 2010, the number of places in childcare institutions should not exceed 60; childcare institutions should be founded by the municipalities or non-governmental organizations; and work with children in these institutions should be organized on a family basis [25]. However, some [26] note that the 2013–2018 Children's Welfare Program and Action Plan, approved by the government, do not forecast sufficient measures to achieve the main objective of the deinstitutionalization reform.

CAPACITY OF FAMILIES

Supportive family environment is not only one of the major elements influencing positive child development but also a significant protective factor against external risks. The European child and adolescent health strategy 2015–2020, based on Health 2020, recognizes that promotion of a life-course approach does not simply mean a longitudinal view but also targeted efforts aimed at disrupting negative intergenerational cycles created by such negative factors as inadequate parenting skills [1]. Moreover, early childhood is considered the period during which parenting capability and capacity is the central determinant of health and well-being of children and adolescents. Strengthening parental skills is one of the five children's mental health policy priorities in EU member states. Attending to the child's physical needs and the development of essential skills are important but not the only aspects of parenting. As noted in research [27], the quality of the parent–child relationship and parental sensitivity are the roots of good mental health and resilience in children.

Parental skills strengthening activities have been available in Western European states (e.g. the UK, Denmark, Germany, Italy) for more than 20 years and start at the pregnancy stage. One of the priorities of such programs should be to reach families at risk. Usually, social risk families do not access such services unless specific efforts are made to contact them.

Owing to its past, Lithuania was isolated from modern parenting recommendations for the majority of the 20th century. Even nowadays Lithuanian psychological culture is pervaded by many old stereotypes which prevent the application of skillful parenting and may provoke a number of serious parenting mistakes. Parenting services in Lithuania are very fragmented [28] and there has been no research into how popular these tools are and how effective they are among parents.

Despite numerous innovations that have been introduced in the field of family support and child protection services during the past 20 years, the adoption of the Family Policy Concept in 2008 had indicated the beginning of retrogressive tendencies with regard to family policies in Lithuania [29]. First, the Family Policy Concept advocates a narrow definition of family, based primarily on the fact of marriage [30]. An attempt was made in 2012 to amend the Lithuanian Constitution and enshrine this narrow concept of family in it. Even though this attempt failed, an intensive political debate reflected that many Lithuanian political figures favored such a narrow understanding of the family.

THE ROOTS OF FLAWED MENTAL HEALTH STRATEGY IN LITHUANIA

In 1990, Lithuania started to develop new quality services in the field of children's mental healthcare. Support for the new approaches and new methods was based on a changing political context as general enthusiasm spread in the society and the government. Children's mental healthcare in Lithuania was very strongly affected by Soviet ideology, thus it was almost obvious that the only way to improve the system was to apply best practices of the Western world alongside clinical activities and academic research.

A new institution, the Child Development Centre, was established by the Ministry of Health in 1990. The Centre was based on an interdisciplinary approach to services and started to develop across three main lines: modern diagnosis and non-medical treatment methods were applied at the clinical level in addition to training of professionals and research activities. In 1993 the Child Development Centre proposed the establishment of a complex service model for children with mental health problems and their families. This model was based on an inter-sector community services network and included not only mental healthcare but also social and educational services. One of its main elements was the accessibility of services at the municipal level. Access to inter-sector services at the local level was envisaged to serve as one of the preventive mechanisms for institutionalization and social exclusion, but all attempts were short-lived and did not receive any extensive support from the government.

The new millennium started with little political will to support changes in child mental healthcare and only in 2005 did political will emerge to implement the WHO and the EU principles in the field of children's mental health. Immediately after the WHO European Ministerial Conference on Mental Health the Lithuanian government took active steps and established a working group for the development of a mental health strategy. In 2007 the Seimas (Lithuanian parliament) approved the National Mental Health Strategy based on the WHO Mental Health Declaration for Europe of 2005. The strategy established several priority areas, including seeking balance within the development of a bio-psychosocial model and establishment of flexible, family-focused and community-based, non-residential services for children with mental health problems. Even though the Lithuanian government had committed itself to expanding the access to psychological therapies and other psychosocial interventions already in 2007, there was no concrete action to ensure this obligation was fulfilled. Thus, the Lithuanian system of mental healthcare remained largely based on hospitalization of mentally ill patients in large institutions (in 2011 Lithuania still had 11 psychiatric hospitals) [31], and significant funding for medication. Meanwhile, the other European states such as the UK, prioritize psychological therapies over medication and have taken political action combined with appropriate financial mechanisms for the promotion of psychological services [32].

2013 is the year when a small increase in political interest in mental health could be felt again. One of the positive signs was the re-establishment of the National Health Council (1996), consisting of high-level politicians from different fields and ministries, with one of the first sessions on 'mental health in all policies' [33]. The main aim of the Council is to coordinate health policy implementation activities in different ministries. However, despite being a strong tool for raising awareness at the highest level, its rare sessions and overwhelmed agenda have not brought any significant changes in the field of children's mental health so far.

The healthcare budget and its allocation to mental health services for children

The total health expenditure per person in Lithuania was 966 USD in 2013, of which an estimated 521 USD was contributed by the government [34]. In 2013, Lithuania spent about 6.2% of its GDP on health (about 2.9 billion USD), which is almost the same percentage as in 2007 (6.3%) [35]. In 2012 Lithuania's health expenditure was 859 USD per capita (583 USD was government's expenditure) of a total of 2.7 billion USD [36]. The total health expenditure, as a percentage of the GDP and in absolute terms, remains comparable with countries such as Poland, Latvia and Estonia. However, government-allocated health spending is in the median range (12–13%) and government health expenditure as a percentage of GDP is low (4–5%) compared with other high-income countries in the region. No information is available on the government's mental health expenditure [37].

Over the past two decades the Lithuanian health system has moved away from an integrated system towards a contractual system where universal insurance is provided to the population by the State Patient Fund, which pools more than 80% of the total heath expenditure and purchases services from providers. The Ministry of Health still runs several health facilities, but its primary function is supervisory [35].

In 2012 the UN Committee on the Rights of the Child expressed concerns about the high suicide rate among teenagers and asked for information on what proportion of the healthcare budget is allocated to mental health services for children. In its additional report of 2013 [12], Lithuania indicated that this was 0.82%. According to UN CRC, a share of less than 1% of mental healthcare budget allocation indicates inadequate and inefficiently managed budget allocations. Already in 2009 Lithuania and other new EU member states were urged about the need to earmark specific funding for children's mental health issues and to avoid mixed funds (for children and adult mental health). In the case of mixed budgetary allocations there is a danger that funds can easily be spent on other areas that have been traditionally funded (e.g. adult mental health) and that are sometimes not as justifiable as a priority in actual population health [38]. Moreover, the risk of insufficient financing of children's mental healthcare in Lithuania is high due to historically determined marginalization and stigmatization of mental healthcare [3].

Lithuania has a three-tier mental healthcare services framework. In 2015 there were 80 specialists in child psychiatry working in out-patient and in-patient services. However, the second tier and primary care mental health centers are unable to perform their role since they have an extremely small number of non-medical staff (such as 1 professional per 30 000 population) [39]. Thus, mental health services lack multi-sector attitude and as noted in recent studies [35], multi-sector collaboration is encouraged by some fractional state programs, but no single institution has defined responsibility for mental healthcare development for young people in Lithuania.

In 2015 a group of Lithuanian mental health experts and NGOs working in the field of human rights prepared an alternative action plan calling for essential mental health policy reforms in Lithuania. The plan emphasizes the high imbalance between medication and psychological therapies supported by the government, where medication and hospitalization or institutionalization are the only accessible forms of care [26]. Traditionally, medication had been the only treatment available for such disorders as depression or anxiety. The modern states had recognized long ago that the traditional road will no longer be appropriate and that psychological therapies (combined where appropriate with medication) should be the first-line treatment of mental disorders. Meanwhile, Lithuania still has a system of mental healthcare that relies on the hospitalization of mentally ill patients in large institutions. Currently Lithuania has three segregated long-term institutions for children with intellectual disabilities, housing a total of more than 600 residents. The problems in priority-setting concern a much broader context. According to recent studies [35] Lithuanian healthcare policy clearly prioritizes areas such as cardiac and transplant procedures, with children's mental health policies remaining marginal.

CONCLUSIONS

Putting a holistic approach to children's rights into practice requires a friendly political and financial environment, in addition to fostering social/family conditions that affect children's right to mental health and holistic development. Our overview of children's mental health situation in Lithuania identifies many challenges and obstacles, which need to be addressed by national authorities and other stakeholders.

Children from social risk families and children suffering from violence in the family deserve special attention of stakeholders first of all in terms of high numbers of such children and high rates of violence they suffer. In addition to that, the quality of child protection services and family support services, including promotion of necessary parenting skills, needs to be substantially improved. Although municipal day-care centers declare being able to provide high-quality comprehensive services (including psychological help) to children from social risk families, in practice they are unable to perform that mission since they have extremely small numbers of staff. According to international standards, deinstitutionalization should be the ultimate goal of every state, but the ongoing deinstitutionalization reform in Lithuania raises some concerns. Although Lithuania has already taken the initial steps to start a deinstitutionalization reform and adopted a legal framework for its implementation, lack of comprehensive implementation measures shows that there are still many challenges and obstacles.

Political and financial decisions reflect just minimal and fragmented measures undertaken so far in improving children's mental health and lack long-lasting goals supported by adequate measures. Although Lithuania belongs to high-income countries, its general expenditure on health is low in comparison with other high-income countries in the region, thus indicating that economic growth has not been followed by investment in modern, human rights-based services. Moreover, less than 0.5% of the total healthcare budget is annually allocated to mental health services for children. This is a clear signal that children's right to mental health is still poorly understood by policy makers and indicates that progress towards a holistic approach to children's rights may be very slow in Lithuania, unless serious changes in health policy happen.

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