Lithuania
Monitoring Report

DIS-CONNECTED: DISABILITY-BASED CONNECTED FACILITIES AND PROGRAMMES FOR PREVENTION OF VIOLENCE AGAINST WOMEN AND CHILDREN

101049690- DIS-CONNECTED

Disability-based connected facilities and programmes for the prevention of violence against women and children (101049690 – CERV-2021-DAPHNE)

COUNTRY: LITHUANIA

Monitoring Report

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NGO MENTAL HEALTH PERSPECTIVES

(PSICHIKOS SVEIKATOS PERSPEKTYVOS – PSP)

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General information on the monitoring visits

Type of facilities	Total No. of facilities	No. of facilities supporting children	Dates of monitoring visits	City	Town
Mental healthcare facilities	4	3	July, October, November 2024	3	1
Social care facilities	2	2	November 2024	2	0

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Methods used

First, following informal telephone communication, an **official letter** was sent to the services inviting them to participate in the project and asking them to allow the monitoring visits to take place. The process and foreseen methodology were explained in detail in a form of an official letter.

Before the monitoring visits, a **Questionnaire** about the facilities' structure and functioning was emailed to and completed by the administrative staff of each service. The Questionnaire contained the following categories of information: 1) Information about the service's structure and subordination; 2) Information about the specificities of their patients or residents, their numbers, and their needs; 3) Information about specific services and programmes provided; 4) Information about their staff members.

During the monitoring visits, the monitoring team first met with the administrative staff and introduced themselves and the objectives of the visit. Then, the monitoring team was shown around the facilities, and all members of the team conducted a general **observation**.

Two members of the monitoring team would then stay with the administrative staff and conduct the **documentation review**. Documents such as follows were reviewed and analysed: Internal rules of the facility; Provisions of the Medical Ethics Commission; Violence and Harassment Policy; Internal Rules of Procedure for Patients or Residents; Minnesota Unit's Procedural Rules, where applicable; Rules of Inpatient Psychosocial Rehabilitation, where applicable.

The rest of the team conducted face-to-face **semi-structured interviews** with the staff of the facilities using the guide for semi-structured interviews.

Before the interviews, all interviewees signed the **Informed Consent Form**.

Anonymised details of each interview were documented in the **Interview Registry Form**.

Results

Total No. of semi-structured interviews and gender of participants:

	Mental healthcare facilities	**Social care facilities**	**Total No. in both types of facilities**
Total No. of interviews	32	12	44
Women	26	9	35
Men	6	3	9

Interviews were conducted with facility directors and managers, psychiatrists, psychologists, nurses, social workers, occupational therapists, and individual care workers.

Profile of the facilities and services provided

Four mental healthcare facilities (mental health units in general hospitals and community-based mental health centres), and two social care facilities (community-based independent living homes) received monitoring visits. Five facilities are located in cities and one in a smaller town.

Gender- and disability-based violence

Training and education

In all the monitored facilities, various training programmes are available to employees, focusing on responses to gender-based violence and other forms of abuse. These courses are not mandatory, and staff rarely mentioned them during the monitoring interviews. Some employees, out of personal interest, attended related workshops, including specialised sessions addressing

the intersection of gender, disability, and domestic violence. Recent years' efforts have included staff being trained by PSP and their partners on these topics.

In some children's units, staff have attempted to raise awareness among children indirectly through methods like movies, followed by discussions. Some adult units' staff provide patients with resources, such as contact details for emotional support lines. Additionally, informational materials about gender-based and domestic violence are displayed in common areas of some facilities, using simplified and easy-to-read materials provided by PSP in the past.

Most interviewees have participated in professional development courses, primarily related to mental health or disability. Continuous learning is considered crucial for effective support delivery. However, in all facilities, the training provided is limited in scope and lacks specialised education on recognising and addressing domestic violence in various specific contexts. Mandatory training is not clearly defined, resulting in uneven competencies among staff. General training sessions are seen as an essential starting point, but their infrequency and theoretical focus reduce their effectiveness. Employees suggest updating training programmes to include practical simulations and discussions to enhance real-world preparedness and practical skills. Specialised training in domestic violence is crucial but irregularly organised, leaving many employees without access to this knowledge. Tailored programmes for different roles, such as social workers or nurses, are needed to equip staff with relevant practical skills.

Despite these gaps, employees demonstrate a strong desire to learn and improve. They also emphasise the importance of developing inter-sectoral collaboration strategies to enhance violence recognition, reporting, and prevention efforts. Structured, frequent, and practical training would significantly improve their response capabilities.

Policies and procedures

Generally, most facilities have a formal policy outlining violence and harassment prevention measures, defining physical and psychological violence, bullying, and sexual harassment, sometimes also including some forms of abuse in digital spaces. These policies may highlight factors that provoke or mitigate violence and describe prevention measures at primary, secondary, and tertiary levels. In some cases, joint mediation meetings between perpetrators and survivors are conducted, provided both parties agree.

However, interviews with staff revealed a lack of clear written procedures or algorithms for responding to gender-based or domestic violence specifically, in both mental healthcare and social care facilities. Each case is addressed individually, based on its circumstances. Some staff in mental healthcare facilities, including nurses, social workers, and psychologists, reported that

they first inform their department heads rather than taking direct action, such as contacting the police or referring patients to psychological or specialised complex support.

Procedures vary significantly between facilities and between departments or units. Adult inpatient and outpatient mental healthcare facilities often lack clearly defined protocols, relying instead on the individual expertise of staff and team meetings. By contrast, the children and adolescent units tend to have more structured guidelines and clear algorithms.

Professionals also emphasised that responding to violence depends heavily on the victim's willingness to accept help. While some staff suspect abuse, they are often constrained by data protection laws and respect for patient autonomy, limiting intervention unless the victim actively seeks assistance. The mental healthcare facilities' overarching guidelines on managing domestic violence cases are inconsistent, with some areas lacking standardised procedures. This results in uneven application and risks that cases may be mishandled or overlooked.

Resource shortages and high workloads further complicate effective responses. Employees highlighted the need for clearer protocols, particularly for extreme situations and inter-sectoral collaboration with law enforcement and Specialised Complex Support Centres (SKPC) that support victims of domestic violence.

Overall, while some systems are in place, gaps in policy clarity, consistency, and resources hinder the facilities' ability to respond effectively to domestic violence. Greater emphasis on standardised protocols and inter-sectoral collaboration frameworks would enhance outcomes for both staff and survivors.

Cases of abuse

Staff acknowledged that gender-based violence and domestic violence are common issues among their patients or residents, with physical violence against women being the most frequently observed. The social and psychological support units in mental healthcare facilities have also encountered and recognised cases of psychological abuse. One notable example involved a woman seeking counselling, during which her partner waited outside the door, entered the room, and demanded the session to end. In another case of physical violence, staff supported a woman by helping her leave her home, mediating with the perpetrator to retrieve her belongings, and assisting her in finding a new place to live.

Despite these efforts, in most facilities, staff's experiences with domestic violence cases are limited. During interviews, very few participants confidently discussed specific situations and knowledge of how to respond, while others mentioned such cases minimally or not at all. This suggests either a lack of recognition of such cases or inadequate training in handling them.

Currently, there is no centralised system for documenting and analysing domestic violence cases, which hampers the facilities' ability to collect data and implement strategic prevention measures. Staff responses to violence cases in all facilities rely heavily on individual experience and quick decision-making, often without adequate legal or psychological resources for either the survivors or themselves. Workers noted difficulties in supporting victims who refuse to cooperate or are afraid to report abuse. Additionally, handling these cases often requires inter-sectoral collaboration, which is not always effectively organised.

While most employees demonstrate sensitivity and adaptability in addressing domestic violence cases, there is no unified system to ensure consistent and effective responses. The lack of focus on developing skills to manage complex situations, particularly involving vulnerable groups such as children or individuals with intellectual disabilities, highlights the need for improved training and systemic support.

Specificities of domestic violence

Recognising domestic violence

Most staff reported that recognising domestic violence often depends on victims sharing their experiences or displaying body language indicative of abuse. Emotional extremes (either heightened emotion or detachment) when discussing personal relationships can serve as cues for practitioners to probe further. However, identifying abuse is hindered by survivors' reluctance to disclose or deny their experiences, as well as by staff's limited knowledge of subtle indicators of domestic violence.

Moreover, cultural norms tolerating gender-based violence and stigma around both domestic violence and mental health, addiction, and abuse further complicate recognition efforts. Interviews revealed significant reliance on staff intuition rather than standardised protocols for identifying violence. While some staff possess strong mental health knowledge and a keen awareness of abuse signs, such as behavioural or emotional indicators, others lack adequate training. Fragmented specialised training and the absence of systematic programs contribute to uneven staff competence.

Survivors' trust is critical for effective intervention, yet collaboration with external institutions, like law enforcement and social services, poses challenges. Many survivors are reluctant to involve authorities due to prior negative experiences, and such involvement can deter them from seeking further help. Social and economic vulnerabilities, including substance abuse and financial instability, often entangle victims in abusive environments, leaving staff feeling powerless to facilitate their escape.

Moreover, limited time with patients (particularly in settings like methadone programs) restricts opportunities for recognising abuse. Documentation and reporting procedures are inconsistent, and no centralised system exists for tracking or analysing cases. This lack of resources and formalised processes weakens the facilities' capacity to address violence effectively. Standardised tools for identifying and responding to domestic violence, combined with regular, targeted training, are essential. Emphasising practical skills and creating robust reporting systems could strengthen staff confidence and improve outcomes for victims, particularly among vulnerable groups such as children or persons with intellectual disabilities.

Reporting domestic violence

Some facilities have a reporting procedure for cases of domestic violence, involving professionals from various sectors. However, in practice, inter-sectoral collaboration often faces significant challenges. Miscommunication and the involvement of multiple actors can result in lost information, leaving victim-survivors vulnerable. When survivors are referred to other professionals, they may feel disappointed with the quality of support received. Additionally, some participants working with children highlighted dismissive attitudes from police towards minors, undermining trust and highlighting the need for better representation and advocacy.

Legal requirements do enforce certain protocols, such as notifying child protection services in cases where children are exposed to unsafe environments due to violence or substance abuse. However, beyond this, the reporting process lacks clarity and standardisation, especially concerning adult victim-survivors. Staff reported no clear guidelines or standardised channels for reporting adult domestic violence cases. The absence of defined algorithms or designated contact persons leaves the reporting system fragmented. Some employees feel confident about reporting, but others avoid it due to a lack of anonymity or procedural uncertainty. Inconsistent practices mean critical information does not always reach the appropriate authorities or institutions. The reporting process also creates additional challenges for both staff and victim-survivors. Employees expressed insecurity about the potential for conflict with their service users or perpetrators and uncertainty about when police involvement is necessary. Victim-survivors, meanwhile, often hesitate to report due to the lack of anonymity and trust in the system. To improve the reporting process, clear, standardised procedures, along with measures to ensure anonymity and foster trust between staff and survivors, are essential.

Responding to domestic violence

All monitored facilities lack specialised mechanisms or distinct approaches for working with survivors of domestic violence. There are no written procedures or algorithms to guide staff in responding to potential signs of domestic violence. Each case is handled individually based on its specific circumstances, without a unified framework.

Interviews with staff revealed insufficiently clear systemic strategies for addressing cases of domestic violence. Specific actions that employees should take in such situations were not mentioned, highlighting the need for comprehensive guidelines, unified algorithms, and action plans. Responses to violence rely heavily on individual staff members' experience and knowledge. While some employees feel confident in handling routine situations, complex cases of domestic violence pose significant challenges due to the absence of clearly defined protocols.

Observations during monitoring visits indicated that the quality and speed of responses depend largely on individual skills rather than systematic support. For example, employees often encounter aggressive perpetrators without adequate training on how to manage such confrontations. Responses are typically limited to short-term interventions, lacking a focus on long-term safety and support for survivors.

To address these gaps, staff emphasised the importance of developing clear action plans covering all stages of response, from recognising signs of domestic violence to implementing follow-up measures. Such frameworks would help professionals feel more prepared to handle crises effectively. Additionally, there is a critical need for practical training to equip staff with the tools and confidence to manage complex or high-risk situations, ensuring both immediate and sustained support for those affected by domestic violence.

Inter-sectoral collaboration

Collaboration between the facilities and external agencies, organisations, and services such as police, social services, and Specialised Complex Support Centres (SKPC) is limited and often fragmented. While crisis centres were mentioned during interviews as a known temporary housing option for domestic violence survivors, knowledge of SKPC was limited. Among most professionals, familiarity with SKPC services and collaboration methods was vague. Direct cooperation with SKPC is minimal, with only occasional patient or resident referrals and no established procedures or feedback mechanisms.

The lack of structured intersectoral collaboration undermines the effectiveness of support systems. Communication with social service case managers exists but is not systematic, and coordination with police and child protection services is often described as bureaucratic and inconsistent. Employees noted that partnerships with SKPC, law enforcement, or other services often depend on personal initiative rather than formalised protocols, leading to inconsistent outcomes.

The absence of regular inter-sectoral meetings and clear communication channels further weakens inter-agency efforts. Some staff highlighted the dismissive attitudes of law enforcement

toward vulnerable groups, such as minors or persons with intellectual disabilities, and the lack of timely cooperation in critical cases.

Employees also expressed that they lack sufficient training on integrating SKPC channels and networks into their work, which hinders the consistency and effectiveness of support for survivors. Despite these challenges, SKPC are recognised as having significant potential to enhance domestic violence prevention and intervention, and potentially providing effective support to survivors. These centres provide comprehensive services, including psychological, and legal advice and support. However, their limited presence and the monitored facilities' staff's lack of awareness restrict their impact.

To improve outcomes, formalised collaboration protocols, regular training, and increased awareness of SKPC among mental healthcare and social care staff are essential. Strengthening inter-sectoral partnerships would ensure more cohesive and effective support for domestic violence survivors.

Domestic violence against children

Child protection is a sensitive area for all the monitored facilities, particularly when addressing domestic violence involving minors. While protocols for responding to violence are in place within the children's and adolescents' units, such as providing emotional support and notifying child protection services, systemic challenges persist. Some professionals face difficulties recognising and documenting signs of abuse, as children may lack the ability to understand or articulate their experiences. This places significant responsibility on staff to detect subtle indicators, such as mood or behavioural changes, conflicts with parents, or physical signs.

Interviews revealed that while some employees possess specialised knowledge and collaborate effectively with social services and child protection agencies, this work is not systematic across facilities and different units. Many staff members feel inadequately trained to handle complex cases involving children, particularly in sensitive situations of domestic violence. The lack of standardised action plans and consistent training leaves staff uncertain about how best to protect children and address their needs.

Family dynamics and systemic challenges in Lithuania further complicate efforts. Children are often unfairly burdened with blame for problematic behaviour, while parents or guardians may lack motivation to participate in parenting programs aimed at improving their situations. Without sufficient engagement from the child's environment, addressing trauma and ensuring long-term solutions become difficult. Some successful interventions have been reported through collaboration with external agencies, but these are hindered by inconsistent inter-agency cooperation and a lack of structured guidelines.

Staff recommend implementing specialised training for working with children, particularly in cases of domestic violence, and creating clear, actionable plans that all employees can follow. Strengthening inter-sectoral partnerships and providing practical skills for communication and intervention would significantly enhance the institution's ability to protect children effectively, especially when children also have disabilities.

Disability and domestic violence

All monitored facilities face significant challenges in addressing domestic violence against persons with disabilities, particularly women and girls with intellectual or psychosocial disabilities. Recognising abuse within this group is especially difficult due to societal negative attitudes towards domestic violence, compounded by stigma, and a lack of awareness. Vulnerabilities are heightened by the unequal power dynamics between individuals with disabilities and their caregivers, often resulting in stricter, more controlling, or even aggressive treatment.

Interviewed staff emphasised the critical role of professionals working with children and adults with disabilities, as they are often the first to potentially identify signs of abuse. However, societal attitudes toward individuals with disabilities remain dismissive, with widespread distrust of their testimony from family members, communities, and even law enforcement. For example, some social workers reported cases where police disregarded statements from individuals with intellectual disabilities solely due to their disability.

Current institutional responses lack specialised procedures or methodologies tailored to this vulnerable group. Staff noted that group therapy is often less effective for people with psychosocial or intellectual disabilities, as they may feel isolated and uncommunicative. Individualised attention has proven more successful in fostering engagement and communication. However, most monitored facilities have not fully integrated such personalised approaches into their practices.

Employees highlighted gaps in training and resources, including the absence of proper facilities to ensure the safety and comfort of individuals with disabilities. Most staff lack the tools, knowledge, and skills to address the complex relationship between disability, gender, and domestic violence. To improve outcomes, facilities must provide targeted training on supporting individuals with disabilities, develop specialised procedures, and collaborate with organisations experienced in disability services. These measures are essential to ensure adequate protection and effective support for this highly vulnerable population.

Emergency settings

During the COVID-19 pandemic, rates of domestic violence in Lithuania significantly increased. However, most institutional staff had far fewer direct interactions with service users during this time, which greatly limited the workers' ability to identify and address domestic violence in its early stages. As a result, cases that went unrecognised initially required more intensive and prolonged interventions at later stages to support victim-survivors in recovering. This highlighted the challenges posed by reduced contact and underscored the need for enhanced strategies to address domestic violence during such crises.

Domestic violence in residential social care facilities

In social care facilities specifically, interviews with staff highlighted significant gaps in how domestic violence legislation is applied within residential social service institutions. In cases where violence occurs among residents, police often fail to classify it as domestic violence, despite meeting legal criteria such as shared living arrangements. This legal oversight leaves victims vulnerable, as perpetrators, even when detained, frequently return to the same environment, endangering the victims further.

Staff expressed concerns about the lack of understanding regarding the dynamics of domestic violence, especially from the side of law enforcement. For instance, victims' decisions to return to their abusers are often misunderstood and used as justification for inaction, revealing critical weaknesses in both response and prevention strategies.

Without clear procedures or standards, staff sometimes take protective actions based on intuition rather than guided protocols. This inconsistency underscores a broader issue: the absence of organisational strategies and inter-sectoral collaboration to address and prevent domestic violence effectively.

The failure to apply domestic violence laws within institutional settings allows abuse to persist, leaving victims without adequate protection or support.

Other issues

Many interviewed staff emphasised the critical need for stronger leadership support, including visible engagement from management and the provision of psychological assistance for employees themselves, when dealing with cases of violence.

While employees frequently reflect on their experiences and express a desire to improve their skills, the absence of structured training and action plans hinders their ability to address issues effectively. The monitored facilities' approaches are often reactive, treating domestic violence as an individual issue rather than a systemic problem requiring inter-disciplinary solutions.

Conclusions

Most staff at all the monitored facilities demonstrate motivation and some experience in supporting survivors of domestic violence, but they lack essential resources, skills, and clear procedures to effectively address complex cases. The absence of standardised algorithms and comprehensive training, particularly on recognising and responding to domestic violence in the mental healthcare sector, poses major challenges. These gaps are further compounded by insufficient inter-sectoral collaboration with other services and agencies.

Specialised knowledge is notably limited in addressing the needs of vulnerable groups, such as women, children, and persons with intellectual disabilities, whose experiences with domestic violence often require tailored approaches. All staff lack familiarity with trauma- and violence-informed care methodologies, which are critical for delivering effective mental health and social care support services to survivors of domestic violence.

Training programs for staff are inadequate, with little focus on the practical application of knowledge. As a result, responses to domestic violence often depend on individual experience rather than systematic support. Social workers in mental healthcare facilities tend to bear a disproportionate burden of responsibility, as they are frequently tasked with managing cases due to their broader knowledge of institutional systems and relationships with external agencies.

Additionally, there is a lack of psychological support and peer assistance systems for employees themselves, who face emotional strain and burnout from managing high-pressure situations without sufficient support. Staff often work in isolation and feel unsupported in their efforts to protect victim-survivors.

While all facilities make some efforts to address domestic violence, these are fragmented and lack consistency. To improve outcomes, a unified training system, clear procedural guidelines, unified algorithms, and stronger inter-sectoral collaboration and coordination are essential.

Incorporating trauma- and violence-informed care practices and also ensuring robust emotional support for staff would enhance both the quality of care provided to survivors of domestic violence and the well-being of employees themselves.

Key recommendations

- Develop and implement unified policies and algorithms for identifying, responding to, and referring cases of domestic violence experienced by service users in mental healthcare and social care facilities.

- Strengthen inter-sectoral collaboration, particularly with Specialised Complex Support Centres (SKPC), to provide comprehensive support to survivors of domestic violence who have mental health conditions and disabilities.
- Ensure victim-survivors of domestic violence are informed about and referred to SKPC for further assistance. Where relevant, it must be in compliance with national reporting obligations for healthcare providers.
- Organise specialised, regular, and if possible mandatory trainings for mental healthcare and social care staff on domestic violence, trauma, and trauma- and violence-informed care, focusing on practical intervention methods, tools, and needed skills.
- Provide targeted training for staff in children and adolescent departments to better support minors with disabilities who have experienced or witnessed domestic violence.
- Deliver specialised training on working with individuals with disabilities, including psychosocial and intellectual disabilities, addressing unique potential needs in domestic violence cases involving women and children with disabilities.
- Begin collecting and recording disaggregated statistical data on service users with disabilities and those affected by domestic violence to improve understanding and resource allocation in both mental healthcare and social care services.
- Enhance support for staff dealing with emotionally taxing cases by implementing psychological assistance programs to reduce stress and burnout.
- Improve working conditions and strengthen managerial involvement to ensure employees feel supported and valued.
- Establish clear, updated, and practical procedures for managing domestic violence cases, ensuring consistency and adaptability to real-world situations.