Substance Use Disorder Treatment Quality Standards in Lithuania 1992–2022: From Grassroots Initiatives to Nationwide Strategies

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BACKGROUND: The implementation of quality standards in the treatment of substance use disorders in Lithuania is not well documented in the literature. **AIMS:** To describe the process of the development of quality standards from grassroots initiatives to their integration into mainstream healthcare under the leadership of the Ministry of Health. **METHODS:** Narrative review of retrieved documents, including related legal acts, followed by a subsequent content analysis. **RESULTS:** The implementation was divided into three stages characterised by specific activities, leading stakeholders, and the degree of integration into the national healthcare system. The driving element in the initial stage turned out to be grassroots initiatives from professional associations and healthcare providers. Because of the availability of private, EU, and UN agencies' funding to curb the HIV epidemic, Lithuanian professionals had an opportunity to provide assistance in establishing quality standards in Eastern European and Central Asian countries and to learn from Western good practices. During later stages the Lithuanian national system of quality assurance was fully developed and SUD treatment was gradually integrated into the mainstream healthcare system, with the Ministry of Health assuming a leading role. **CONCLUSIONS:** In the period of deep transition since 1990, when the national quality assurance system was weak, professional associations have played a major role. Exposure to best practices in other countries was valuable in empowering professionals to initiate and implement quality standards which were later integrated into the national quality assurance system.

Keywords | Substance Use Disorders – Treatment – Quality Standards – Quality Assurance

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1 INTRODUCTION

The treatment and care of substance use disorders (SUD) are not necessarily always understood as an integral part of healthcare (WHO & UNODC, 2020). Because of different factors (stigmatisation by the general public and medical community, the chronic and relapsing nature of disorders, lack of awareness about successful evidence-based interventions, or an overreliance on law enforcement measures), SUD treatment may be assigned a low position among the priorities of medical services in countries.

Since 1990 the Republic of Lithuania has experienced profound political, economic, and societal changes. During the 1990s a healthcare reform was designed and implemented. A three-level healthcare service system was introduced, with an emphasis on the importance of the primary healthcare level. The funding of healthcare services was transformed through the establishment of a National Health Insurance Fund (NHIF), which paid for services for patients.

During the above-described healthcare reform SUD treatment services and institutions were left behind. Since 1990 the existing infrastructure of SUD treatment services has included two municipal stand-alone centres in Vilnius and Klaipeda, and also two subdivisions at the Psychiatric Hospitals in Kaunas and Šiauliai. In both stand-alone SUD treatment centres funding was continued from the state budget. The explanation included the fact that a relatively high proportion of patients with SUD were out of the labour market and did not have health insurance. Treatment of acute health conditions related to SUD, such as psychoses, suicidal behaviour, or severe withdrawals, was reimbursed by the NHIF and took place in psychiatric hospitals. SUD treatment in Lithuania slowly gained a higher priority, which may be demonstrated by the establishment of three new stand-alone SUD treatment centres in 2000, funded by the government. And two decades later the Ministry of Health (MoH) adopted the first-ever National Action Plan (2021–2024) containing measures to improve access to, and the quality of, SUD treatment and harm reduction services (MoH, 2021).

In this article we try to document the evolution of quality standards (QS) and the quality assurance (QA) system in SUD treatment from professionally-driven grassroots initiatives to nationwide strategies and their implementation.

2 METHODS

2.1 Design

Narrative review documenting the process and stages in developing a nationwide QA system in the SUD treatment field.

2.2 Setting

Republic of Lithuania; period from 1992 to 2022.

2.3 Information sources

The retrieved literature originated mainly from manual searches within the framework of the FENIQS-EU project.[1] During the search key information sources were identified, including legal acts related to the development and regulation of QS and the national QA system of SUD treatment.

2.4 Data collection and content analysis process

After a review of the retrieved documents, texts were selected for further analysis. The subsequent content analysis of all the texts was focused on the identification of relevant thematic areas and their content. The relevant sources were analysed through the following categories:

a) the temporal process of developing QS in SUD treatment and implementation of QA;

b) leadership and key stakeholders in the development of QS and QA systems in SUD treatment;

c) the level of integration of the QS and QA system for SUD treatment in the national QA system (medicine and social services).

3 RESULTS

3.1 1992–2004. Grassroots initiatives in developing and implementing quality standards in substance use disorder treatment

As described in the introduction, the development of QS in the treatment of SUD disorders in the 1990s received little attention from the national authorities. Therefore, the efforts to develop QS in SUD treatment were grassroots initiatives of professional psychiatrists and specialised treatment providers. The professionals operated informally and later formally under the Lithuanian Association of Addiction Psychiatry, established in 1998. The main initiatives included the adaptation of QS from Western countries into the existing Lithuanian treatment infrastructure and advocacy of the integration of SUD treatment into the national healthcare system. By 2002, as a result of international networking, the Lithuanian Association of Addiction Psychiatry had developed a draft legal act on standards of treatment and the rehabilitation of SUD, which was approved by the MoH (MoH, 2002). This document became a reference guide for the further development of QS in outpatient and inpatient SUD treatment.

3.1.1 Minnesota model

The Minnesota inpatient treatment model was introduced as a psychosocial treatment in the Vilnius Centre for Addictive Disorders in 1992. It combined the 12-step programme of

1 | Further Enhancing the Implementation of Quality Standards in Drug Demand Reduction across Europe. https://feniqs-eu.net/

Alcoholics Anonymous (AA) and specialist interventions. These programmes were later opened in the existing infrastructure in Kaunas and Klaipėda (Subata, 1999; Subata & Širvinskienė, 2012). The Minnesota programme was prompted and supported by AA communities in the US and Lithuania. AA became legal in Lithuania in 1988. In 1992–93 professionals had opportunities to attend traineeships in the US and Denmark after private funding for study visits became available, including the local Soros Foundation (Open Lithuania Fund). The QS of the Minnesota model were approved internally by institutions. This model enjoyed great popularity among patients with alcohol use disorders and their families and employers. The retention rate in the 28 days of inpatient treatment is still as high as 90%, mainly because it was aimed at patients with higher motivation.

3.1.2 Development of long-term residential rehabilitation

Long-term residential rehabilitation centres for drug users have been established since 1993, mostly as a result of the initiatives of former drug users, as non-commercial organisations or charity foundations. Most of these residential rehabilitation centres used the12-step approach. The duration of the stay was 12–14 months. With some exceptions they were not publicly funded till 2004 and received private payments from their clients. There were no national legal acts on the QS or minimal requirements for the contents and quality of services, staff composition and staffing levels, or indicators for the monitoring till 2015 (Subata & Širvinskienė, 2012).

3.1.3 Development of opioid agonist therapy

OAT (opioid agonist therapy) with methadone in Lithuania was initiated (in 1995) as an effort on the part of the professional community to provide an attractive service for patients who inject illegal opioids (Subata, 1999). Study visits of medical professionals to Sweden, the Netherlands, and the UK (funded by the EU) preceded the implementation of OAT (Subata, 1999).

The Ministry of Health accepted the recommendation of professionals to implement OAT with the available human resources and infrastructure in Vilnius, Kaunas, and Klaipėda. It adopted OAT as a legal act on May 15, 1995, but did not allocate additional funding. Therefore, initially, patients had to pay for medication (methadone) from their own pocket.

The situation was softened by the newly-emerged possibilities of receiving funding from Open Lithuania Fund projects. In 1995 the Open Society Institute (US) launched the International Harm Reduction Development programme – IHRD OSI (Coffin, 2002). IHRD OSI, together with the Open Lithuania Fund, funded professionals' study visits to European countries, attendance at international training events and conferences, and networking within the professional community. It also provided national grants for OAT services. The national OAT QS were constantly refined by professionals and the MoH to become more patient-oriented and flexible. Though a legal act on OAT existed as early as 1995, it was only in 2004 that the NHIF started to provide additional funding for medications.

3.1.4 Know-how export to Eastern Europe and Central Asia and its impact on quality assurance at home

Starting in the mid-to-late 1990s, the HIV/AIDS epidemic among people who inject drugs in Eastern Europe (Ukraine, Belarus, and later Estonia) and Central Asia started to cause great concern worldwide (Dehne et al., 1999; DeHovitz et al., 2014). Drug treatment and harm reduction-oriented services, especially OAT, became high priorities on the political agenda in EU countries and UN organisations (UNODC, 2001; WHO, 2004).

The Open Society Institute (OSI), based in the US, had on its agenda strategies to soften the global drug policy and increase the access of harm reduction services to people who inject drugs. Limited OSI funding became available to support a harm reduction approach in these regions (Sarang et al., 2007).

The introduction of OAT in Lithuania in the mid-1990s resulted in Lithuanian professionals gaining expertise in the region early on. Therefore, Lithuanian experts used OSI International Harm Reduction Program (IHRD) financial grants to support pilot OAT projects in Belarus, Moldova, Ukraine, the Caucasus (Azerbaijan, Armenia, Georgia), and Central Asian countries (Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan).

In the process of the implementation of projects, there was an opportunity for Lithuanian specialists to provide technical assistance in those countries as well as to organise multiple site visits for Eastern European and Central Asian colleagues to Lithuania to observe SUD treatment, including OAT.

Lithuanian SUD treatment professionals were able to benefit from multiple contacts with international experts. The following international projects helped to continue to improve local QS of SUD treatment:

- WHO Collaborative Study of Opioid Substitution Therapy and HIV 2002–2007: the study took place in the Eastern European region (Lithuania, Poland, Ukraine), Asian countries (China, Indonesia, Iran, Thailand), and Australia. The study had a service quality evaluation protocol. It also included the translation into national languages of several instruments for service quality assessment. The results of the study showed the effectiveness of OAT in spite of economic or cultural peculiarities across different societies (Lawrinson et al., 2008). National data showed that OAT significantly improved the quality of life of patients (Vanagas et al., 2004; Padaiga et al., 2007). The experience gained during that multi-country study, including QA, was important in the development of global OAT guidelines for pharmacotherapy of opioid dependence (WHO, 2009).

- 2007–2011 UNODC project "HIV prevention and care among injecting drug users and in prison settings in Estonia, Latvia, and Lithuania"(UNODC, 2011): the project awarded grants to establish new OAT programmes in the Baltic states, including in prisons. An extensive external OAT service quality evaluation in Lithuania was carried out. The Lithuanian Psychiatric Association developed and

published National Clinical Guidelines on OAT with methadone in line with the WHO recommendations (Subata et al., 2010a) and buprenorphine/naloxone (Subata et al., 2010b). A comprehensive patient assessment instrument (Addiction Severity Index – ASI) was translated into Lithuanian (McLellan & Carise, 2010) and professionals were trained. Intervision, as a routine clinical skills enhancement technique, was also developed and professionals trained (UNODC, 2010).

OAT was long considered a controversial treatment option in Lithuania, particularly among followers of an "abstinence-only" treatment orientation. There were periodic attacks on OAT in the media from members of parliament, with threats to close it down entirely. The process of defending OAT included the provision of evidence and closer alliance with outside experts, UN agencies, and NGOs ("I Can Live", 2009). Outside threats to existing services stimulated the closer monitoring of the quality of OAT treatment. Nevertheless, it was a factor which created additional barriers to the normalisation of SUD treatment and its integration into a national QA system.

3.2 2005–2016 Gradual acceptance of the treatment of substance use disorders into a national quality assurance system of healthcare and social services

In the period 2005–2016 national authorities such as the MoH and NHIF started increasingly to accept SUD treatment as "normal" medical services. From 2005 the NHIF allocated additional funds for SUD treatment and five specialised centres were able to allocate some funds to cover medication for outpatient treatment, including methadone. Patients no longer had to pay from their own pocket.

Residential long-term rehabilitation services became licensed by the Ministry of Social Affairs and Labour in 2015, after the legal act on social services was approved in 2012 (Ministry of Social Affairs and Labour, 2012).

3.2.1 National quality assurance system in healthcare

Several key institutions have played a key role in ensuring the quality of healthcare services through the national QA system under the MoH in the past two decades.

3.2.1.1 State Health Care Accreditation Agency under the Ministry of Health https://vaspvt.gov.lt/en (SHCAA)

The SHCAA implements overall quality assurance and control of medical services. This agency issues licences for institutions to provide healthcare services if they meet the necessary requirements as established by the law. The employees of the SHCAA, after issuing a licence, may perform audits and may revoke the licence if the requirements for services have been seriously breached. Audits are most often carried out through submitting copies of QS and related medical records to the SHCAA.

The SHCAA licenses healthcare institutions and health professionals, too. The licence for an institution is not limited in terms of time, while professionals have to prove their continuous training and engagement in medical practice every five years to renew their licence.

A licence for healthcare (any kind) from the SHCAA is needed for organisations/institutions which provide low-threshold (harm reduction) services and provide personal healthcare, such as HIV testing in blood samples, naloxone injections to prevent a lethal opioid overdose, and wound care. In this case a low-threshold organisation must most often have an agreement with a licensed healthcare institution.

Licensed psychiatrists and mental health nurses need to be employed if the institution seeks to get a licence to provide specialised SUD treatment. Clinical psychologists and social workers are mandatory according to the legal acts of the MoH in OAT and inpatient SUD treatments (withdrawal treatment, psychosocial rehabilitation, and Minnesota). Ergotherapists are mandatory for outpatient and inpatient psychosocial rehabilitation. A child and adolescent psychiatrist is obligatory for an institutional licence to provide outpatient and inpatient treatment of children and adolescents with SUD. All psychiatric residents from Vilnius University and the Lithuanian University of Health Sciences who are going through their post-graduate training spend four months in specialised RCAD units and are rotated through different treatment modalities; therefore, they all have competencies in addiction psychiatry.

Psychiatrists, nurses, ergotherapists, and social workers have to renew their licence every five years and prove their participation in continuous educational courses which are approved by the MoH or a university. The licensing of medical professionals is the responsibility of the SHCCA. Professional associations are not involved in this process.

3.2.1.2 National Health Insurance Fund under the Ministry of Health https://ligoniukasa.lrv.lt/en/ and the Ministry of Health

The Ministry of Health and the subordinate National Health Insurance Fund are responsible for decisions about the funding of outpatient and inpatient medical services. The MoH adopts legal acts as QS for services. Most of the descriptions of specialised SUD treatment services were developed in consultation with the Republican Centre for Addictive Disorders (RCAD) and professional associations. The synergy between three institutions (the MOH, NHIF, and RCAD), and also professional societies, such as the Lithuanian Association of Addiction Psychiatry and Lithuanian Association of Psychiatry, under the leadership of the MoH has gradually become the driving force for developing QS and QA in SUD treatment.

The NHIF may perform audits. In the event of a breach of legal requirements, it may withdraw the financial reimbursement if the institution did not comply with the QS set by the MoH and NHIF.

3.2.1.3 Internal minimum quality assurance system in healthcare institutions

Routine QA is implemented through the institution's internal QA system. Each healthcare provider/institution is obliged to establish an internal minimal quality assurance (QA) system according to the legal act (MoH, 2008). This legal act requires each healthcare institution to approve local QA documents: treatment procedures/protocols to protect patients' rights, safeguard patients' personal data, investigate complaints by patients, and provide emergency medical aid. The head of the institution is responsible for the development and approval of the QA policy and its implementation, shaping the culture of patient-staff relations, values, attitudes, models of perception, competence, and behaviour. The head of the institution is also responsible for the determination of clinical and organisational indicators according to the institution's priorities, the scope of its services, activities to monitor and evaluate service effectiveness and risks, and the development of internal control procedures (audits, risk and adverse effect management, etc.). Regular anonymous surveys on patient satisfaction with outpatient and inpatient services are mandatory. At the end of the year the treatment institution provides a yearly report for stakeholders, which includes activities in QA.

Local QA teams have to be established in each healthcare institution. The leader of the QA team has to undergo an initial 48 hours of training on QA and then 24 hours every five years. A member of the local QA team has to undergo an initial 24 hours of training and then 12 hours every five years. The State Health Care Accreditation Agency under the Ministry of Health requires that the internal minimal QA system is functional in each healthcare provider.

The head of each healthcare institution is obliged to approve an internal Code of Ethical Conduct for employees as required by the legal act of the MoH (MoH, 2021a), as well as an Ethics Commission as required by the legal act of the MoH in 2021. One of the objectives of the Ethics Commission is to deal with any risk situations for patients and to ensure that services are provided in an ethical way.

3.2.1.4 National legal acts on developing clinical guidelines and training programmes

A legal act (MoH, 2006) sets minimum standards for the development and approval of national clinical guidelines. During past 15 years SUD treatment-specific guidelines were usually developed through the cooperation of the RCAD, Lithuanian Association of Addiction Psychiatry, Lithuanian Psychiatric Association, and universities. These include guidelines for opioid dependence treatment with methadone (Subata et al., 2010), with partial agonists (Subata et al., 2010), and with antagonists (Subata & Pincevičiūtė, 2008).

There is a legal act (MoH, 2011) which sets minimum standards and procedures for the development of national training programmes for medical professionals as well. Training programmes, such as ones on screening with AUDIT and brief interventions, case management, motivational interviewing, early diagnosis and outpatient treatment of alcohol use disorder, and smoking cessation have been developed by the RCAD and approved by the MoH and were followed by training professionals nationwide.

3.2.1.5 Integration of treatment of substance use disorders into overall personal healthcare

During this second phase from 2005 to 2016 the motivation of the professional community and the five specialised SUD treatment centres aimed to refine the existing QS and also seek legal approval from the MoH and NHIF.

Through the synergy of the MoH and RCAD and with the participation of NHIF several SUD treatment QS were approved as legal acts of the MoH. Reimbursement for these by the NHIF followed. The first and most important was a legal act on QS on specialised outpatient SUD treatment, approved by the MOH in 2015 (MOH, 2015). This act normalised nationwide specialised outpatient services, including OAT. In addition, the QS of specialised day care programmes for adults (2016) and short-term inpatient psychosocial rehabilitation for up to 15 days (2016) were nationally approved and started to be reimbursed by the NHIF.

The above-mentioned QS included the requirement for a licence of a healthcare provider (Addiction Psychiatry, 2nd level), medical indications for treatment, and minimum requirements for premises, medical staff and equipment, and the number of professional staff.

3.2.2 National quality assurance and control system in social services

In 2012 the Ministry of Social Affairs and Labour established, and since 2015 has enacted, legal QS for long-term residential rehabilitation communities (Ministry of Social Affairs and Labor, 2012). Rehabilitation Centres are under the supervision of the above-mentioned ministry. Long-term residential rehabilitation services were defined as social services. They were provided by NGOs and private non-commercial legal entities. The duration of the care was 12-14 months. Licensing is mandatory if the centre seeks funding from governmental funds. A licensed centre has to employ professionals: psychologists, social workers, and nurses. The evaluation of a rehabilitation programme is performed and the decision to issue a licence is made by the Drug, Tobacco, and Alcohol Control Department, which is commissioned by the Ministry of Social Affairs and Labour to ensure service quality control and coordinate services. Rehabilitation centres have to renew their licences every five years by submitting an updated programme and a list of employees.

3.3 2017–2022. Leadership is taken over by the Ministry of Health (since 2017)

3.3.1 New quality standards developed under the leadership of the Ministry of Health

In this latest stage the MoH decided (in 2017) to merge the five specialised centres into a Republican Centre for Addictive Disorders with five regional branches. Internal SUD treatment QS were gradually unified. Further QS, training programmes, and clinical guidelines were included into the RCAD Strategic Plan for 2022–2024 (RCAD, 2020)

In 2017 the MoH adopted a legal act on the reimbursement of screening with AUDIT and brief interventions performed by family doctors (MOH, 2017). Since then, it has been routinely available in primary healthcare provided by family doctors.

A separate Mental Health Department in the Ministry of Health was established in 2019. It took over the responsibility for developing policies and their implementation in order to improve mental health services nationwide. Mental health was formulated as one of the priorities of healthcare. The MoH developed an Action Plan for 2021–2024 (MoH, 2021b) to enhance access to SUD treatment and harm reduction and its quality. This plan also included the development of new QS of specialised SUD treatments. In implementing the Action Plan the following QS have already been adopted and implemented by the MoH:

a) the Minnesota 28-day inpatient programme has been given national approval after 29 years of existence (MoH, 2021c). This decision, including the decision to reimburse this treatment from the NHIF, was made after a Cochrane review was published on the 12-step facilitation programmes as an evidence-based intervention (Kelly et al., 2020) and other supporting publications;

b) buprenorphine/naloxone became fully reimbursed for the treatment of patients with opioid dependence in 2022. Medications are collected by patients at pharmacies (MoH, 2022);

c) psychosocial rehabilitation QS was provided with specific criteria for patients with SUD in order better to meet the specific needs of patients (MoH, 2022);

d) smoking cessation outpatient therapy (pending 2023).

3.3.2 Further plans for improving quality standards

The MoH is currently involved in political decisions to develop an Action Plan for 2022–2027 on mental healthcare reform (MoH, 2022). This will include activities to significantly increase access to SUD outpatient and inpatient treatments (e.g. the Minnesota programme and psychosocial rehabilitation), while the outpatient form of treatment is a priority. The plan includes the implementation of systemic improvements to care in the field of mental health. Currently, it has the following objectives:

a) to introduce a recovery paradigm for patients with mental disorders (through the introduction of case management on the primary mental health level, regional mobile teams for the most difficult patients, etc.);

b) to strengthen individualised treatment and continuity of treatments;

c) to pilot and introduce new service quality instruments which will allow the quality of the service to be monitored as a routine activity;

d) to monitor human rights aspects of services routinely;

e) to adapt and systematise psychological assessment instruments and make them more accessible for professionals.

4 DISCUSSION

During the initial period (1992–2004) professionals and SUD treatment providers initiated the development of QS. They were mostly internal documents, and in some cases, as in the case of the Minnesota model programme, they remained such till 2021. QS for OAT as a legal act was necessary from 1995 to allow the use of controlled medications. It was only in 2015 that the MoH approved full QS for specialised outpatient services, including OAT with methadone, and agreed on the methods to be used for full reimbursement. Similarly, opioid dependence treatment with buprenorphine/naloxone has been available since around the late 1990s, but it was only in 2022 that the MoH approved QS and reimbursement from the NHIF.

During the initial stage (1992–2004) the absence of national normative acts restricted SUD treatment to two, and since 2020 to five stand-alone centres for addictive disorders. By the end of the middle stage (2005–2015) and especially in the third stage (since 2017) the MoH and NHIF showed initiatives in normalising SUD treatment. The MoH took over the leadership in developing new QS of services and reimbursing them through the NHIF. This became a precondition for more healthcare institutions nationally to provide SUD treatment.

During the initial stage (1992–2004) the decisive role in developing QS for new services was played by professionals and existing treatment institutions. It was not unusual to start services after internal QS were approved in institutions only, without nationally approved QS or national clinical protocols. Most often internal QS were developed and implemented in the existing infrastructure by adapting QS from Western countries.

In Lithuania's case, the situation allowed professionals to be engaged with colleagues and prominent professionals from European countries, the US, and Australia. Since 1992 the Open Society Institute and its branch in Lithuania (Open Lithuania Foundation) have provided grants for Lithuanian specialists to travel to the US and EU to observe good practices there. Later, at the end of the 1990s and around 2000 these possibilities were complemented by EU projects. As the HIV outbreak happened in neighbouring Eastern European and Central Asian

countries, Lithuanian professionals had an opportunity to engage with European, US, and Australian SUD treatment professionals through the involvement of joint projects of the WHO, UNODC, and OSI.

In this way, Lithuanian specialists had good opportunities to take best practices from abroad and refine QS at home through extensive involvement in international networking. The driving force and leadership in developing SUD treatment QS at home came from bottom-up professional grassroots initiatives.

After 2017 the leading role in planning new QS and reimbursement from the NHIF was taken over by the MoH. The adoption of the 2021–2024 Action Plan includes steps to develop new QS and start new services, develop training programmes and implement training, and develop clinical guidelines. The RCAD, which has a Unit for Methodological Guidance and Monitoring, was commissioned by the MoH to implement a major part of the planned activities. A close partnership exists between the MoH and professional associations as well.

QA is essential to provide safe and quality medical services for patients. Institutions which provide SUD treatment comply with the nationwide QA system for medical services. An internal minimum QA system in healthcare institutions provides a mechanism for everyday QA practice.

Clearly defined procedures of QS in the institution help patients and staff or management to have a common understanding of a) what the goals of treatment are, b) how it works, c) who are specialists and what their responsibilities are, d) which external institutions need to be linked with, e) what outcomes are expected and how effective treatment can be, f) what the expected follow-up treatment would be, g) which indicators of treatment are monitored on a routine basis, h) what international "good practice" is and how this particular treatment could be improved, and i) patients' complaints about service quality (if they happen) are seen as a tool to bring about improvements.

The practical impact of well-defined SUD QS helps to shape realistic expectations among the general public about the value of current treatments and reduce the stigma of treatments and patients. SUD treatment in Lithuania used to exist in the realm of self-help activities and non-evidence-based approaches, such as various religious approaches, hypnosis, acupuncture and laser therapies, etc. Evidence-based QS help to promote a clear perception about the differences and increase the transparency of treatment approaches.

5 CONCLUSIONS

The case study of Lithuania shows that in a period of deep political, economic, and societal transition in countries where the national QA systems are weak, professional associations may play a major role in developing internal institutional QS and QA systems and implement evidence-based SUD treatment programmes. Exposure to best practices in other countries may empower professionals to initiate and implement internal QS. In due time internal QS may be incorporated into national healthcare and quality assurance systems, especially if SUD treatment is placed higher on the priority list by the national authorities.

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