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Exploring the content of blindness rehabilitation programmes in Lithuania: models and approaches

Abstract

The field of research on blind and visually impaired services is broad, diverse, and dominated by empirical and interdisciplinary research. It is determined by the object under study, which includes a whole range of services, starting with social services and ending with personal health. On the other hand, the achievements of ophthalmologists in this field (compared to scientists in other fields) are significantly higher. However, it is noticeable in academic studies that NGOs must be professional and ready to provide more complex social services (research reveals that NGOs provide these services to the blind and partially sighted in about half of the world's countries). This article aims to conceptualise the social rehabilitation policy, legal regulation, and models of the blind and visually impaired in Lithuania. Scientific and expert literature analysis, semi-structured interviews, and case studies are used to achieve the goal. The current research found that a gradual development of services is necessary to increase the

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availability and effectiveness of rehabilitation services for blind and partially sighted persons. It is necessary to ensure the expansion of the service system to achieve the interoperability of health and social services. Systematic monitoring and evaluation become important to ensure the quality of such services.

Keywords: visual impairment, social rehabilitation, blind person, blindness rehabilitation programme, non-governmental organisations

Introduction

Rehabilitation programmes and services for the blind and low vision are fairly widely studied in the field of interdisciplinary research, as revealed by meta-studies and general reviews (van Nispen et al., 2020; Binns et al., 2012; Ryan, 2014). Obviously, this is determined by the nature of the applied programmes or the services themselves. Most of the time, the problems with programme availability, content, application of individual measures, benefits for participants and other issues are raised and analysed by ophthalmologist researchers, less often by optometry specialists. On the other hand, the research field has notable publications authored by occupational therapists, psychologists, sociologists or social work researchers (Ravenscroft, 2019). It is noteworthy that hundreds of publications have been published in various approaches, on different topics, since 1986, when the modern model of visually impaired rehabilitation programmes was developed at an international conference (USA, Canada, and UK) supported by the American Foundation for the Blind (Markowitz, 2016). Similar content-responsive models have been developed for individuals with vision loss. On the other hand, both Samuel N. Markowitz, one of the leading research scientists in the field, as well as some scholars of the World Health Organization and other researchers emphasise that there is no best or evidence-based "gold standard" – Preferred Practice Pattern (Markowitz, 2016; Mogk, 2016).

Based on the publications summarising the research field, it can be observed that the following thematic directions are mostly examined: 1) the need for services and barriers that reduce accessibility (aspects of service financing, acceptability to clients, timeliness, etc.); 2) content of programmes (models, nature of applied interdisciplinary interventions and contexts, cases of their application); 3) benefits of provided services (projects, multi-annual programs, etc.) and their effectiveness; 4) rehabilitation programmes in personal health or social service systems (Ravenscroft, 2019; van Nispen et al, 2020; Binns et al., 2012; Ryan, 2014). It is difficult to find a clear research direction that combines service providers, compatibility with service systems (personal health, social), funding and the like. There are indeed quite a few individual studies but there are no groups connecting researchers at conferences or anything like that. Looking at the field of research, it is important to note that most studies are empirical in nature, based on a quantitative or qualitative research approach, however, there are also generalising studies.

The field of research on blind and visually impaired services is broad, diverse, and dominated by empirical and interdisciplinary research. This was determined by the

object under study, which includes a whole range of services, starting with social services and ending with personal health. On the other hand, the achievements of ophthalmologists in this field (compared to scientists in other fields) are significantly higher.

This article will contribute to the discussion of the concepts of social rehabilitation for the blind and partially sighted (concepts, contexts of their application), the conceptual approach of studies and the results of empirical research. A separate subsection will examine models of social rehabilitation service provision and their application. Such an analysis of concepts and empirical research will allow us to evaluate the achievements of scientists and experts, and existing concepts.

Rehabilitation programmes for the blind and partially sighted in national public policies

There are many questions for decision-makers about the effectiveness of programmes for the blind and visually impaired (van Nispen et al., 2020; Wallace et al., 2022; Virgili et al., 2022; Binns et al., 2012). Also, policymakers put questions about their effectiveness, from a cost-benefit perspective (Longo et al., 2020; Binns et al., 2012; Ryan, 2014; Patty et al., 2014). Finally, the question arises as to which executive authorities (ministries, departments, agencies) are responsible for rehabilitation and how services are delivered (Longo et al., 2020; Fontenot et al., 2018).

Factors determining the choice of organisational model. As the research shows, the responsibility for social rehabilitation programmes for the blind and partially sighted depends on complex factors: 1) the structure of state governance (federal or regional states have more pronounced differences from unitary states); 2) nature of public policies and service systems (health care, social, rehabilitation systems are sufficiently different); 3) regimes and traditions of legal services**.** In general, the institutions of the central government (how different it is in federal or what is referred to as regional states, e.g., in Spain, Italy) are responsible for a significant part of rehabilitation services. Thus, social rehabilitation programmes are part of health, social security or rehabilitation public service policies (they are integrated into health service systems more often, but inevitably overlap with social services) (Markowitz, 2016; Luu et al., 2020; Longo et al. , 2020; Rabiee et al., 2015; Jaiswal et al., 2021). A significant number of countries do not have special rehabilitation programmes for the blind and partially sighted (e.g., based on multidisciplinary access or special psycho-emotional therapeutic programmes). Residents of parts of Europe can receive services that are an integral part of rehabilitation systems (LRS, 2022).

When examining organisational models of blind and partially sighted services (it is important to distinguish them from multidisciplinary team models here, which are related to interventions/services and their content), we can see that we are dealing with five different types (see data in Table 1).

Table 1. Organisational models of blind and partially sighted rehabilitation services

Organisational model	Main features and advantages and disadvantages
Institutions controlled by state and subnational institutions, also called "in-house"	**Key features:** Blind and visually impaired programmes are an integral part of systems (usually of integrated health care). Services are mostly provided by specialised rehabilitation service centres. **Advantages:** More consistent integration into service systems, and better hierarchical coordination is possible. The state, regional authorities or municipalities monitor and control the activities of subordinate institutions and can change the directions of activities based on incremental decisions. Financing is directly linked to budgets or insurance funds. **Disadvantages:** Procedures in institutions and institutions are sometimes bureaucratised, procedures are formalised, etc., i.e., it reduces the acceptability of the programmes. Several studies reveal that their costs are significantly higher than purchasing services from businesses or NGOs. Institutions of different areas of management and subordination have cooperation gaps, horizontal coordination is insufficient.
National blind unions (friendships, associations)	**Key features:** Unions of the blind (membership-based NGOs) as accredited institutions take over separate rehabilitation programmes or carry out activities in this field on a project basis. The role of these organisations is greater in countries which have not developed service systems, e.g., in Central Europe and the Baltic States. Unions of the blind have created specialised support centres and specialists who can be used to provide rehabilitation services. **Advantages:** Blind unions, as strong membership organisations, have accumulated considerable resources (members, hired staff, volunteer networks, sponsors, material assets) and developed systems of communication, self-help, and (often) professional services. Trust and support in society also come from interested actors. One of the benefits is the organisations' networking and connections with their members and potential new programme participants. Specialists of blind unions have a good understanding of the complex needs of potential programme participants and their changes. **Disadvantages:** Limited opportunities to provide a wider range of services, difficulties in cooperation with other organisations, and a lack of professional specialists.
NGOs (or more broadly NPOs, social economy enterprises)	**Key features:** The model is implemented by financing the services provided by NGOs: 1) from foundations, NGOs or rehabilitation service support programmes; 2) after accreditation, providing for continued financing. In the USA, Canada, and some European countries, services are often provided by university clinics or specialist teams working in their vicinity. People working in the rehabilitation of the disabled or similar and having specialised centres are experts in this activity. In some countries, services are provided through community organisations. **Advantages:** NGOs better assess the needs of the participants and their relatives and can choose more precise interventions and solve problems more quickly. NGOs can involve volunteers in their activities and are more flexible in terms of service delivery. They are more trusted. It is important in long--term or staged rehabilitation, where blind and partially sighted people

	receive some part of their services at or near their homes. NGOs are more creative in proposing interventions. They create cooperation networks in communities and with other organisations. NGOs can bring together multidisciplinary teams of professionals and provide organisational and other support. NGOs can raise additional financial resources from sponsors. **Disadvantages:** Limited opportunities to provide a wider range of services due to specialisation (social and psychological consultations are provided more often), which can reduce the quality of services (it is more difficult to apply the model of multidisciplinary teams). Greater possible risk of non-completion or extension of services if services are financed through projects (pressure due to insufficient funding or increased costs).
Contracting-out model (and accreditation or certification to include business in service provision)	**Key features:** Rehabilitation services are purchased from private clinics, specialised centres, specialist teams, etc. The contracting-out model envisages participation by NGOs and public institutions. Services are purchased based on established procurement legal procedures (organisation of tenders, evaluation of offers according to established criteria, conclusion of contracts) or based on accreditation models. **Advantages:** The possibility of purchasing services in the absence of government agencies, NGOs, and the like. It is a common belief (there is not enough evidence, only a few studies support this) that this way is more beneficial (in terms of price and quality) to get the best value services. **Disadvantages:** Contracting out does not provide certainty or strengthen specialised businesses or other organisations (especially in smaller countries). Some studies reveal that contracting-out increases the cost of services (according to several studies in the UK).
Individual rehabilitation model	**Key features:** Individual services are provided by individual specialists on the basis of accreditation. This method is usually combined with others. Its advantage is attracting the necessary specialists.

Source: OECD, 2015; EBU, 2018, Longo et. al., 2020; Rabie et al., 2016; Rabie et.al, 2015; LRS, 2022; Fontenot et al., 2018; Luu et al., 2020; Jaiswal et al., 2021.

The most commonly used model is a government-controlled agency(ies) model, or it is combined with others, otherwise outsourcing service provision to NGOs, national blind organisations or businesses. The model of government-controlled institutions allows for complex and integral coordination of multidisciplinary teams and/or ophthalmic services (at all three levels in the health system – clinical, secondary, and primary). On the other hand, this model has its drawbacks. First, not all countries have integrated healthcare service systems or integrated social and personal health services. In addition, it is relatively expensive (for others, see: Table 1). Some studies reveal that national or regional blind and partially sighted rehabilitation programmes have significant coordination gaps, and lack good planning or sufficient funding (Swift et al., 2021; Jaiswal et al., 2021).

A more effective (admittedly, there is insufficient evidence) alternative can be considered the provision of services to the blind and partially sighted using the rehabilitation centres and teams of NGOs and national blind unions. As already discussed, they have experience (most national blind unions are more or less active in these areas) (EBU, 2018; review of web pages of 20 national blind unions). Their

accumulated resources, rehabilitation service centres or specialists, the trust of society and the disabled, and their work are or can become a prerequisite for effective cooperation. Furthermore, such collaborations respond to contemporary paradigmatic attitudes and values related to the ideas of public governance, service transfer/delegation, co-production, and co-creation (Dvorak, 2013; McMullin, 2022).

We should stop at one question, which way of involving NGOs or blind unions in the provision of services would be the most appropriate? In terms of conceptual access, the involvement of the blind union would correspond to the concepts of commissioning and co-production. The latter would mean that the organisation representing the blind and partially sighted provides services in cooperation with the authorities. As can be seen from scholarly publications, membership in institutions would make it easier to implement services (Park, 2020). Organisations themselves are both service providers and represent user groups, and such roles and interests can be useful for quality assurance. Research conducted in recent years reveals that these models of social care and mental therapy services are promising (Park, 2020). On the other hand, national organisations of the blind are very strong as NGOs and can provide quality rehabilitation services for the blind and partially sighted. This argument reduces doubts about the limited capacity and potential risks of such organisations. Social mission and representation of public interest can be singled out as another argument in favour of disabled NGOs as service providers. It is true that they partially represent the interests of their members, but at the same time, through their activities (often providing services to members or other beneficiaries), they also carry out a social mission.

However, even for large organisations, financial certainty and long-term service provision are important, as evidenced by empirical and conceptual ideas based on the New Collaborative Governance theory (Kekez et al., 2019; Loeffler, 2015; Sturgess, 2018). Commissioning services through accreditation (i.e., non-competitive provision under short-term or long-term agreements). Clearly, accreditation or similar models have been used in social services in most European countries, and their choice has been determined by established policy priorities (Wollmann, 2018; Erlandsson et al., 2013).

Research issues of rehabilitation programs: accessibility, acceptability, quality in national public policies

Service demand and its research. Researchers, when starting an analysis, first notice that often, even in the richest countries, services are available only to a part of the visually impaired. This is determined by the extent of the need. Researchers estimate that around 10–30% of people require these services (reported data by researchers varies due to different methodologies for assessing needs) population and it is on the increase in Western societies (Cruess et al., 2011; Jaiswal et al., 2022; Ryan, 2014; Markowitz, 2016).

Bright et al. (2018) conducted a meta-study (examining data from 27 empirical studies) which revealed that access to services is low in all continents and especially in

countries with medium and low economic development. In addition, the researchers' study showed that services are more accessible to urban residents and groups of people with a higher socio-economic status. When explaining the reasons for accessibility, researchers explained it by several factors: lack of services (unavailability), transport, and unacceptability (no understanding of the importance of such services, etc.) (Bright et al., 2018). Similar research results have been obtained by other researchers who have examined accessibility and related issues in the rehabilitation of the blind and partially sighted (Lam & Leat, 2013; Kaldenberg, 2019; Matti et al., 2011; Fraser et al., 2019). After summarising all the research data, the following four limiting factors (also called barriers by scientists) can be distinguished (see: Table 2).

Table 2. Factors limiting rehabilitation services for the blind and partially sighted

Limiting factors	**Presentation of factors**
Factors significantly limiting accessibility	
Accessibility (service delivery gaps)	Waiting for service, no service.
Awareness – acceptability (gaps related to service recipient and social environment)	Low awareness and awareness, lack of perceived need (both by the potential client and their family/relatives), emotional fears, other priorities, side effects of illnesses, shame/stigma, psycho-emotional state, mistrust of service providers, stereotyping, and interactions with other individuals.
	Minimal limiting factors
Geographical availability (gaps related to service provider and/or service recipient)	Distance to the place of service, transport problems, lack of escorts.
Quality (service delivery gaps)	Discrimination and poor quality services, bad relations with suppliers, communication difficulties, and lack of skills of the service provider. Insufficient customer-oriented services. Insufficient coordination and other organisational problems.

Source: Lam & Leat, 2013; Kaldenberg, 2019; Matti et al., 2011; Fraser et al., 2019; Bright et al., 2018, Nguyen et al., 2008.

Understandably, the most limiting factor in the availability of services is their absence (see: Table 2). As already discussed, in many countries such public services do not exist or are provided in a highly specialised and limited manner. This is a systemic problem that cannot be solved on organisational level and using operational solutions. Naturally, in such a case, it is necessary to address issues and change public policies. On the other hand, it is a certain space for blind and partially sighted representatives (NGOs, medical organisations, etc.) to act and try to influence decision-makers. Availability is also reduced by the limitation of waiting for the service. True, scientists do not agree on this limiting factor. Scientists, especially psychologists, believe that participation in rehabilitation programmes is individual and can be determined by psycho-emotional status, and negative effects of the social environment (e.g., after a sudden loss of vision, a large number of patients experience depression).

Patient awareness is another significant barrier (see: Table 4). Many research studies discuss why information does not reach target groups and what factors could help solve the problems. For example, studies in Western countries show that not all ophthalmologists, and nursing professionals (both in clinics and on the secondary level) are well informed and do not refer blind and visually impaired people to these programmes (Basilious et al., 2019; Lam & Leat, 2013). A similar problem exists with general practitioners and their awareness of the potential support available to patients. Some studies have suggested that the problem can be solved by educating doctors and other medical professionals (Lam & Leat, 2013; Swift et al., 2021).

On the other hand, not all blind or partially sighted people are ready and motivated to apply for services and participate in rehabilitation programmes. A number of studies reveal that there is a notable gap in service delivery due to lack of understanding, misconceptions, and triggering stigma among patients and their relatives (Fraser et al., 2019; Jaiswal et al., 2021; Kaldenberg et al., 2019). In general, psychological factors that form barriers are quite numerous and they are significant enough. In this case, it is very important to get help and understanding from people who can help overcome the barriers of "fear" – doctors, psychologists, social workers and, of course, relatives. There are quite a lot of customer-related factors that lead to low motivation of service users and they affect some people in a complex way. Factor analysis requires attention from researchers and appropriate research.

An unfavourable social environment and other people's attitudes are considered by scientists as additional obstacles. For example, a group of researchers led by Sarah Fraser conducted a qualitative study and concluded that stereotyping of others, and social stigmas limit participation in rehabilitation programmes (Fraser et al., 2019). Attempts are undertaken to solve these problems through public education and changing attitudes on the basis of information campaigns and more targeted informing of people. It is also said that proper counselling (proper explanation of benefits) can be an effective tool in increasing motivation to join a blind and partially sighted programme (Jaiswal et al., 2021).

Barriers to getting involved in programmes are not only factors of an individual nature or an unfavourable social environment but also related to the poor quality of services provided by service providers (see: Table 2). These factors are not critically important, but they are significant for some people who are blind or visually impaired. As research reveals, quality is primarily determined by failure to meet expectations due to complex factors (Jaiswal et al., 2021; Fontenot et al., 2018; Basilious et al., 2019).

The quality of rehabilitation services is examined through several research approaches. As already discussed in the previous part, it is usually analysed in terms of the impact on the patient, introducing the criteria of impact on vision-related quality of life and health-related quality (Binns et al., 2012; Luu et al., 2020). This approach is also called post-intervention, where quality is understood in a complex way (includes a whole group of factors: physical, social, functional, psychological) and examines quality in terms of effects on behaviour and health. In this perspective, research optometrists and ophthalmologists use special questionnaires and research methodologies (Selivanova et al., 2019). This approach aims to holistically measure the pre- and post-engagement characteristics of programme participants. Also, on the basis of these research concepts, the effects of close people are also examined.

Visual impairment and interpersonal effects. Some researchers (mostly psychologists, and ophthalmologists) focused on the topic of the effects of blind or visually impaired relatives (Mamali et al., 2022; Lehane et al., 2017; 2018). These studies partially cover the themes of help, and coping with disability by relating them to the involvement of people with visual impairments in rehabilitation programmes. For example, a team of Danish and Canadian researchers led by Freideriki Carmen Mamali (2022) examined several topics in a qualitative study: 1) the changing life contexts of a visually impaired person and their loved ones (spouse, children, subjects) while living together (new challenges and problems, difficult emotional condition and disorders, communication problems); 2) adjustment and readjustment to new problems by creating coping strategies and accepting or rejecting help. Importantly, researchers examine coping strategies in relation to effective help from loved ones for the blind, using several concepts: 1) accepting and rejecting help; 2) positive and negative support (van Nispen, 2016; Mamali et al., 2022). The findings of other researchers show that relationships between loved ones after major visual impairments are affected by complex factors, and it is quite difficult to evaluate all of them by operationalisation (van Nispen, 2016; Mamali et al., 2022). After examining the literature, it is important to distinguish the main categories that can help clarify the emotional and social dimensions which comprise the interactions of loved ones (see: Table 3).

Table 3. Interactions between the blind and partially sighted and their relatives as well as their implications for rehabilitation programmes

Conceptual dimensions	Categories and subcategories
Problems and challenges with vision loss	*Psycho-emotional effects* (frustration, depression, tension, isolation, etc.); *reduced activity and social limitations (orientation* – mobility, reading, travel, sports, job loss, mobility, isolation, communication difficulties); *reactions of other people* (little understanding, stereotyping, others do not adapt, discrimination, family members doubt the disabled person's ability to adapt); *feeling of loss of one's self (loss of self-esteem*, being treated as less capable).
Support and coping	*Assistive measures* (assistance with the application of technical measures). *Social support* (finding positive optimism, deciding to live a quality life, gratitude, learning experiences after losing sight). *Recognition* (help in coming to terms with visual impairment, raising self-esteem, …). *Avoidance and denial* (avoidance of acknowledging the effects of disability on self and others; failure to recognise limitations; avoidance of situations that will reveal disabilities). *Strategies for overcoming problems*: 1) support in order to receive services (vision rehabilitation, family counselling, support and services provided by the state-municipalities); 2) social support (emotional support and daily care of family, friends and other people with vision loss).

Source: van Nispen, 2016; Mamali et al., 2022; Lehane et al., 2017.

Analysing the data presented in Table 3, it can be observed that the involvement of a blind or partially sighted person in rehabilitation can be determined by an active relative (family members, friends) but can also become a limiting factor. Researchers have studied extensively how effective the involvement of relatives in coping strategies for a blind or partially sighted person is. Effective support mechanisms related to finding information, counselling, motivation, etc. are established. Research reveals that unexpected blindness or severe low vision places a significant burden on families and solving the problems requires the cooperation of all family members. In this case, blind relatives are the main source of coping with the disability and managing strategies can be coordinated according to it (Mamali et al., 2022). On the other hand, spouses, children, parents, and friends can act as mediators.

Data and research methods

The article is based on a case study of Lithuanian blindness rehabilitation policy. At the same time, the conceptual basis of the study is based on the concepts of public management (reforms of public services, transformations of applied models, public policy formation process) and evaluation of social rehabilitation programmes (barriers to rehabilitation services, family involvement in rehabilitation, adequacy of rehabilitation activities).

During the research, the following methods were used: literature analysis, case study, and semi-structured interview. *Analysis of scientific and expert literature*: we conducted scientific literature to determine the concept of rehabilitation services for the blind; updated the classification of blind and partially sighted rehabilitation programmes in national public policies. *Semi-in-depth structured interview:* semi-structured interviews were conducted to analyse the attitudes, experiences, and performance of the research participants. Targeted sampling was chosen for the study by predicting categories of informants. The aforementioned choice was based on several grounds such a sampling: 1) responds to several different topics included in the study; 2) responds to conceptual access; 3) is frequently used in service provision research for the blind and visually impaired (Rapley, 2014; Colorafi & Evans, 2016). The data collected in the semi-structured interview is taken from a larger study and used here in this study to support some of the arguments. The number of respondents is not presented separately, because the method of individual interviews was not used exclusively for this research. We asked the respondents pre-prepared questions. However, some questions were rephrased or additional questions were asked. *Case study*: we chose the case study method for empirical research because, according to Yin (2009), a case study is an empirical inquiry that examines contemporary phenomena in a real-life context, when the boundaries between the context and the phenomenon are unclear. Blind rehabilitation programmes as research objects have a project structure, which means that the research object is constantly changing, something disappears, and new elements appear.

Social rehabilitation of the blind and partially sighted in Lithuania: policy, legal regulation, and models

In order to better understand and reveal the rehabilitation policy for the blind and partially sighted in Lithuania, this chapter will examine the goals and assessments of this policy, examine the existing legal regulation, allocate financial resources and describe the service delivery model.

Policy objectives. In Lithuania, the rehabilitation policy aims to include disabled people in society, ensuring a higher quality of social life in the community. Lithuania is obliged to develop this policy on the basis of ratified treaties (UN Convention on the Rights of Persons with Disabilities) and on the basis of European strategic documents (LRS, 2010). These documents determined one of the directions of state policies – ensuring sustainable and fair access to rehabilitation. National strategies for the integration of the disabled, legal acts (Law on the Social Integration of the Disabled), and the programme documents implementing them (the Action Plan for the Social Integration of the Disabled 2021-2023) identified the main goals and principles (SOCMIN, 2020; LRS, 1991).

Without delving into the general principles and goals of the integration of the disabled, it can be seen that the Lithuanian state's policy for the disabled aims to: form or restore their social and independent life skills, help them acquire education, ensure opportunities to participate in public life, and the labour market (LRS, 1991). The National Action Plan for Social Integration 2021–2023 details these goals and stipulates that the state's objective is to: *ensure the continuity of the implementation of social integration measures for the disabled, implement new measures necessary to include the disabled in social life, encourage state institutions to cooperate with non-governmental organisations working in the field of social integration of the disabled.* In this policy, the state emphasises cooperation with NGOs specialising in the aforementioned management area. This corresponds to the priorities of the 18th Government (led by Ingrida Šimonytė) related to the transfer of social services and adequate financing (Item 93.2 of the Government Programme) (LRS, 2020; LRV, 2021).

One may wonder what area of government social programmes for the blind and partially sighted belong to. As discussed earlier, in some countries blind rehabilitation is classified as personal health management because it involves medical service interventions. On the other hand, it is determined by the specificities of national health and social security systems and the management responsibilities of their overlapping areas. In Lithuania, social rehabilitation services for the disabled are a subsystem of the social integration system of the disabled (Valstybės kontrolė, 2020).

Institutional responsibility for the implementation of the social rehabilitation policy for the blind and partially sighted. This policy is implemented by the Government of the Republic of Lithuania, based on the Ministry of Social Security (SOCMIN), as the institution responsible for the management area (LRS, 1991; Valstybės kontrolė, 2020). SOCMIN organises and coordinates the implementation and controls the implementation of the social rehabilitation policy (LRS, 1991). The Department of Disability Affairs (DDA) subordinate to the Ministry, with the help of other organisations and associations of the disabled, is responsible for policy implementation

and administers programmes and their measures, and projects (LRS, 1991). It should be noted that disabled people's associations are understood as actors of policy implementation and have a clearly defined status. In addition, Article 7 of the Law on the Social Integration of the Disabled defines and clarifies the possible functions of associations of the disabled: represents the interests of the disabled, helps implement measures and projects for the social integration of the disabled: *organises the provision of social rehabilitation services for the disabled, recreation for the disabled, sports, tourism, cultural activities, international cooperation. When organising their activities, associations of the disabled cooperate with state and municipal institutions and can receive financial support from these institutions and institutions* (LRS, 1991). The norms of this article presuppose and specify the fact that the state grants disabled associations the right to provide public services (they are legalised actors of the integration policy and social rehabilitation system of the disabled). Such a system and roles could be determined by the historical context of 1991. At that time, some of the disabled organisations were significant service providers due to the available capacities and a large number of subordinate companies and institutions, as well as concentrated specialists. However, later (2016–2022), the concept of association of disabled people is no longer unused in the accompanying orders of the Law on Social Integration of Disabled Persons, adopted quite recently (SOCMIN, 2020; 2021).

Objectives, model and organisation of comprehensive social rehabilitation services for the blind. The rehabilitation service policy for the blind and partially sighted (with severe visual impairment; RA less than 0.05) was introduced in 2017. The provision of services (what is called trainee programme) is defined by the description of the procedure approved by the order of SOCMIN (SOCMIN, 2017). The purpose of this policy is *to restore, develop, and consolidate spatial orientation and independent movement (mobility), daily life, and communication skills, increasing their independence and opportunities to participate in public life* (SOCMIN, 2017). The goal defined by the legal act foresees the desired results – improvement of the quality of life of the blind and partially sighted through the formation or consolidation of abilities and skills. It also defines an expectation that changes behaviour and allows participation in social life. It is also important that service integration is defined using a team of professionals and a holistic approach to integrate a number of interventions. On the other hand, the goal definition does not include ophthalmic and optometric care services as recommended by WHO, authoritative ophthalmological associations, and numerous studies (as discussed, although there is no "gold standard" for such programmes, a number of recommended models have been developed). This is a significant shortcoming and potentially limits interventions. In the interview study, the informants explained that the gap arose due to the fact that there is no way to systematically integrate personal health and social services in Lithuania due to the closedness of management systems, institutional interests, and deficiencies in management coordination (interviews with INF12; INF17).

Moving on to the analysis of service provision procedures, it should be noted that complex social rehabilitation services for the blind are organised, supervised, and controlled by DDA. The created legal regime provides that the aforementioned services are provided in accordance with the Law on Public Procurement (SOCMIN, 2017).

The procedures established by the order of the Minister of Social Security and Labour also determine rehabilitation interventions for the blind, which include: 1) orientation in space and development of independent movement (mobility); 2) development of everyday skills; 3) the help of a medical psychologist; 4) professional counselling and guidance. According to the established procedures, these services must be provided by a team of five specialists, including social workers, medical psychologists, special educators, and computer literacy specialists (SOCMIN, 2017). The work process is also defined according to the established procedures. It includes assessment of complex needs, planning, and delivery of interventions. The procedures established by the legal act provide that the multidisciplinary team should work in a coordinated manner under the guidance of a designated manager.

The complex social rehabilitation service is small in terms of its scope (see: Table 4). Relatively few blind people participate in it (an average of 18 disabled people). Relatively little time was devoted to work with the blind and partially sighted (2,781 hours, mostly devoted to spatial orientation and independent movement and the development of daily skills). By the way, these services were provided in specialised service centres (see: Table 4).

After completing the services, the blind cannot continue to receive complex social rehabilitation services for five years and can participate in the new programme only after five years (this is partially compensated by LBU using its territorial networking and the work of specialists, branch chairpersons) (Interview 3 focus group; SOCMIN, 2017). This does not ensure the continuity of the service and greatly reduces its availability to people in need (e.g., due to the decreasing residual vision).

The empirical material reveals that three organisations provided comprehensive social rehabilitation services for blind persons (see: Table 4). The state-controlled institution – VšĮ Valakupių rehabilitation center (Kaunas branch) won the procurements twice and provided the services. The rights and obligations of this owner are implemented by DDA.

Table 4. Provision of comprehensive social rehabilitation services in Lithuania in 2017–2022

Year	Service provider	Type	Number of participants	Scope of services, hours	Financing, thous. EUR.
2022	LBU southwest centre	NGO, Organisation of the disabled persons	22	2,392	32
2021	LBU southwest centre	NGO, Organisation of the disabled persons	18	2,104	40
2020	VšĮ Valakupių rehabilitation centre	State-controlled, owner rights DDA	21	2,713	40
2019	VšĮ "Vilties žiedas"	NGO, NPO, social enterprise	15	3,554	21
2018	VšĮ "Vilties žiedas"	NGO, social enterprise	16	3,564	21
2017	VšĮ Valakupių rehabilitation centre	State-controlled, owner rights DDA	18	2,361	21

Source: LASS, 2022b; SOCMIN, 2022.

VšĮ Valakupių rehabilitation centre is one of the largest providers of social services. It specialises in providing a full range of services – medical and professional rehabilitation, social care, and nursing services for seniors, the disabled, people with poor health and families (VšĮ Valakupių reabilitacijos centras, 2022a). This institution has employed 102 employees and provides services in several service centres. It received 128,311 euro of income for the provision of rehabilitation services. (VšĮ Valakupių reabilitacijos centras, 2022b). After reviewing the positions of this service provider in the rehabilitation services industry, it can be seen that it is not a specialistic institution and it does not work exclusively with disability groups. On the other hand, it has service centres, general competence specialists (medical, social field). This institution participated in the public procurement competition in 2022. It would be interested in continuing to provide services, as it has a service centre and specialists (a clarifying interview with the head of the VšĮ Valakupių rehabilitation center).

NGO "Vilties žiedas" (legal form Public Entity; shareholders – two private individuals) is another institution that participated in public procurements and provided rehabilitation services to the blind after winning several times (see: Table 4). This institution has the status of a social enterprise and provides vocational rehabilitation for the disabled, vocational training, provides social services, and manufactures and adapts orthopaedic devices. It received an income of 1,064,110 Euro in 2021 (no income from social rehabilitation was received) (VšĮ "Vilties žiedas", 2022a; 2022b). By its very nature, it is a social (or social economy) business enterprise, and this is revealed by its declared social mission. VšĮ "Vilties žiedas" has accumulated considerable experience working with disabled persons. However, social rehabilitation is not, as publicly published reports reveal, a permanent area of activity for this company. The aforementioned institution faced difficulties in forming a multidisciplinary team of specialists for work with the blind, as the interview material reveals (interviews with INF10; INF14).

LBU also participated in the provision of complex social rehabilitation services (see: Table 6). This union of the blind and partially sighted (with approximately 5,425 members) entered with a considerable track record of project activities and service delivery. It has both a service delivery centre (the LBU southwest centre of the public entity, which is one of the three regional institutions under LBU) and a multidisciplinary team. In addition, LBU cooperates with the Palanga recreation and rehabilitation centre "Pušynas" (an institution under the Ministry of the Interior), where its members and other people with visual impairments receive medical and social rehabilitation services (social typhlopedagogical assistance is provided by a specialised employee). A fairly large number of blind people received services here (in 2020 – 21, in 2019 – 46; in 2021 – 38) (LASS, 2022c). It is true that this is not the programmatic provision of public services but works with clients according to their needs (LASS, 2022c; 2021). In 2021–2022, two LBU specialists provided mobility skills development services for the blind throughout Lithuania (outbound services are financed by DDA, with support through the funding instrument for supporting disabled associations) (NRD, 2021; LASS, 2022d).

The organisational model of providing social rehabilitation for the blind and partially sighted was one of the main themes of the qualitative research. While

examining it, it was explained what the experts' views are. Most informants (both LBU representatives and experts) prioritised the accreditation model (see: Table 5). True, at the same time, the opinion was clearly expressed that after the accreditation of LBU or another NGO with the transfer of services, financing that meets the needs of disabled people and continued financing according to objective criteria should be ensured. On the other hand, some informants noticed that LBU can also provide services by participating in public procurements because the quality of their services is higher (the truth is that, as examined, it is faced with more than one limiting factor) (see: Table 5).

Table 5. LBU contributions and activities in providing complex social rehabilitation services and ensuring their continuity

Roles	**Quotes from participants**	**Guidelines for the development of an organisational model**
LBU representatives	*We are still in the process of deciding which model we want which laws should be changed and which sources of funding should be available. When we clear up, then maybe we will discover what we want, what we expect […] Because until now, LBU itself wants to do that. There was an attempt to give it to the state but it turned out that it would happen during public procurement. It was thought that maybe some rehabilitation institution would get involved and do it well. However, we have come full circle and come back to this model. We want to make a reasonable proposal to the state so that there will be opportunities to enter one or the other in the law so that funding will appear for one or another institution to do so, and so that a system will appear* (Focus group 3). *Well, now is better than nothing. The department [DDA] understands that there will be quality here because of the participation of the LBU centre and they can do to win. Because it is always based on quality. The Finns are also following the path of competition. That's what I asked them, that's how you win them. They answered that we provide such quality services that others cannot compete with us. But, they say, we noticed that another organisation is emerging, which has already accumulated* (interview with INF12).	1) The vision for the development of the blind and partially sighted system and the choice of ways to realise it (related not only to LBU involvement but also to members and public interests); 2) the most sustainable ways of financing rehabilitation services and compatibility with the service delivery model are sought with state institutions; 3) investments are made in the provision of social services in communities to ensure the highest possible quality of consultations and other services; 4) in the complex model of providing social rehabilitation for the blind, the social rehabilitation model is preferred (based on interviews with INF10; INF11; INF14; 3 focus group opinions).

Experts	*[…] My basic position is that NGOs should get involved and provide social, and social rehabilitation services. But everything happens systematically and there are areas where NGOs have a network throughout Lithuania. If NGOs have their network, they can be trusted to provide services at the national level* (interview with IDV16). *When NGOs are systematised, when there is a very clear algorithm, some kind of service structure and allocated resources, there is nothing for state and municipal institutions to do in the service sector. Then all resources are attracted by NGOs, starting with members and volunteers. And when NGOs work, they become a community together with service recipients. It seems that this could also be the case with LBU* (interview with IDV17). *Now it is hard to say. After all, now, NGOs can participate. After that, there are evaluations of project proposals and some win and some don't. And the one who provides the best, highest quality services does not necessarily win. Be aware that there is a question of which model is better. It is also effective to give accreditation to one NGO to make the system work. Similar to the case of the supportive care service. Then it was aimed to create such a model so that the system would work […] I don't know, but if there are strong associations like LBU, for example, then maybe it would be more useful. Maybe it would be better than this kind of practice, where different organisations always win competitively. Lithuania is not big and everyone knows each other, and they don't want other organisations to start learning* (interview with IDV12). *Regarding monopolisation, your first part question. Even in vocational rehabilitation, different organisations and their capacities are ambiguously evaluated. The same is true of the foster care system. There are suppliers who are not trusted and the state does not enter into a contractual relationship with them. On the other hand, I would say there is also a disadvantage to the first step. We need to start taking that first step and talk to the ministry with LBU, as a partner, not as an executor who we suspect is doing something wrong. Because that relationship is like this, first the money is shared, and then the control is carried out. But there is a lack of such*	1) LBU is accredited for 3–5 years (making it possible for other NGOs to enter the service provision sector later); 2) a sustainable funding scheme is agreed ("uncut" allocations for the service facility after a year, and increased according to reasonable need); 3) a quality objective algorithm for determining the need is created, quality supervision is ensured; 4) assumptions are made for higher quality of services; 5) relations between institutions representing the state interest and LBU are based on trust; 6) politicians remain aware and leave room for criticism that LBU carries out on behalf of the blind and partially sighted (based on interviews with INF12; INF16; INF17; INF13; opinions of experts who participated in focus group 3).

	a serious, high-quality discussion about what is important for the system, and how the system needs to be developed. Such a reflective relationship is missing or very little (interview with IDV17).	

Informants, considering the importance of choosing an organisational model of services, also saw the need for a comprehensive restructuring and to include such elements in the entire rehabilitation system for the blind as 1) development of complex social rehabilitation services for the blind in stationary centres ensuring greater accessibility and continuity and quality (higher competencies of multidisciplinary teams, medical involvement); 2) provision of professional services in communities or clients' homes (systematic funding of mobile teams and wider involvement of competent professionals) (see: Table 5). It was also noted that LBU, with its resources and networking, could complement the system through consultation and other assistance from members and others.

After analysing the opinions, the proposals of LASS representatives and experts who participated in the study were summarised, and how the organisational model can be improved. These were then compared with research evidence and recommendations based on it. It would be important for state decision-makers to 1) provide for the gradual development of services by ensuring greater accessibility and effectiveness of rehabilitation services (both in homes for the blind and visually impaired, closer to the place of residence, and in professional centres). Make services available not only to blind but also to other visually impaired persons; 2) expansion the service system (ensuring the continuity of social rehabilitation; provision of interoperability elements of health and social services); 3) transition to LBU accreditation for 3–5 years under a trust-based arrangement (making it possible for other NGOs to enter the service sector later); 4) quality monitoring and evaluation is created and thus the prerequisites for higher service quality are created; 5) expansion of the multidisciplinary team by integrating doctors (optometrists and possibly ophthalmologists) and supplementing the mobile team with specialists of other specialisations (according to individual needs).

Conclusions

After analysing the organisational models of blind and partially sighted rehabilitation programmes, it was observed that four main organisational models are applied – institutions controlled by state and subnational institutions, national blind unions, transfer NGOs, and public procurement. The most commonly used model is a government-controlled agency(ies) model, or it is combined with others, otherwise outsourcing service provision to NGOs, national blind organisations or businesses. This model has a number of advantages (more consistent integration into service systems is possible, better hierarchical coordination; financing is directly linked to budgets or insurance funds), but at the same time, there are also significant disadvantages. State, regional or municipal institutions are too integrated into health

care systems (not all of them include social services), sometimes inflexible and expensive. A more effective (admittedly, there is insufficient evidence) alternative can be considered the provision of services to the blind and partially sighted using rehabilitation centres and teams of NGOs as well as national blind unions. Their accumulated resources, rehabilitation service centres or specialists, the trust of society and the disabled, and their work are or can become a prerequisite for effective cooperation.

Concluding the analysis of rehabilitation service providers, it should be noted that the public procurement model has faced some competition between service providers. Some public contracting theorists and proponents of neoliberal ideology (or public management doctrine) argue that it was to reduce cost and ensure higher quality (Greve, 2007; Hodge, 2018). On the other hand, empirical studies based on meta-analyses do not confirm the correlation between the purchasing model and lower service prices (some utilities have a lower price) and higher quality (no effect) (Hodge, 2018; Petersen et al., 2018). As shown by a meta-study by Danish researchers, service purchases do not usually reduce the price of the service (Petersen et al., 2018). Examining the procurement model, one can notice another factor that could potentially lead to opacity and reluctance to change the service delivery model. The organiser of the blind and partially sighted policy is the DDA. It also purchases the services in question. At the same time, the department is also the founder of VšĮ Valakupių rehabilitation centre. This may lead to several potential risks: 1) reluctance to change the model and transfer service provision to NGOs outside of public procurement; 2) possible interest in supporting a subordinated and controlled institution; 3) less attentiveness in monitoring and evaluating the service provision process and results. In addition, through the relationship of indirect subordination, VšĮ Valakupių rehabilitation centre falls under the management area of the Ministry of Social Security and Labour and may influence the interests of the policy maker (e.g., support state-controlled institutions in this steering area).

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