VIEWPOINTS

Challenges of the development of mental health care in Slovenia

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With the implementation of The Mental Health Act in 2008 and The National Mental Health Programme in 2018, Slovenia made important progressive steps in the development of mental health care in the direction of community-based multidisciplinary approach on the primary level of the health and social care system. One of the main obstacles in the realization is the lack of mental health professionals – psychiatrists, psychologists and psyhotherapists. The increase of mental health problems during COVID-19 pandemic, like increased number of suicidal attempts, alcohol abuse, number of criminal attempts of domestic violence and mental health problems of children and adolescents, have further increased the need for the development of various forms of community-based multidisciplinary mental health services on the primary level.

Introduction

Slovenia is a central European country with a population of around 2 million people. Although health care is an universal right, access to some health care services is limited due to lack of providers or long waiting times. Health care services in primary care are mainly provided by primary health care centres (PHCs), which are owned by the local community as well as by independent primary care providers. Doctors in primary care have a list of patients and act as gatekeepers to specialist services.[1]

Studies in Slovenia show that men, single people, younger people, people with lower levels of education and those living in regions with a higher suicide rate are less inclined to seek help if they experience mental health problems. Stigmatisation of and discrimination against people suffering mental illness are also evident in the fact that people delay seeking help, which worsens the outcome of treatment and rehabilitation and results in feelings of helplessness. Stigma appears at all levels of society and in all systems. It leads people to dismiss, play down or deny the seriousness of the issue, and to a shortfall in resources for adequate, high-quality, accessible mental health programmes.[2]

An important development in recent years has been the reorientation of the health system towards prevention and public health activities, particularly aimed at non-communicable diseases and risk factors, through health promotion centres, model practices, counselling and screening in primary health care. In 2002, health promotion centers (HPCs) were established within all 61 primary health care centers across the country. They are now the main providers of preventive and health-promotion services, including mental health services.[3] These services also aim to tackle geographic barriers to health care and increase equity of access and outcomes for underserved populations.[4]

Among health indicators it is known for a long time that Slovenia has high suicide index.[5] Every year between 400 and 450 people commit suicide in Slovenia, with the average suicide rate standing at 25 per 100,000 people between 1996 and 2016. This is above the European average, which was 11 per 100,000 people in 2014. Approximately four times as many men commit suicide as women, with older people at greater risk. One very concerning statistic is that suicide is the second most common cause of death for young people aged between 15 and 19, behind road accidents.[2]

The COVID-19 epidemic has caused a growth in the number of suicide attempts, in 2020 there were 15% more such attempts than the year before. There has been a 10% increase in the number of criminal offenses of domestic violence, while research among students has shown that 89% of them show signs of depression and anxiety.[6]

The second important health indicator is alcohol consumption and abuse. Slovenia is a country of very high alcohol consumption, which is one of the major mental health risk factors.[4] Since 2008 an average of 881 people died every year of a disease directly attributable to alcohol, with mental and behavioural disorders caused by alcohol consumption being the second most common cause of alcohol-related mortality. During the COVID-19 pandemic consumption increased, especially among vulnerable groups, which consume even more alcohol than before the pandemic. An average adult in Slovenia, consumes 38 liters of vine, 93 liters of beer and 3 liters of spirit, what places the Slovenia in the most "wet" European Nations. Every second Slovenian is an alcohol abuser, one quarter of 17 year's teenagers are overdrinking every week. In year 2020, the direct costs in connection with the alcohol consumption reach 50 million Euros. Among the SOS calls there the abuse of alcohol was the trigger for violence and despair.[7]

Most common mental disorders in Slovenia

In 2016 in Slovenia approximately one quarter of the Slovenian adult population experienced stress on a daily basis and had problems managing it, that more than 7% had been diagnosed with depression, and that around 7% of adults used sedatives and sleeping pills and 5% used anti-depressants. Between 2008 and 2015, in addition to a rise in the use of medication to treat mental illness and behavioural disorders, there was an increase in the number of visits to primary and secondary healthcare institutions.[2] Figure 1 shows the most common mental illnesses at different stages of life.

Mental health care policy

The Mental Health Act was adopted in 2008 and The National Mental Health Programme in 2018.[2] The Mental Health Act represents the first law in the area of mental health.[8] The legislation joins the health and social welfare

Figure 1.

Young children (up to 5)	Older children (6–14)	Adolescents (15–19)	Adults (up to 65)	Elderly (over 65)
Developmental disorders	Emotional disorders	Response to severe stress and adaptive disorders	Anxiety-related disorders	Dementia
Emotional disorders	Conduct disorders	Other anxiety- related disorders	Depressive episodes	Depressive episodes
ADHD	Hyperkinetic disorders	Depressive episodes	Stress-related and adaptive disorders	Anxiety-related disorders
	Developmental disorders (minor)	Eating disorders	Alcohol-related problems	Stress-related and adaptive disorders
			Schizophrenia	

Most common mental disorders at different stages of life (NIJZ health statistics 2008–2015).[2]

systems into a tightly interwoven entity, primarily focused on individuals' needs and aiming to protect and assure basic human rights. The main components of the Act outline the admission conditions and procedures for:

- treatment in a psychiatric hospital ward under special supervision with and without consent (the latter on the basis of a court order);
- treatment in a secure ward of special residential institutions with and without consent (the latter on the basis of a court order);
- supervised psychiatric treatment; and
- community treatment.

The legislation lays down special treatment methods that may be applied only exceptionally under certain conditions and only in psychiatric hospitals; it also defines the use of special security measures under specific conditions. The law defines the obligations of both the health and social welfare ministries. The latter is responsible for guaranteeing the conditions of secure wards within special residential institutions as well as assuring the network of community care coordinators and the network of professional advocates for people with restricted rights; these advocates work in secure wards.

The treatment processes outlined under the legislation define new stakeholders in the management of mental health patients as well as their roles, obligations, responsibilities and communication pathways. These include:

- community care coordinators;
- advocates for people with restricted rights, working in secure wards; and
- multidisciplinary teams (consisting of psychiatrists, community care coordinators, social workers, practical aid nurses, clients and/or their relatives, NGO representatives and others, which are important for the reintegration process).[8]

The Mental Health Act encourages deinstitutionalization with establishing a wide support system to accelerate the safe and monitored transfer of people with mental health problems from institutions to local communities. The role of the regional network of community care coordinators has been very important in this process. Coordinators are employed in state centres for social work and their main task is to help and support people with mental health problems to reintegrate into a community environment as soon as possible after medical psychiatric treatment or special treatment in a residential institution.[8]

Since 1990, Slovenia's efforts to strengthen community-based approaches to mental health care have also been supported by NGOs, which have provided many examples of good practice, particularly in devising more individualized and personalized care for people with mental health problems of all age groups.[9,10]

Unfortunately, Slovenian psychiatry is still predominantly hospital based. There are historical, political, professional and service organisation characteristics that impede the development of community psychiatry in Slovenia.[11] The network of outpatient clinics was established by the 1970s, but was gradually dissolved after the healthcare reforms in the 1990s when Slovenia gained independence. During the development of community psychiatry the expertise of British community psychiatry assertive community treatment (ACT) was followed. By 2006, in three psychiatric hospitals in Slovenia, teams that included a psychiatrist, a social worker, an occupational therapist and three graduate nurses were established to follow up frequently readmitted patients, most commonly those with a diagnosis of schizophrenia in the community.[10] These teams did not manage to provide 24-hour cover, and they covered only frequently hospitalised patients. Nevertheless, the result of their work was that they managed to reduce hospitalisations by over 50% in selected groups of patients. The number of patients included reached almost 200 in 2012.

Through The National Mental Health Programme 2018-28 there is an intention to strengthen and widen the current network of community-based care and to link programmes aimed at integrated and quality treatment, adjusted to individuals' needs, expectations and social/working abilities. These are to be addressed through coordinated action involving primary care professionals, non-government organisations with service users and carers, the Health Insurance Agency and politicians involved in the planning of health services.[2]

Delivery of mental health services

There are two main groups, for which institutional care is provided: people with mental health problems and people with learning or intellectual disabilities. There are various types of state-run institution providing such care[8]:

- psychiatric hospitals (five hospitals plus one unit/department): the one at the University Medical Centre Maribor has a special unit for forensic psychiatry patients;
- special residential institutions for people with mental health problems (five institutions with 1520 residents in 2016);
- special residential–vocational institutions for children with learning or intellectual disabilities, combined with mental health problems and other disabilities (five institutions with 431 children and 795 adults in 2016); and
- residential institutions–care homes for the elderly (55 residential homes with 18 295 residents in 2016): general long-term care homes for older people and not specifically for residents who suffer from dementia or other mental health conditions.

There are also various types of community-based programmes whose common aim is to ensure that users have as independent a life as possible; they are organized by NGOs and public institutions that are aware of the negative effects of institutionalization. These include:

- residential units for adults, established by NGOs (46 units for 230 residents in 2016); and
- special residential public institutions, which are downsizing their capacities and establishing smaller units (36 residential units for approximately 200 residents in 2016).[8]

There are also other programmes for people with long-term mental health problems who need coherent care and for people experiencing mental health crises with psychiatric diagnoses of various types; these programmes are co-financed by the state and implemented by NGOs. These are:

- occupational day centres established by NGOs (11 units for 118 programme users in 2016);
- occupational day centres established by the state (18 units for 585 programme users in 2016);
- information offices and counselling units (3 units for 1574 programme users); and
- phone counselling (10744 programme users in 2014).[8]

The Social Security Act also provides for other non-institutionalized programmes for people suffering from mental health problems and/or disabilities, such as personal assistance, organized help at home for special target groups and family assistance.

Despite the progress in the development of mental health care in Slovenia, in 2015 the World Health Organization proposed the following strategic improvements in response to the findings:

- transferring the focus of mental health institutions and services to the local level and making them more accessible
- setting up emergency children's services responsible for assessment and psychological first aid
- reducing the duration of hospitalization and the number of readmissions to hospital through the community-based monitoring of people suffering from severe mental illness
- expanding the number and capacities of community-based teams on the basis of needs assessments;
- providing further training to professional staff at the primary healthcare level and in social care;
- planning, educating, training and employing professionals in line with national needs;
- increasing the number of clinical psychologists;
- providing trained professionals from recognized;
- schools of psychotherapy with psychotherapy work in healthcare and social care services;
- assessing the needs of residents of social care institutions and the options for their deinstitutionalization;
- reducing institutional capacities over the long term;
- updating legislation and regulations on care for forensic patients who present a danger to the community;
- setting up a secure unit for children and adolescents;
- developing more sector-based psychosocial teams for children and adolescents;
- supporting the gradual introduction of regional interdisciplinary centres to support children with learning difficulties.[2]

The National Mental Health Programme 2018-28

The National Mental Health Programme was passed by parliament on 27 March 2018 with cross-party support. It is the first time in its history that Slovenia has attempted to address this vital area in a comprehensive and integrated manner. The programme lays down the fundamental principles of support and care for the mental health of the individual (and, indirectly, of society as a whole), and sets strategic goals for the ten-year period leading up to 2028. The goals are ambitious. They require intersectoral cooperation and political support, backed up by measures aimed at protecting vulnerable individuals, children, adolescents, adults and older people, as well as their families, and involving all stakeholders and representatives of local environments in the process. A key component of the National Mental Health Programme is its attempt to expand mental healthcare from treatment alone, to encompass activities and measures aimed at preventing mental illness. It emphasizes the importance of promoting mental health as a key aspect of health – one that fosters the well-being and prosperity of the individual, their loved ones, their immediate environment and society as a whole – and incorporates into mental illness treatment the key principles of swift, local access and high-quality integrated care provision based on multidisciplinary approaches. It encourages professionals working in the field to gather their expertise around the individual needing help, as well as their families, and to prioritize the provision of effective, evidence-based health and psychosocial approaches to treatment. It includes programmes that already constitute examples of good practice, opening a path towards the creation of the new practices that will have to be introduced and developed over the next decade.[2]

Mental health care for children and adolescents

Health insurance coverage for children and adolescents is universal in Slovenia. Health care services are delivered at primary care level and cover preventive health care. Prescribed systematic checkups that consist of a staged approach to child and

adolescent health are part of the fundamental elements of health care services. The programme of health education included in systematic checkups is currently being revised. Counselling services for children, adolescents and parents are provided in every elementary and secondary school and the provision of diagnostic and therapeutic services is ensured through an additional network of public counselling centres.[12]

Primary health care for children and adolescents includes preventive programmes for preschool children and schoolchildren and health promotion for children and adolescents. These preventive programmes for children are regulated by legislation and include:

- preventive well-child visits for preschool children at 1, 3, 6, 9, 12 and 18 months and 3 and 5 years; and

- preventive well-child visits for schoolchildren before school entry, in the first, third, fifth and seventh grade of elementary school and first and third grade of secondary school.

All three-year-old toddlers also have a psychological examination and all five-year-olds are assessed by a speech and language therapist. All of the mentioned examinations consist of a medical examination, obligatory immunization in accordance with the immunization programme and health education.

Every elementary and secondary school in Slovenia has a school counselling offi ce employing a professional in mental health (psychologist, social worker or (social) pedagogue). They specialize in learning issues and preventive services in the school environment and also offer counselling and referral to children, adolescents and parents. In addition, a network of public institutions established as early as 1955 provides diagnostic, counselling and therapeutic services. These are counselling centres for children, adolescents and parents, and are situated in four Slovene cities. The counselling centres integrate the fi elds of health care, education and social welfare and are professional institutions bringing together a wide variety of experts. The role of these centres is the provision of counselling activities (including assessment, interventions, consultation, supervision, training, prevention and psychological education) and therapy for children, adolescents and parents. These centres are founded and financed primarily by the municipality and by health insurance. All children and adolescents (from 3 to 29 years) have access to the centres, but because of local financing, children and young people from the cities have priority. Usually schools (teachers or advisers) suggest the idea of attendance to parents, but young people sometimes attend on their own volition. Specialists in the centres assess their problems and work with them, their parents and their communities.[12]

The National Mental Health Programme 2018-28 launched the establishment of 25 regional mental health centres for children and adolescents, responsible for prevention services and for integrated, multidisciplinary clinic- and community-based treatment.[2]

Lack of psychiatrists, clinical psychologists and psychotherapists

One of the main problems in the implementation of The National Mental Health Programme is the lack psychiatrists, clinical psychologists and psychotherapists. In Slovenia, which has 2 million inhabitants, there are 293 psychiatrists, 251 of them are public and 42 private. There are also 61 psychiatrists specialized in child and adolescent psychiatry (53 public, 8 private). As can be seen in the register (RIZDDZ - https://www.nijz.si/sl/rizddz-register-izvajalcev-zdravstvene-dejavnosti-in-delavcev-v-zdravstvu), there are also 126 clinical psychologists in Slovenia (113 public, 12 private) and 359 psychologists (348 public, 24 private). According to Eurostat data in 2017, there were 27 psychiatrists per 100.000 people in Germany, 25 in Greece, 24 in

Finland, and 23 per 100.000 people in France, The Netherlands and Sweden. In our neighboring Italy there were 17 and in Croatia 16. Somewhere at the bottom of the list, there is Slovenia with 14 psychiatrists per 100.000 people. In 2021 there are still only 14 psychiatrists per 100.000 people in Slovenia. However, there are even less clinical psychologists, about 6 per 100.000 people. In average there are 9 new specialists per year and many who retire. This contributes to long waiting times.

There are approximately 300 psychotherapists, who are qualified by European standards for psychotherapy as autonomous profession, but they are not allowed to work in the healthcare system. Psychotherapy is not regulated by law and the psychotherapeutic profession is not registered.[13]According to the current healthcare regulation psychotherapy is formally still only a service, which can be delivered in the healthcare system by psychiatrists and clinical psychologists, however they do not have the time to practice psychotherapy. Clinical psychologists agree that there are not enough of them, and that psychotherapy is very difficult to access in the healthcare system. The normative of the WHO is one psychotherapist on 1000 citizens, which means that Slovenia would need 2000 psychotherapists, but psychotherapists who are not psychiatrists or clinical psychologists by their primary education cannot get concession for psychotherapeutic services.

The patients who get psychotherapy from psychiatrists and clinical psychologists in the health system are treated free of charge, i. e. the cost is covered by the national health insurance which pays the same for psychotherapy in the public or private sector. A few others have the luck of possessing sufficient financial means and may find a psychotherapist practicing psychotherapy in his free time. The charges for those clients who pay themselves range from 20 to 100 Euros per hour of psychotherapy. Most of the clients can afford the lowest charge and most of the clients can't afford the highest.[14] So the time for the psychotherapy law which would define psychotherapy as an autonomous profession and enable the integration of psychotherapy services to the health and social care system is ripe.

Access to mental health services

Most patients with mental health problems first seek help by general practitioners (GP).[15] The shortage of GPs is one of the major health system challenges in Slovenia. In particular, the low numbers of GPs negatively influence waiting times.[1,4] More doctors are currently being trained, and salaries have been corrected to reduce the wage gap in comparison to hospital specialists. Primary care research conducted in the country demonstrated that among GPs there are serious barriers to becoming involved in the treatment and prevention of mental health disorders.[16,17]

Long waiting times have been an enduring challenge, despite efforts to address them, for example through occasional added funding. Survey results show that waiting times are the main reason for self-reported unmet medical needs. On a positive note, little variation in levels of unmet needs among income groups indicates that access to care is generally equitable.[4]

When GPs refer patients to psychiatrist urgently, they are checked within 24 hours in the outpatient or on-call clinic. This usually happens with severe mental distress, the threat of hurting oneself or others or their property. The waiting time for a regular referral to psychiatrist is on average two or three months, for a clinical psychologist 6 to 9 months. The waiting time for an appointment with a psychiatrist or a clinical psychologist who also practices psychotherapy in the public system is from a few months to two years. Meanwhile, the waiting lists in private practices are expectedly shorter. Waiting times for children, who are dealt with by pedopsychiatrists and clinical psychologists, especially trained to work with children and adolescents, are even longer. One half of all mental disorders in Slovenia starts before the age of 14, but many of the are overlooked and not referred to a specialized professional.

Conclusion

The benefits of community-based multidisciplinary teams for mental health care are well documented and researched. Provision of services in this way increases user satisfaction, increases the number of met needs and improves adherence to treatment.[18] This kind of approach gives greater hope for social integration, human rights protection, comorbidity treatment, reduction of stigma, and better access to treatment and rehabilitation. The community-based multidisciplinary approach is now the norm for delivering high-quality mental health services for the benefit of the population.[11] The Mental Health Act and The National Mental Health Programme 2018-28 represent a good framework for political decisions and allocation of resources for the development of community-based interdisciplinary approach on the primary level of mental health care. We hope that this framework will be also used to increase the number of mental health professionals (psychiatrists, psychologists and psychotherapists) on the primary level, without whom community-based interdisciplinary approach will not be possible to realize.

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REFERENCES

1. Rotar Pavlič D, Švab I, Brinovec Pribaković R. Primary Care in Slovenia. In: Kringos DS, Boerma WGW, Hutchinson A, Saltman RB, eds. *Building Primary Care in a Changing Europe: Case Studies*. European Observatory on Health Systems and Policies; 2015. https://www.euro.who.int/__data/assets/pdf_file/0018/271170/BuildingPrimaryCareChangingEurope.pdf

2. Maučec J et al. *MIRA for Mental Health Programme: National Mental Health Programme*. National Institute for Mental Health; 2020. https://www.nijz.si/sites/www.nijz.si/files/publikacije-datoteke/mira_resolucija_ang_splet.pdf

3. Vinko M et al. *Local Mental Health Support in Slovenia during COVID-19: Setting up Primary Health Care Helplines*.; 2020. https://eurohealthnet-magazine.eu/local-mental-health-support-in-slovenia-during-covid-19-setting-up-primary-health-care-helplines/

4. OECD/European Observatory on Health Systems and Policies . *Slovenia: Country Health Profile 2019, State of Health in the EU*. OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels; 2019. https://ec.europa.eu/health/sites/default/files/state/docs/2019_chp_sl_english.pdf

5. Beškovnik L, Konec Juričič N, Švab V. Suicide index reduction in Slovenia: The impact of primary care provision. *Ment Health Fam Med*. 2011;8(1):51-55.

6. Kamenarič K. Absurdno dolge čakalne vrste, neurejena zakonodaja in čedalje več zdravil [Absurdly long waiting lists, unregulated legislation and more and more medicines. Published online 2021. https://www.24ur.com/novice/slovenija/psihiater-psiholog-ali-psihoterapevt.html

7. Malovrh P. Alkoholizem in Slovenci [Alcoholism in Slovenia]. *Delo*. 2021;31:12.

8. Albreht T, Pribakovic Brinovec R, Josar D, Poldrugovac M, Kostnapfel T, Zaletel M, et al. Slovenia. *Health System Review Health Syst Transit*. 2016;18(3):1-207. https://apps.who.int/iris/bitstream/handle/10665/330245/HiT-18-3-2016-eng.pdf?sequence=5&isAllowed=y

9. Možina M. Can we remember differently? A case study of the new culture of memory in voluntary organisations. *Int j soc welf*. 2002;11(4):310-320. doi:10.1111/1468-2397.00240

10. Švab V, Tomori M. Mental Health Services in Slovenia. *International Journal of Social Psychiatry*. 2002;48(3):177-188. doi:10.1177/002076402128783226

11. Švab V, Švab I. Barriers and errors in the implementation of community psychiatry in Slovenia. *Ment Health Fam Med*. 2013;10(1):23-28. doi:10.25149/1756-8358.1001001

12. Bevc Stankovič M et al. *Slovenia: Mental Health and Well-Being for All Children*. Institute of Public Health of the Republic of Slovenia; 2007. https://www.euro.who.int/__data/assets/pdf_file/0010/74773/Hbsc_Forum_2007_Sloveniapdf.pdf

13. Možina M, Bohak J. Na poti k slovenskemu zakonu o psihoterapevtski dejavnosti [Steps to a Slovenian psychotherapy law. *Kairos – Slovenian journal of psychotherapy*. 2008;2(3-4):119-142. http://kairos.skzp.org/index.php/revija/article/view/66/59

14. Bohak J, Možina M. Psychotherapy in Slovenia. In: Pritz A, ed. *Globalized Psychotherapy*. Facultas Verlags- und Buchhandels; 2002:283-299. https://www.researchgate.net/profile/Miran-Mozina/publication/295858225_Psychotherapy_in_Slovenia/links/56ceaf1708aeb52500c3751c/Psychotherapy-in-Slovenia.pdf

15. Rifel J, Švab I, Šter MP, Pavlič DR, King M, Nazareth I. Impact of demographic factors on recognition of persons with depression and anxiety in primary care in Slovenia. *BMC PsyChiatry*. 2008;8(1). doi:10.1186/1471-244x-8-96

16. Kersnik J, Poplas Susič T, Kolšek M, Švab I. What may stimulate general practitioners to undertake screening and brief intervention for excess alcohol consumption in Slovenia? A focus group study. *Journal of International Medical Research*. 2009;37:1561-1569. doi:10.1177/147323000903700534

17. Poplas Susič T, Kersnik J, Kolšek M. Why do general practitioners not screen and intervene regarding alcohol consumption in Slovenia? A focus group study. *Wiener Klinische Wochenschrift*. 2010;122:68-73. doi:10.1007/s00508-010-1335-z

18. Semrau M, Barley EA, Law A, Thornicroft G. Lessons learned in developing community mental health care in Europe. *World Psychiatry*. 2011;10(3):217-225. doi:10.1002/j.2051-5545.2011.tb00060.x