WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Looking back, looking forward:
Rapid assessment of the mental health system in Slovenia

Report of a virtual mission by the WHO Regional Office for Europe (September 2020)

Summary

Slovenia is in the process of reviewing its mental health system performance and planning the future development of services in the country. As part of this, the WHO Regional Office for Europe was requested by the Ministry of Health to undertake a mental health system assessment, with a view to identifying recent achievements as well as continuing gaps in service provision; this evaluation will inform the continuing implementation of the national mental health action resolution and plan for the period 2018-2028.

This report sets out the context for and findings of the mental health system assessment mission. Members of the mission team were Dr Dan Chisholm (Programme Manager for Mental Health), Dr Aiga Rurane (WHO Representative to Slovenia) and Dr Francesco Amaddeo (WHO consultant), with support from other regional and country office colleagues. Owing to the prevailing COVID-19 situation in Europe in 2020, the mission was carried out virtually over the course of three working days in early-September, during which a wide range of national stakeholders were invited to share their views concerning past achievements as well as the current status and future needs of the mental health system and services.

Looking back at progress made since an earlier WHO mission in 2015, a key development has been the preparation and approval of a new Resolution on mental health for the period 2018-2028, which provides a comprehensive framework and strategy for multi-sectoral action on mental health service development in the country. There has been important progress made in implementing different elements of the Resolution as well as the recommendations of the earlier WHO mission, notably the establishment of several new community-based mental health centres. However, mental health and social care services are inequitably distributed, remain fragmented and mainly rely on institutional modes of service delivery. Accordingly, several opportunities exist for improved performance, including closer inter-sectoral planning and coordination, renewed prevention efforts, enhanced service access and further development of the mental health workforce.

1. Introduction

1.1. Context for the assessment mission

In 2017, the Ministry of Health of the Republic of Slovenia launched an initiative to prepare a *Resolution of The National Mental Health Programme* 2018-2028. This Resolution was unanimously passed by the National Assembly in March 2018 after public discussion and coordination with relevant ministries.

Now in 2020, the government of Slovenia is in the process of reviewing its mental health system performance in relation to the implementation of the Resolution, and planning the future development of services in the country over the next period of implementation (2021-2023). As part of this, the WHO Regional Office for Europe was requested by the Ministry of Health to undertake a mental health system assessment, with a view to identifying recent achievements as well as continuing gaps in service provision. This request follows the conduct of an earlier mental health country visit and service evaluation by the WHO Regional Office for Europe in 2015, which serves as a relevant baseline for the current mission.

1.2. Process for the assessment mission

In view of the prevailing outbreak of COVID-19 in Slovenia and Europe, it was agreed to hold a 'virtual' mission in place of an in-country visit. The virtual mission was carried out on 2, 4 and 7 September 2020 by means of a series of pre-arranged on-line meetings. This mission was carried out by:

- Dr Dan Chisholm, Programme Manager for Mental Health, WHO Regional Office for Europe
- Dr Aiga Rurane, WHO Representative and Head of Country Office in Slovenia
- Dr Francesco Ammadeo, Professor of Psychiatry, University of Verona (WHO consultant)

They were supported by colleagues in the WHO Regional Office (Dr Elena Shevkun) and WHO Country Office (Anita Stefin, Administrative Assistant). Before the mission, discussions were held with a working group of national mental health focal points to determine the content, scope and objectives of the system assessment; in addition, a desk review of relevant national and international materials was carried out, along with an examination of existing and potential mental health system performance / outcome indicators (based on a compilation prepared by the National Institute for Public Health).

During the mission, interviews were carried out with a broad range of governmental and non-governmental stakeholders, spanning policy and planning, service provision, health system financing, and community actions. A list of interviewees was drawn up by the technical working group, informed by the earlier WHO assessment report in 2015 as well as the envisaged scope of the assessment in terms of government ministries or agencies, different sectors and service providers. The names and organizations of all interviewees are provided at Annex 1. Each session was 45 minutes and in some cases was attended by more than one interviewee in a related filed of work (e.g. primary health care). The interviews were structured as follows: 1) welcome and context/purpose; 2) core questions (general insights into needs, gaps, priorities,

successes); 3) specific questions (service / system / setting-specific follow-up questions); 4) final comments and conclusions.

Following the preparation, circulation and review of this report, it is envisaged that it may serve as a basis for policy dialogue between national authorities and other stakeholders regarding mental health system and service development in Slovenia, in particular the next implementation period of the national Resolution on mental health (2021-2023).

2. Looking back: recent developments and remaining challenges

In 2015, the WHO Regional Office for Europe was requested to carry out a similar assessment of the mental health system in Slovenia; the resulting report contained several recommendations that had an influence on the development of a national mental health strategy, and provides an appropriate baseline against which other recent policy and service developments can be gauged. Based on analysis of available surveillance data and policy documents as well as the inputs and insights of the stakeholders who were interviewed over the course of the virtual mission, this section of the current mission report therefore sets out to:

a) describe some of the key trends and developments over the last five years, including specific actions taken in relation to the 2015 WHO mission report recommendations;

b) provide a current snapshot of the mental health situation in the country, covering both the systemic elements of mental health service provision (governance, financing, service organization, workforce, information systems) and also the range of services (promotion, prevention and protection; treatment, care and rehabilitation).

2.1. Demography and epidemiology

Life expectancy at birth is 78 years for males and 84 years for females; when combined with a low fertility rate, this is indicative of an ageing population, which has a consequent influence on the prevalence of mental and behavioural health conditions since more people fall into the age groups where the incidence of these health conditions is greater. For example, 26% of the population is above 60 year old, according to the 2017 Slovenia country profile of the WHO Global Dementia Observatory.[1]

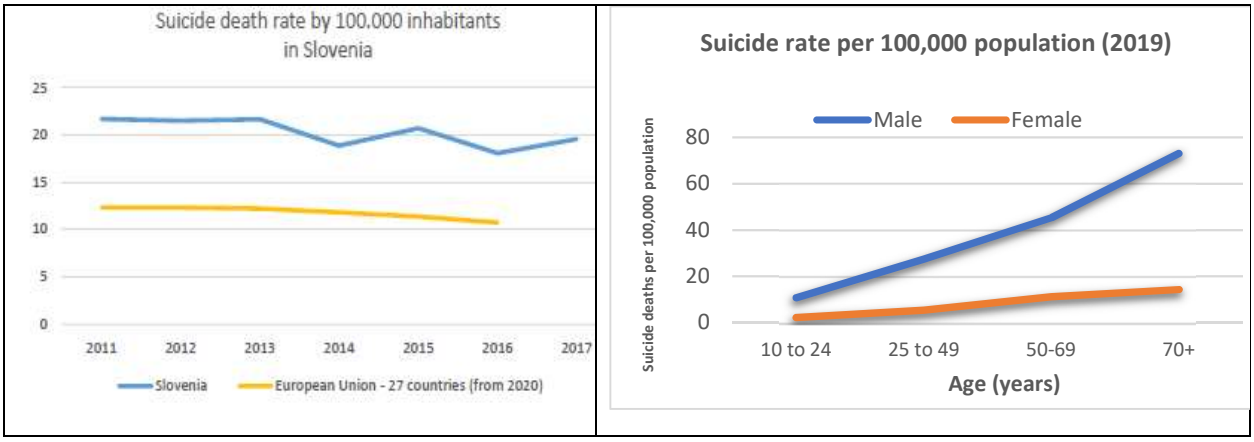
Latest prevalence estimates extracted from the Global Burden of Disease study suggest that 85,000 persons or 4.3% of the population have a depressive disorder and a further 80,000 or 4% have an anxiety disorder.[2] In addition, it is estimated that there are over 20,000 people with bipolar disorder and psychosis. As shown below, the rate of suicide exceeds the EU average and

[1] https://www.who.int/docs/default-source/mental-health/dementia/gdo-country-profiles/gdo-slovenia.pdf?sfvrsn=61c8907_6&ua=1

[2] http://ghdx.healthdata.org/gbd-results-tool

has remained close to 20 per 100,000 population over the last several years. Rates of suicide vary widely across age and sex groups, with very high rates estimated for older males.

Despite robust and successful efforts to diagnose, treat and manage leading contributors of premature mortality such as cardiovascular diseases, noncommunicable diseases remain the largest contributor to overall rates of disease burden in the country, accounting for over 80% of Disability-Adjusted Life Years (DALYs) in 2019.[2] Out of that NCD burden, mental, neurological and substance use disorders account for 15%, or when considering only the non-fatal component, 25%.



2.2. Socioeconomic determinants and consequences related to mental health

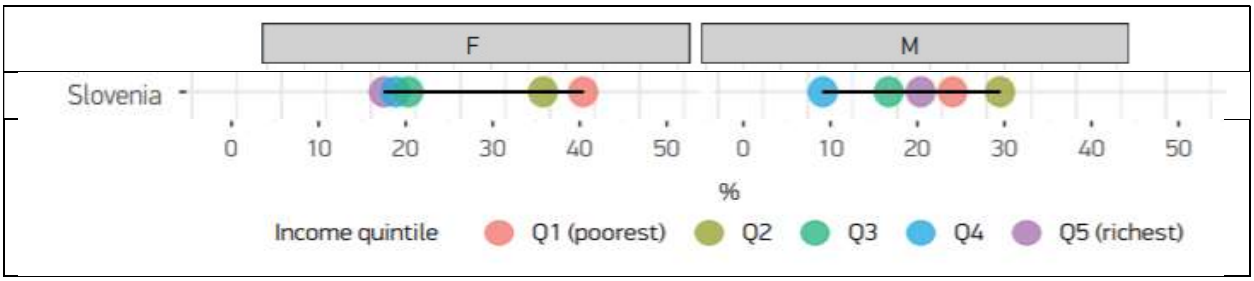
Mental health or psychological well-being is an integral part of an individual's capacity to lead a fulfilling life, including the ability to form and maintain relationships, to study, work or pursue leisure interests, and to make day-to-day decisions about education, employment, housing or other choices. Good mental health is put at risk by a range of factors including biological characteristics, social or economic circumstances and the broader environment in which individuals find themselves. Exposure to these risk factors or stressors can lead to a range of mental health problems, especially among more vulnerable population groups.

Analysis of the environment in Slovenia, as in other countries, highlights the relationship between social and economic factors, the opportunity to be healthy, the risk and severity of disease, and the risk of premature death. These factors include the number of years in education, level and security of income and employment, housing conditions and security, and social and community capital. The effects of differences in socioeconomic opportunities and circumstances accumulate over a lifetime and contribute to the gradient in life expectancy and mortality rates observed across the Slovene population.[3]

[3] WHO (2014). Positioning health equity and the social determinants of health on the regional development agenda in Slovenia. WHO Regional Office for Europe; Copenhagen, Denmark.

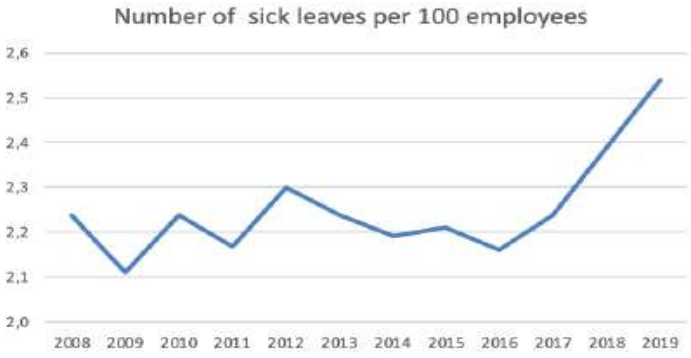
As shown in the Figure below, the socioeconomic situation that people find themselves in also accounts for differences in mental health and well-being, with appreciable differences seen in self-reported mental well-being seen between lower and higher socioeconomic groups (higher values on the WHO-5 mental well-being index denote better levels of health) (WHO, 2019).[4]

Slovenia has been taking action on these wider social, economic and environmental conditions via a range of policies in the fields of social security, education, health and taxation. Throughout all stages of development since 2000, the Ministry of Health has demonstrated commitment to tackling inequity and its understanding of the need for intersectoral action to address it. These policies have enabled accelerated progress towards improved equity and health. The patterns and magnitude of health inequalities in Slovenia are similar to those found in other European Union (EU) countries.[5]



Since 2015, however, there has been a noticeable increase in the number of work absences due to mental disorder (see Figure below).

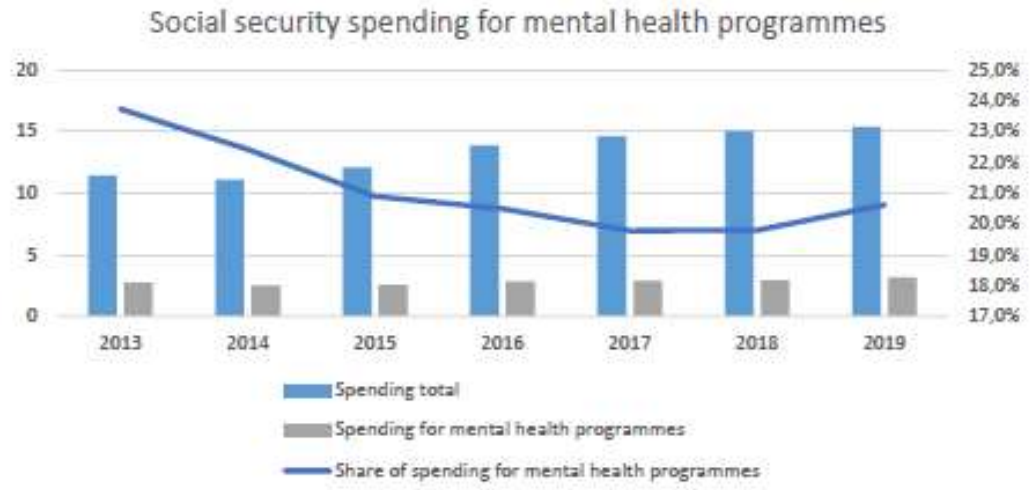
Indicator: Sick leave due to mental disorder



Description: The indicator shows cases of sick leave due to a diagnosis from Chapter V. of the ICD-10 per 100 employees.
Source: 2020, National Institute of Public Health

[4] WHO (2019). Healthy, prosperous lives for all: the European Health Equity Status Report. WHO Regional Office for Europe; Copenhagen, Denmark.
[5] https://www.euro.who.int/en/health-topics/health-determinants/social-determinants/news/news/2011/01/high-level-forum-on-social-determinants-of-health-and-health-inequalities/socioeconomic-determinants-of-health-in-slovenia

The majority of persons with severe mental health conditions, and also some with non-severe mental health conditions, receive state social support. Social security programmes receive their funding from various sources. Majority of funding comes from the Ministry of Labour, Family, Social Affairs and Equal Opportunities (MLFSE). Presented data below show total spending for social security programmes by MLFSE and spending for mental health programmes by MLFSE (in millions of Euro per year). Mental health programmes consist of community residential groups, day care centres, counseling centres, mental health helplines and advocacy activities.[6]



2.3 The mental health system

Governance

As stated at the beginning of this report, a Resolution on the National Programme of Mental Health 2018-2028 was adopted in March 2018 following an extensive period and process of development and consultation.[7] The value and importance of such a framework document cannot be too strongly emphasized, since it provides all national stakeholders with a clear and concrete set of objectives, actions and measures for the sustained development of the mental health sector in the country. The adopted Resolution sets out a comprehensive and ambitious plan that is grounded in essential public health principles, is based on sound analysis of national and international trends, addresses critical issues such as the rights and social inclusion of persons with psychosocial disabilities, and – on the basis of the interviewees spoken to – has a good degree of 'buy-in' from national stakeholders. The Resolution therefore represents a key achievement and fills a long-standing gap in the country's strategic approach to mental health.

[6] Social Protection Institute of the Republic of Slovenia (2020).

[7] Juričič NC, Zakotnik JM, Dernovšek MZ, Švab V, Anderluh M, Roškar S, Klanšček HJ, Bajt M, Roškar M, Čobal N (2018). The importance of the Resolution on the National Mental Health Programme 2018-2028 for Slovenia. *European Journal of Public Health*, 28 (suppl_4); doi.org/10.1093/eurpub/cky218.202

The main identified challenge lies in the degree to which the Resolution is being implemented as planned, not least because of the comprehensive, multi-faceted and inter-sectoral nature of the stipulated actions. Key identified obstacles to implementation of agreed Resolution actions include: a) unstable political support; b) insufficient financial support, both for the management and governance structures as well as the actual implementation measures; c) inter-ministerial and inter-professional disunity concerning the management, oversight and coordination of Resolution implementation activities; d) absence of local / regional mental health committees or councils.

A similar picture emerges in relation to mental health legislation. In 2008, the government passed a new mental health law, which represented a critical and basic step towards better supporting and protecting persons with mental health conditions or psychosocial disabilities, and in subsequent years the government has also become a signatory to international covenants such as the UN Convention on the Rights of Persons with Disability (CRPD). However, there remain legitimate concerns about the speed or rate of change, as evidenced by prevailing stigma and discrimination and the continuing reliance on institutional models of care for persons with mental health conditions and those with cognitive, intellectual or psychosocial disabilities. There also remains some important gaps in legislation and regulation, for example in relation to the standards, requirements and working conditions of psychotherapists.

Financing

Financing is a critical factor in the realization of a viable mental health system and provides the mechanism through which plans and policies are translated into action through the allocation of resources. In Slovenia the care and treatment of people with mental health conditions (psychosis, bipolar disorder, depression) are included in national health insurance / reimbursement schemes. Individuals do not pay at the point of service use (both in-patient and out-patient services are fully insured).

Estimation of total spending is complicated and compromised by the fragmented nature of mental health expenditure across ministries and sectors, and this is an impediment in itself to holistic planning and tracking. Recent submissions to WHO's mental health Atlas rely on old estimates: mental hospital spending of Euro 54.7 million in 2011; and total government mental health spending of Euro 177.1 million in 2006 (equivalent to 5.8% of all government expenditure on health).[8] If this proportion were to be applied to total health expenditure of Euro 3.5 billion in 2017, the total would be close to Euro 200 million or Euro 100 per head of population. Data submitted by Slovenia to Atlas this year of 2020 gives the following approximate percentages attributed to specific mental health expenditures: Mental hospitals: 40-60%; Community mental health services: 21-40%; Mental health care at general hospitals: 6-10%; Mental health at primary health care: 6-10%; Mental health promotion: <5%. This indicates that although the Resolution calls for a re-allocation of funds towards community-based mental health services, a large proportion of funding is still allocated to psychiatric hospitals and long-term care institutions.

[8] https://www.who.int/mental_health/evidence/atlas/profiles-2017/SVN.pdf

The issue of mental health system financing is complicated by the fact that funding of inpatient mental health care and long-term residential care in social institutions is the respective responsibility of the Ministry of Health and the Ministry of Labour, Family, Social Affairs and Equal Opportunities. Accordingly, there is a clearly identified need to enhance joint, coordinated financial planning in order to address the fiscal fragmentation and protectionism that exists now. A further financing issue concerns payment mechanisms for service providers, which is geared towards quantity rather than quality; for example, at the hospital level payment is made per case, without account taken of indicators of quality / performance.

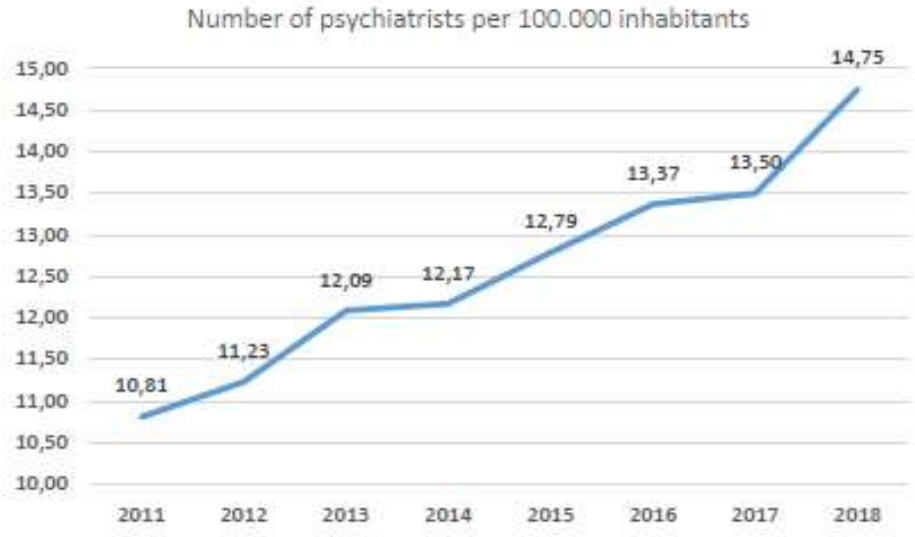
Workforce

Slovenia has more than 1,500 mental health professionals working in or outside government services, equivalent to approximately 75 per 100,000 population (WHO Atlas 2017). Close to half that total are nurses, and there are 12 psychiatrists and 9.3 psychologists per 100,000 population. Most of the workforce is working in specialized mental health care facilities, although an increasing number are now being deployed in the community mental health centres that have been established. A particular issue that was raised by several interviewees – as well as the earlier WHO mission report – concerns the inadequate number of trained clinical psychologists to meet demand, as shown by long waiting times (e.g. up to 18 months in the case of children and adolescents). There remains a shortage and the total number of trained clinical psychologists is only 96 in Slovenia.

Number of psychiatrists per 100,000 inhabitants in Slovenia is rising consistently over the last few years. International comparison shows that Slovenia is still under the EU average. Total number of child and adolescent psychiatrists – 31 (Atlas 2020) vs. 25 as indicated by WHO 2015 report. In 2015 WHO also noted a low number of nurses; the reported rate was 36,73 in 2017 and 40,5 per 100,000 of population in 2020, according to WHO Atlas data.

There is a disproportionate number of psychiatrists employed in specialized psychiatric hospitals and wards (134 out of 215 psychiatric specialists work in hospitals and 17 out of 32 child and adolescent psychiatrists work in hospitals). The number of trained clinical psychologists is low (96 in total), of which 40 work in hospitals. Only 44 psychiatrists and 9 child and adolescent psychiatrists work at the primary level (in health centers). Only 46 trained clinical psychologists work at the primary level. Out of 54 trainees in psychiatry, 48 are in hospitals and only 6 in primary health care, and out of 22 trainees in child and adolescent psychiatry, 13 are in hospitals and only 9 in primary health care. Specialists often have additional contracts to work in other health facilities. Of the 191 specialists working in specialized psychiatric hospitals or hospital wards, 128 have contracts to work in external health care facilities - mostly at the primary level, which indicates a great need for specialized staff in primary mental health.[9]

[9] Source:Register of health care providers and health care workers (RIZDDZ)



In addition to increasing the training of clinical psychologists, there are also clear opportunities to enhance the capacity, skills and competencies in early identification or prevention of mental health conditions among other related workers, including primary health care paediatricians and school psychologists.

Information systems and surveillance

As demonstrated by an inventory of indicators prepared in advance of this mission, as well as its participation and contribution to EU, WHO and other international datasets, the National Institute of Public Health already collects, analyses and reports on many different dimensions of the mental health system, thereby enabling the country to appropriately monitor activities and progress towards nationally agreed objectives. In common with many other countries, the main gap in mental health system surveillance relates to indicators of service quality and also service user impact / outcomes. Greater effort could also be made to better identify, assess and use data on the social determinants of mental health as a means towards better understanding of their contribution to mental health needs and impacts at the population level.

2.4 Mental health services

Promotion, protection and prevention

Risks to mental health manifest themselves at all stages in life. Taking a life-course perspective is particularly important in showing how risk exposures in the formative stages of life can affect mental well-being or predispose towards mental disorder many years or even decades later. For example, insecure attachment in infancy or family violence in childhood are important predictors of subsequent problems such as substance use or criminal behaviour in adolescence, which in turn increase the likelihood of exposure to other established risk factors in adulthood such as unemployment, debt and social exclusion. The consequent need to promote and

protect the mental health and well-being of the population, and children and adolescents in particular, should be self-evident.

Slovenia has developed several initiatives and participated in a number of international projects that focus on the protection of the mental health of specific groups of the population, including children, adolescents and parents, and this is to be strongly commended. Examples are provided in the Box below. Since prevention and promotion is so vital in the formative years of life, these programmes could be further scaled-up; a number of interviewees spoke to the limited reach of and funding for such activities, which have often been linked to time-limited projects supported by the European Union or other partners. It was noted, for example, that despite the robust evidence for the effect of socio-emotional learning in schools, a national programme does not currently exist. An evidence based program the Incredible Years Teacher Classroom Management has been successfully introduced in Slovenia in 2019 but has not been implemented on a larger scale to date. School counsellors and psychologists – as well as health sector workers such as PHC paediatricians – could all potentially benefit from new opportunities to acquire and complete competency-based psychosocial skills training.

Slovenia has also participated in a number of international projects that specifically address stigma and discrimination, including ASPEN (Anti-Stigma Programme - European Network) and the INDIGO network. An NGO movement has been developing that advocates against discrimination of persons with mental health conditions or psychosocial disabilities and their families, and promotes recovery-based approaches to care and rehabilitation in the community.

OMRA - An innovative program on strengthening mental health awareness and creating an anti-stigma attitude in the society. The program is intended for those who face problems, as well as their relatives and the general public, including the professionals; https://www.omra.si/
A (se) štekaš?!? - An integrated approach to mental health promotion and primary prevention of suicidal behavior for adolescents aged between 12 and 18 years; http://zivziv.si/a-se-stekas/
The Incredible Years - Early child development project with the purpose to introduce effective, evidence-based preventive program, which improves the sound growth of each child and wellbeing of the entire family. https://neverjetna-leta.si/
The Preventive Health Care Program for Children and Adolescents - Parental program that includes a strong mental health component https://zdaj.net/
To sem jaz (It is me) - the programme is directed at strengthening mental health in adolescents, the development of self-esteem, social and emotional skills and other life competencies to support adolescents in their everyday lives. http://www.tosemjaz.net

Treatment, care and rehabilitation

Primary health care

A recent situational analysis and report by the WHO Regional Office for Europe has highlighted the impressive achievements made in relation to strengthening the primary health care system and services in the country and thereby attaining a high level of universal health coverage in the population.[10] As pointed out in this report, there also remain some important challenges, for example in relation to governance structures, staff burnout, clinical information system weaknesses and quality improvement mechanisms. Over and above these systemic concerns, continuing development of the competencies of the health workforce at PHC level will be essential for further improving both the mental and somatic health of the population. WHO's mental health mission report in 2015 specifically referred to the need to continue the successful primary care training programs in mental health care and strengthen integration of mental health into PHC.

Over the last 20 years general practitioners have been regularly educated about depression, self-harm and suicide, and have accordingly acquired expertise in the recognition and management of these conditions in line with international guidelines and evidence. More than 75% of primary care facilities have available both pharmacological and psychosocial interventions for mental health conditions. Furthermore, in collaboration with WHO, Slovenia initiated in 2019 the adaptation and implementation of WHO's mhGAP Intervention Guide for mental, neurological and substance use disorders, which is an evidence based tool for doctors, nurses and other health workers to identify and manage these conditions in non-specialist settings. Initial application and training in the use of the mhGAP intervention guide was targeted on children and adolescent mental health conditions, with plans in place to extend capacity-building to other priority conditions.

Community mental health care

The Resolution aspires to the development of a composite and integrated network of services that respond to the needs and rights of individuals and communities and works across a range of service levels, sectors and providers. WHO also recommended in 2015 to consider the establishment of psychiatric out-patient clinics in primary care centers or other community centers, shifting the focus of care away from mental hospitals. A key development that has taken place is the establishment of a new network of community mental health centres, which have already demonstrated the value of multi-disciplinary team working, increased service user satisfaction and reduced the need for referral up to more specialized care centres. Currently there are 20 Community-based mental health outpatient centers in Slovenia (split evenly between those for children and adolescents, and those for adults). Number of visits in 2019 reached 21,727. There are also 6 psychiatric hospitals delivering mental health outpatient services for adults and 3 hospital wards for children and adolescents with an outpatient service.

Inpatient and residential care

In 2015, there were 59 psychiatric hospital beds per 100,000 population, mainly in mental hospitals (83% of beds), with the others found in general hospitals (CEPHOS Data). The mean

[10] WHO (2019). Integrated, person-centred primary health care produces results: case study from Slovenia. WHO Regional Office for Europe; Copenhagen, Denmark.

length of stay was 6 weeks. According to latest data from the Atlas 2020, the total number of mental health hospital beds is 1163 (56 beds per 100,000 population). In addition, there are a further 1,788 beds in the 81 mental health community residential facilities in the country. These institutions, mainly social care homes, were referred to by several interviewees as having the potential for further deinstitutionalization; protocols are available but opportunities for re-settlement of the residents of the social care homes in community remain constrained by financial and administrative barriers.

Looking at these data as well as more detailed information provided by the National Institute of Public Health, it seems that, during the period 2015-2019, the deinstitutionalization process was moving slowly, with the exception of the length of stay for patients with a diagnosis of schizophrenia which decreased in Maribor (from 68.4 to 37.7 days) and Idrija (from 66.6 to 35.4 days). All others indicators (average length of stay for other diagnoses, as well as number for admissions) remained largely unchanged over the last five years. Accordingly, there remains a relatively high level of psychiatric inpatient beds and admissions by European standards and a prevailing 'institutional culture' in the delivery of many mental health services.

Rates of admission to and length of stay in mental hospitals over time

2.5 Summary of recent developments (since 2015) and current situation (2020)

The table below sets out the principal recommendations arising from the WHO Europe mission in 2015, together with summary comments on the extent of progress made in relation to them.

Summary of progress made towards WHO mental health mission recommendations (2015)

WHO mission report recommendation (2015)	Progress since 2015
Adult mental health services	***Adult mental health services***
Consider the establishment of psychiatric out-patient clinics in primary care centers or other community centers, shifting the focus of care away from mental hospitals.	Significant progress made in establishing community-based mental health centres
Continue the successful primary care training programs in mental health care.	Several educational programs continued and among them WHO mhGAP training initiated (ToT workshop for CAMH) but yet to be rolled out
Evaluate the efficiency of requesting psychiatric assessments for sickness certificates.	*Issue not specifically addressed by 2020 mission (but a separate report on PHC points to continuing workload pressure due to sickness certification)*
Reduce length of stay of patients in mental hospitals and reduce readmissions by establishing community follow-up of people with severe mental health problems.	Length of stay decreased in 2 of the 6 hospitals; admission rates remain stable, if not increasing
Support the evaluation of community teams, and on the basis of results, expand numbers and capacity.	Benefits of team working in community-based mental health teams recognized and acted upon
Plan workforce developments and training on basis on national strategic needs, rather than in response to the business plans of individual clinics or hospitals.	Workforce planning is not based on national needs and there remain shortages of certain professions and national funds for their training
Increase numbers of clinical psychologists.	There remains a shortage of trained clinical psychologists and national funds for this specialization; there are long waiting lists
Approve professionals with certificates from recognized psychotherapy courses for reimbursement.	Professional accreditation for psychotherapists and their reimbursement still needs addressing
Regulation/legislation concerning care of forensic patients who pose a risk to the community needs updating.	*Issue was not specifically addressed by 2020 mission, but the need for updating remains*
Assess the needs of residents of social care homes and the potential for deinstitutionalization.	Protocols are available but there remain limited opportunities for re-settlement in community
Child and adolescent mental health service	***Child and adolescent mental health service***
Establish a child emergency service, responsible for assessment and triage.	2 centers in Ljubljana and 1 in Maribor serve as emergency referral centres; there is strong demand for / pressure on these services
Prevent admission of children to adult wards by establishing the necessary number of CAH beds, with a small sub-unit for highly disturbed young people.	Psychiatric intensive care unit with 8 beds established in 2019 but there remain less than 50 CAMH beds in the country and consequent continuing pressure on bed availability.
Develop multi-sector psycho-social child mental health teams linked to primary care clinics or social care centers.	Significant progress made in establishing community-based mental health teams
Support the roll-out of Regional Interdisciplinary Centers, supporting pupils with learning difficulties.	No substantive progress in establishing regional interdisciplinary centers for these pupils

Looking more holistically at the current overall state of the mental health system and services, we also present a composite analysis of Strengths, Weaknesses, Opportunities and Threats (SWOT). Key developments made in addition to the establishment of community mental health centres include formal adoption – and strong stakeholder endorsement – of the Resolution on the National Programme of Mental Health 2018-2028 and implementation of innovative practices and programmes relating to mental health promotion and protection in some localities (e.g. the Incredible Years Parenting Programme). Identified weaknesses and ongoing challenges relate mainly to issues of governance (fragmented planning and resource allocation), workforce (training, supply and access to specialists) as well as equity (geographical variability in service access). Opportunities for addressing these systemic issues – as well as barriers or threats to their realization – are considered in the following section.

SWOT analysis of mental health system of care in Slovenia

Strengths:	**Weaknesses**:
• Comprehensive (and seemingly well-accepted) strategy / resolution • Many well-trained and knowledgeable / committed professionals • Good / clear examples of good practice / innovation • Newly established Community Mental Health Centres – going well where established, esp new team working abilities • Strong network of NGO organisations established all over the coutry providing rehabilitation and prevention.	• Slow / insufficient implementaiton of agreed plans, strategies and legislation • Territorial / fragmented planning, financing and services – esp health versus social services as well as education (e.g. poorly coordiated national response to the high rate of suicide) • High level of institutionalisation / pervading institutional culture • Geographical variation and inequity – more remote areas have worse access / quality/ opportunities • Concentration of psychiatrist in psychiatric hospitals • Insufficient training (and associated funding), esp for clinical psychologists but also for others like primary care paediatricians (communication skills) • Long waiting lists for clinical psychologists, psychologists and psychotherapists, including for children and adolescents
Opportunities:	**Threats**:
• Better inter-ministerial coordination / cooperation • Further scale-up and state funding for evidence-based prevention activities, e.g. Incredible Years, NGO working in social & employment rehabilitation • Further scale-up of CMHCs, in line with plan • Development of community-based alternatives to institutions (e.g. small group homes, independent living) • Greater use / supply of day hospital services and general hospital units • Better utilisation of the large school psychologist workforce (e.g. to provide socio-emotional learning programmes)	• Stigma – not as prevalent as before but still much to do • Lack of coordinated planning / silo budgeting / fiscal fragmentation & protectionism, esp psych hospitals • Payment by numbers at expense of quality (inpatient services and their reimbursement by health insurance company) • Lack of incentives – system does not encourage re-settlement of LTC residents or reallocation of resources to community-based services • Transintitutionalization

3. Looking forward: options for consideration

Following the information collected during the 'virtual' mission and reported in Section 2, this Section sets out a number of suggested actions or options for consideration relating mental health system and service development in Slovenia. It follows the same overall structure as the preceding section.

3.1 The mental health system

Governance and financing

The development and endorsement of a National Programme of Mental Health 2018-2028, complete with clearly defined objectives, actions and measures, was noted as a vital accomplishment for the country; however, as detailed in section 2.3, its implementation has encountered a number of obstacles. To address these, it will be necessary to improve inter-sectoral collaboration; to this end, consideration should be given to the formation of an inter-ministerial steering committee that is supported by a scientific council with representation of the relevant stakeholders in the mental health field, including professional associations and scientific societies as well as users and family associations. Establishment of similar committees at sub-national level is also indicated and likely required to enable appropriate coordination and implementation of the national programme.

The national steering committee could also help to overcome the fragmentation that currently exists in relation to the funding system, whereby Ministry of Health and the Ministry of Labour, Family, Social Affairs and Equal Opportunities cover inpatient care and residential care in social institutions, respectively. At the sub-national level, local committees should be encouraged and given opportunities to introduce innovative, person-oriented support strategies that address or overcome the negative effects of a silo-ed approach to budgeting, such as the use of 'personal health budgets' (as already introduced in UK and Italy with good results).

The information collected during the mission clearly points to a need to reduce the centralization of services in Slovenia; interviewed stakeholders reported that people in rural and remote areas of the country receive less treatments or do not seek care at all. A relevant component of health inequalities that can be assessed through a geographical lens is distance from services, considered as a proxy of spatial accessibility. Moving from a hospital-based system of care to a community-based one can be expected to lead to a reduction in geographical inequalities. Specifically, moving resources from large institutions and increasing the number of more accessible community mental health centers, outpatient services and small acute psychiatric wards in general hospitals could reduce the inequalities with respect to service access, quality and opportunities in remote/rural areas. As such, it can be considered that the deinstitutionalization process is directly connected to the geographical inequalities related to variation of available mental health services in rural and remote areas.

Workforce

Despite an observed increase in certain professions over the last few years (such as psychiatrists), there remains an overall paucity of mental health professionals relative to the need and demand for their services, which has a negative impact on access and availability, especially waiting time. In particular, there is a lack of specialists in mental health at primary health care level - for children and adolescents as well as adults and this is hampering the establishment and functioning of multi-disciplinary teams in mental health centers. For many young people in need, for example, waiting lists to access services provided by clinical psychologists are currently running at 15-17 months.

Part of the problem is again related to financing, since payment for multi-year post-graduate training in clinical psychology or residency programmes falls on individual institutions or centres. The qualification and recruitment of clinical psychologists needs to be revisited from a national planning perspective aimed at systematically increasing the numbers and facilitating a better circulation of professionals among services (rather than disincentivizing such flows, as shown by the compulsory stay in the service that paid for the qualification of clinical psychologists). Linked to this issue is the continued need to establish clear national guidance for the regulation for psychotherapy, including forms of evidence-based psychotherapy (like CBT and others) eligible to be covered by the health insurance system.

Information systems and quality assurance

The development of a comprehensive and integrated Mental Health Information System can help the monitoring of services delivery as well as of their quality. The objective of a MHIS is to serve as a tool for improving the mental health of a population and its individual members; for example, the MHIS should include electronic health records for mental health that increase the collaboration among different services and then increase the continuity of care for patients that use several services at the same time.

A set of specific mental health quality of care indicators should be developed and used together with universal indicators for general health on a routine basis. A mix of quantitative indicators and qualitative measures that encompass inputs, processes and outcomes should be implemented.[11] The consolidated identification of several mental health quality indicators across four countries of the Danube region could provide a useful basis for consideration.[12]

3.2 Mental health services

Promotion, protection and prevention

Anti-stigma programmes should be further developed and rolled-out in collaboration with the relevant ministries as needed, using an approach that is able to effectively reach the whole

[11] Thornicroft, G, Tansella, M (2009). *Better Mental Health Care*. Cambridge University Press: Cambridge.
[12] Gaebel et al (2020). Quality indicators for mental healthcare in the Danube region: results from a pilot feasibility study. *Eur Arch Psychiatry Clin Neurosci*. doi: 10.1007/s00406-020-01124-z

population. It is noted that the NGO anti-stigma movement is using the principles of protest, education and the personal involvement of service users. In Slovenia, the NGO movement and also OMRA Platform are good examples of innovative mental health literacy programmes but with the limitation that this type of programs usually only reach those persons that already have some interest in the field. Approaches to stigma reduction must be multi-faceted to address the many mechanisms that can lead to disadvantaged outcomes; they also need to be multi-level, to address stigma perpetuated at the individual and social-structural levels (see typology of anti-stigma interventions below).

Box 1. Types of anti-stigma interventions (by Stuart, 2016)[13]

1. *Awareness raising, key stakeholders come together to engage in activities designed to increase the public profile of mental health issues;*
2. *Literacy programs, improve knowledge about mental illnesses, their signs and symptoms, their treatments, and where to go to seek help;*
3. *Protest, Interventions that use protest are designed to suppress stigma through objection or denouncement. They are often focused at the structural level, attempting to change organizational behaviours and practices. They have been used successfully to take offensive products off of shelves, change the marketing strategies for films, and to take offensive content out of television and entertainment media;*
4. *Advocacy, aimed at inequities that are created by social structures that intentionally or unintentionally limit the rights of individuals with mental disorders;*
5. *Social contacts, based on the idea that greater social contact with members of a stigmatized group could replace faulty perceptions and generalizations, and reduce prejudice and discrimination.*

Similarly, it is recommended to further support and extend the delivery of preventive and programmes and interventions, including those already introduced, evaluated and shown to be effective in Slovenia, such as the Incredible Years parenting programme. Such programmes, which have been restricted in time and support by research project funding, have recently started to be embedded in the first community mental health centers. They could be systematically rolled-out in and by early child development (ECD) and community mental health centres to the benefit of children, adolescents and parents.

There also exist untapped opportunities to strengthen school-based mental health programmes, utilizing the existing human resource capacities present there such as school psychologists. The IY Teacher Classroom Management Program has already been piloted and shown to be well accepted in Slovenia, but there is the lack of support for wider implementation from the Ministry of education, science and sport.

Socio-emotional learning programmes offer an effective means by which mental health issues can be discussed, promoted and prevented; they have also been shown to enhance school

[13] Stuart H (2016). Reducing the stigma of mental illness. *Global Mental Health*, 3: e17.

attendance and scholastic attainment.[14] To successfully introduce school based promotion and prevention school based mental health programs there is a need to establish continuing intersectoral collaboration between the Ministry of Health and the Ministry of Education, Science and Sport.

Treatment, care and rehabilitation

Primary and community health care

Community-based mental health services will require ongoing strengthening of the integration between all the components of the mental health system of care to guarantee the necessary continuity of care. Starting from primary care (as gatekeeper) through outpatient care, mental health centers, rehabilitation facilities and finally inpatient care.

As highlighted in a recent WHO report, a vital and well-performing component of health care in Slovenia is Primary Health Care (PHC).[15] Slovenia's PHC system has reached a high level of universal health coverage (UHC index 78/100). In the Report (WHO, 2019), some challenges that threaten the sustainability of PHC system have been identified, including the long waiting lists for specialist care and the high and increasing workload of general practitioners (GPs). As for many physical health conditions, GPs can and do play an important role in the early identification, prevention and management of mental health conditions. The Resolution called for the increased capacitation of primary health care providers in this regard, and has been partially brought about by the conduct of a WHO mhGAP workshop, which was focused on training of trainers in the identification and management of child and adolescent mental health conditions. Since the feedback from this workshop was positive, and in the interest of ensuring 'continuity of care' and coordination between primary and secondary care levels, it is recommended that continued efforts are made to offer such capacity-building opportunities, and they can be extended to cover also adult mental, neurological and substance use conditions.

In addition to the lack of staff and consequent long waiting lists, a further specific issue for child and adolescent psychiatry is the connection with adults' services, in particular the need to develop protocols to guide the transition of patients around the age of eighteen from child and adolescent services to adults psychiatric services. Moreover, for child and adolescent, geographical inequalities are still present as more services are available in the main cities and less in rural and remote areas. This produces inequalities and it forces patients and their parents to move or to give up seeking the necessary care. There is a consequent need to improve access to primary level services across the whole county.

Inpatient and residential care

[14] WHO Guidelines on mental health promotive and preventive interventions for adolescents; https://www.who.int/publications/i/item/guidelines-on-mental-health-promotive-and-preventive-interventions-for-adolescents

[15] WHO (2019). Integrated, person-centred primary health care produces results: case study from Slovenia. WHO Regional Office for Europe; Copenhagen, Denmark.

Key steps have been taken to improve quality and availability of mental health care outside the hospitals in the last 5 years in Slovenia, most notably the establishment of 20 community-based mental health centres. Despite these positive developments, a corresponding reduction in hospital-based services was not observed; the number of hospitalizations remains stable from 2015 to 2019, and in some cases increased. A high level of institutionalization and a pervading institutional culture was reported by several interviewed stakeholders. In order to move towards Objective 4 of the RNPDZ 18-28, and meet the target of a 40% reduction in institutional beds, the deinstitutionalization process needs now to be stepped up.

The shift from a hospital-based system of care to a community-based one can be reached if resources and staff will be gradually moved from hospitals to community mental health centers and outpatient care. Moreover, an evaluation of needs for those patients admitted to mental hospitals should be carried out and community alternatives to institutional solutions should be found (i.e. home care, residential facilities, group homes and supported independent living). This goal will be only achieved with the cooperation of the social and the health sectors, as well as of the NGOs. Throughout this process, particular attention should be given to avoiding the risk of or actual practice of trans-institutionalization. To change the institutional culture, specific trainings and courses should be made available for residents in psychiatry as well as for the educational programs dedicated to all mental health professionals.

As noted in the Resolution, a critically important component of a well-functioning mental health system is well developed primary and community mental health care. The current paucity of workers and programmes at primary care level needs to be addressed as a central element of the reform process; supplementary funding and human resources could be leveraged or re-allocated from the institutional care system. It is vital that high skilled workers, including psychiatrists, child and adolescent psychiatrists and clinical psychologists, are distributed equitably across the different levels of the health system in relation to population need, since the existing concentration of human resources for mental health in psychiatric hospitals presents an obstacle to equitable accessibility and continuity of care. Through such a process of steady reform, the envisaged network of functioning community mental health centers working in tandem with general hospital and primary health care services can be progressively realised. To support and enhance the links between general hospital services and mental health care at the primary and community level, a renewed attention to and investment in liaison-consultation psychiatry can be recommended.

Finally, the COVID-19 crisis and associated response and recovery needs calls for an expedited consultation and implementation of these recommendation because of the gravity of the socioeconomic as well as health crisis; the ongoing pandemic has rapidly increased the need and demand for person-centred, responsive and community-based mental health care, and has in fact reinforced the major reform objectives laid out in the *Resolution of The National Mental Health Programme* 2018. In short, the mental health of population depends on the timely and comprehensive implementation of the national mental health plan for the country.

A summary of the key issues and options for addressing them is provided in the table below.

Key issues / needs	Options for consideration / recommendations
Governance and financing	
1. Inter-sectoral coordination, planning and financing	• Invest in inter-sectoral, multi-stakeholder governance mechanisms to oversee joint planning, shared budgets, implementation and monitoring of RNPDZ 18-28 activities at national and sub-national levels
2. Equality in access	• Reduce geographical inequalities through continued development of locally-determined and community-based mental health services • Enhance access to child and adolescent mental health services across the country.
Human resources and workforce planning	
3. Access to specialist care professionals	• Plan, recruit and train clinical psychologists on a national / state basis and bring up their number and capacity to better meet population need • Develop regulatory guidance for the practice (and reimbursement) of psychotherapy
Health information systems and quality assurance	
4. Quality and impact of care	• Develop and routinely apply mental health quality indicators
Service organization and delivery	
5. Prevention and promotion	• Strengthen mental health awareness, literacy and adovacy efforts • Introduce socio-emotional learning programmes in schools • Roll-out effective prevention and support programmes for families
6. Integration of mental health into primary and community health care	• Build capacity of non-specialists to identify, manage and follow-up people with mental health conditions • Continue to develop, learn from and monitor the roll-out of community mental health centres, including inter-disciplinary working arrangements
7. Inpatient and residential care	• Accelerate efforts to relocate services away from large institutions by a) enabling and financially supporting community-based alternatives (including supported housing and day care), b) training of institutional and community staff and c) monitoring care quality standards in line with CRPD

Annex 1 Mission schedule of appointments (September 2020)

Wednesday, September 2nd

09.00-09.45	**Users experiences** • Marjana Dautović - parents representative • Anja Črepinšek – adolescent representative • Dejan Sotirov - zavod Mavrični bojevniki
10.00-10.45	**NGOs for adult mental health services users and families** • Tilen Recko – Društvo Altra • Nace Kovač - ŠENT – Slovensko združenje za duševno zdravje
11.00-11.45	**Educational insitutions** • Dr Mateja Hudoklin - The Counselling Centre for Children, Adolescents and Parents Ljubljana
14.00-14.45	**Community Health Care Centre Ljubljana** • Dr Mateja Vintar Spreitzer - Community Health Care Centre Domžale

Friday, September 4th

09.00-09.45	**Mental Health Centre for Children** • Anita Požin - Mental Health Care Centre for Children and Adolescents Celje • Tamara Polanič - Mental Health Care for Children and Adolescents Murska Sobota
10.00-10.45	**Mental Health Care for Adults** • Vladimira Tomšič - Community Health Center Sevnica • Maja Bundalo Bočić - Community Health Center Ptuj • Prof. dr. Vesna Švab – ŠENT Slovensko združenje za duševno zdravje
11.00-11.45	**Psychiatric Hospitals** • Miloš Židanik - Director of Psychiatric Hospital Ormož • Bogdan Tušar - Psychiatric Hospital Idrija • Dr Miran Pustoslemšek - Psychiatric Hospital - Forensic Unit Maribor
14.00-14.45	**Social Care Homes** • Petra Hameršak - Social Care Home Hrastovec
15.00-15.45	**General Hospital** • Jadranka Buturovič - University Medical Clinical Centre of Ljubljana Daniel Grabar - Medical Director, General Hospital Murska Sobota

Monday, September 7th

9.00-9.45	**Financing** • Miriam Komac - The Association of Health Institutions of Slovenia • Dr Agata Zupančič - Ministry of Health
10.00-10.45	**Ministry of Health** • Nadja Čobal - Ministry of Health • Dr Agata Zupančič - Ministry of Health
11.00-11.45	**Ministry of Education** • Mišela Mavrič - Ministry of Education • Anton Baloh - Ministry of Education, Director of Directorate
14.00-14.45	**Ministry of Social Affairs** • Barbara Goričan, Renata Brdar Tomažinčič and Teja Podgorelec - Ministry of Labour, Family, Social Affairs and Equal Opportunities
15.00-15.45	**National Institute of Public Health** • Dr Marija Aderluh - National Institute of Public Health • Prof Dr Vesna Švab - National Institute of Public Health • Prof Dr Mojca Zvezdana Dernovšek - National Institute of Public Health

Tuesday, September 15th

12.00 – 12.45	**National institute of Public Health** • Jožica Maučec Zakotnik - National Institute of Public Health • Matej Vinko - National Institute of Public Health

Thursday, September 17th

13.00 – 13.45	**Ministry of Health** • Vesna Kerstin Petrič - acting Director General, Public Health Directorate, Ministry of Health