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Country Profile Slovenia

Community-based Mental Healthcare Networks: Key Facts and National Priorities

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Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL (ja-implemental.eu). It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises six Work Packages (WPs), four horizontal WPS and one for each best practice. WP5 on community-based mental healthcare aims to implement elements from Belgian Mental Health Reform, which is based on the principle of deinstitutionalization, i.e., the transition from care primarily provided in institutions to community-based care in order to improve mental health outcomes and quality of life and avoid unnecessary hospitalizations. In addition, the reform is based on the principles of rehabilitation and inclusion, decategorization, i.e., multisectoral cooperation, strengthening care in hospitals to make stays shorter, but with more intensive treatment, and the principle of consolidation, providing funds for pilot projects.

The present country profile is one of the major deliverables of the JA, presenting key facts of the national and local mental health system. It summarizes results of the recent situation analysis and needs assessment (SANA), lists lessons learned, recommendations, challenges and opportunities as well as outlining next steps necessary to scale-up, promote national/regional community-based mental health care services. The country profile forms a basis for strategy formulation, decision-making and commitment.

This country profile is based on a situation analysis conducted in two parts and subsequent needs assessment. For the situation analysis, two questionnaires have been developed by WP5, one for the analysis of the situation regarding the overall health system and community-based mental health care at national level, and another one for the analysis at implementational level. Following the data collection, a SWOT analysis was conducted by the countries to assess the needs in terms of community-based mental health care.

Slovenia will implement a "mental health network" (MHN) in two pilot areas. MHN will aim to bring together all relevant stakeholders in an area and therefore will serve the whole population.

1 Situation Analysis (SA)

1.1 Country, Health and Social System at national level

Slovenia is a parliamentary democratic republic with approximately 2.1 million inhabitants (1). It is located in central Europe with Ljubljana as a capital.

Table 1: Population structure: 2021, expressed as number of persons, by age and sex (2)

Age group	Male	Female	Total
<18	192 689	181 521	374 210
18 - 64	678 677	620 385	1 299 052
65+	188 582	247 133	435 715
Total	**1 059 938**	**1 049 039**	**2 108 977**

The population structure according to age and sex is described in Table 1. Healthy life expectancy at birth is 73.7, and 14.3 at age 65 (3). A total of 13.2 % of the population is at risk of poverty and social exclusion, which is lower than the European average (21.7%) (4). Income inequality, expressed as the Gini coefficient, is 23 (compared with 30.1 in EU) (5), and total healthcare expenditure relative to GDP is 9.45% (compared with 10.9% in EU) (6).

Slovenia has a statutory health insurance system with a single public insurer, the Health Insurance Institute of Slovenia (ZZZS), providing almost universal compulsory health insurance (more than 99% of the population). Public financing is the primary source of health system resources – 72.8% of the total in 2019 – with private sources accounting for 27.2%, above the EU average of 20.3%. The Ministry of Health oversees strategic planning and is responsible for governance and leadership of the health care system. Slovenia's primary health care is mainly delivered by 63 community primary health centres owned and managed by municipalities, which offer a wide range of services by family medicine specialists, dentists, community nurses, and others (7). The country is ramping up health promotion and prevention in line with its integrated, community-based primary care model, especially for vulnerable populations. Most secondary level outpatient services and nearly all inpatient services are provided in hospital. Hospital care is accessible through referral by specialists, by direct referral from primary care physicians or through an emergency service. Inpatient care is provided by 30 public and private hospitals (7, 8). Emergency care provision was restructured in 2015, with a clearer division of emergency medical units. The rights and services for long-term care (LTC) are provided and financed through different routes across the health and social sectors, with a new LTC Act currently in the phase of inter-ministerial harmonization (7).

1.2 Mental Health Care at national level

Mental health care in Slovenia is predominantly hospital-based; however, over the years, Slovenia has endeavoured to establish conditions for deinstitutionalization and shift to new models of community-based care. Since 2018, 16 Community Mental Health Centres (CMHC) for Adults and 19 CMHC for Children and Adolescents were established. The number of psychiatric beds is slowly decreasing, with 18% fewer psychiatric beds in 2019 than 1990. Outpatient services are provided in health care centres/CMHC (primary health care level), by private practitioners (concession holders within the public health care system), by private practitioners (for-profit) and in hospitals (tertiary and secondary level of health care). Mental health services in Slovenia are also included in the social care (residential support etc.) and educational system (counselling etc.) as well as the NGO network, which receive government funding for mental health support services (residential, day care facilities etc.). In 2018, after four public consultations (2009, 2011, 2014, 2017), the National Assembly passed the National Mental Health Programme 2018–2028 (NMHP18-28) (7). The National Institute of Public Health was assigned with the role of the coordinator of the implementation of the NMHP18-28. The programme provides national stakeholders with a set of objectives, actions and measures to guide development in public health interventions related to mental health; mental health care service organization and delivery; human resources and workforce planning; and health information and quality assurance. Six

priority areas include (i) community-based approach to improving mental health, (ii) mental health promotion and the prevention and destigmatisation of mental illness, (iii) mental health network, (iv) alcohol and mental health, (v) suicide prevention and (vi) education, research, monitoring and evaluation. The Programme covers multiple principles of community-based care: deinstitutionalisation, user-centredness, recovery orientation, participation of users and families in decision-making, intersectorality, multidisciplinarity, integrated care, local networks and health promotion. Child and adolescent mental health is an integrated element of the Programme, but there are no procedures for the transition from adolescent to adult mental health services (8).

The care and treatment of persons with mental health conditions is fully covered by health insurance. In 2014, 2.5% of people in Slovenia reported not receiving mental health care due to financial reasons (9). However, there are inequalities in access across regions of Slovenia, with longer waiting lists for psychotherapy and outpatient mental health care compared to other types of care. Despite the gradual establishment of CMHC and the increase in numbers of certain professions, Slovenia is still lacking mental health workforce to meet the needs of population (7).

The Ministry of Health, Ministry of Education and Ministry of Labour, Family, Social Affairs and Equal Opportunities are actively involved in the implementation of the NMHP18-28. The Ministry of Justice is also collaborating in the area of mental health as an active member in the national council on mental health (8).

Table 2: Facilities, number of beds and hospital admissions related to mental health (10)

Indicator at national level		Number	Rate per 100.000 adult/minor population
Mental health hospitals	Facilities	5	0.29
	Beds	1163	67.04
	Admissions	9402	541.97
Psychiatric wards/units of general hospitals	Wards/units	1*	0.06
	Beds	198	11.41
	Admissions	1546	89.12
Mental health community residential facilities	Facilities	81	4.7
	Beds	1788	103.1
	Admissions	/**	/**
Mental health inpatient facilities specifically for children and adolescents	Facilities	3	0.80
	Beds	46	12.29
	Admissions	/**	/**
Mental health community residential facilities specifically for children and adolescents	Facilities	19	5.1
	Beds	/**	/**
	Admissions	/**	/**

* We have one psychiatric ward in general hospital - that is a psychiatric clinic of the University Clinical Centre Maribor.

**No data available.

More than 75% of people with mental health conditions discharged from hospital receive a follow-up outpatient visit within one month after discharge. The outpatient services for adults are covered by 10 hospital-based, 87 community-based and 31 other facilities. For children and adolescents, there are 6 hospital-based and 19 community-based outpatient facilities. Counselling services are present in every

educational and student-residential institution in Slovenia. There are also 20 mental health day care facilities that offer services for children and adolescents (10).

Table 3: Mental health workforce (11)

	In MH service (all)		In child & adolescent MH services (totals of government and non government services)	
	Total number	Rate per 100.000 total population	Total number	Rate per 100.000 minor population
Psychiatrists	333	15.8	---	---
Child psychiatrists	---	---	61	16.3
Mental health nurses	849	40.3	100	26.7
Psychologists	313*	14.8	146	39.0
Social workers	66	3.1	31	8.3
Speech therapists	56	2.7	45	12.0
Occupational therapists	80	3.8	20	5.3
Others	91	4.3	17	4.5
Total	1788	84.8	420	112.2

*We have counted all (clinical) psychologists that work in adult mental health services. However, large majority of them provide services both for child and adolescent and adult population.

The newly established CMHCs facilitate an increase in the mental health workforce at primary level. Still, primary health care doctors (general practitioners or family medicine specialists) play a key role at primary level as the gatekeepers in the Slovenian health care system. They refer patients to specialist care and also manage common mental health disorders.

Mental health data is reported as part of a general health information system, but the mental health indicators are not defined at the governmental level. Report on mental health activities and mental health data is an integral part of the National mental health programme evaluation.

1.3 Population profile in pilot areas

1.3.1 Population profile in the pilot area of Nova Gorica

The Nova Gorica (NG) region is located in the western part of Slovenia. The population of NG region fares well in most socio-economic and health indicators. The quality of life is slightly above average compared to the country as a whole. However, there is a high share of population at risk of social exclusion, which indicates the presence of inequalities. Share of population with low education (primary school or lower) is slightly higher in NG region than the national average (12). Mental health indicators show above-average mental health and wellbeing in the region (11).

The share of unemployed among the working age population (15-64 years) of the pilot area is **7.1**%. The life expectancy is **83.73** years on average for women and 78.51 years for men (12).

Table 4: Population structure in 2021 of municipalities in the pilot area of NG expressed as number of persons, by age and sex (13)

Age group	Male	Female	Total
<18	7786	7255	15041
18 - 64	26129	23355	49484
65+	8483	10849	19332
Total	**42398**	**41459**	**83857**

1.3.2 Population profile in the pilot area of Murska Sobota

The Murska Sobota (MS) region is situated in the eastern part of Slovenia. It is relatively underdeveloped compared to the national average and regions in western Slovenia. However, in the context of eastern Slovenia, the MS region is a regional hub and has favourable socio-economic and health indicators compared to more rural neighbouring regions (11). Mental health indicators show that the MS region has a statistically higher consumption of drugs used to treat mental disorders (14). However, unlike many other regions in eastern Slovenia, the suicide rate in the MS region is not statistically different from the national rate (11).

Table 5: Population structure in 2021 of municipalities in the pilot area of MS expressed as number of persons, by age and sex (13)

Age group	Male	Female	Total
<18	6026	5677	11703
18 - 64	23276	21891	45167
65+	5533	7623	13156
Total	**37043**	**37770**	**74813**

The share of unemployed among the working age population (15-64 years) of pilot area is **12.1%**. The life expectancy is **82.50** years on average for women and **75.67** years for men (12).

1.4 Community-based mental health care at pilot areas

A key development towards community-based mental health service in recent years in Slovenia has been the establishment of CMHCs for adult and child and adolescent population, which are also present in the two pilot areas. The centres operate at the primary health care level and do not require referrals for access to specialist services. Part of CMHC for adults in each pilot area also include outreach services for adult population. Mental health services were already present in health care centres before CMHC, but the new organisation of services has changed the concept of service provision towards a person oriented and intersectoral approach. The new service organisation also allows for the recruitment of additional health professionals (8).

The availability of mental health services for each pilot area will be presented separately in sections 1.4.1 and 1.4.2. Here we will mention the services and prevention/promotion activities that are available at national level or are present in both pilot areas. Such services are e. g. the national crisis hotlines and web-based interventions available for both children and adolescents and adults. There are also some prevention/promotion activities taking place at both pilot areas (i.e. Incredible years), but they are not widespread and there is a lack of activities for adults. For adult population, health promotion workshops (coping with stress, etc.) are available through "health promotion centres" within the health care centres. Schools reach out to various intervention providers - NGOs and also National Institute of Public Health. Some schools are also involved in thematic networks that address mental health ("healthy schools network"). Schools have a variety of interventions available through a

national "catalogue of interventions and courses". Schools decide which activities to include in their curricula.

As regards persons with disabilities, they are entitled to different rights to disability insurance at national level. They are classified in three categories according to their ability to work, which have different rights, including: disability pension, vocational rehabilitation and disability allowance. At the level of the pilot regions, there are services to support social inclusion and integration, including: day care centres, adult education centres and education activities for early school leavers.

As we are implementing mental health networks, we should mention the priority area and specific objective in the NMHP18-28, which is specifically dedicated to coordinated intersectoral cooperation: "Establishment of regional mental health councils and local (interdisciplinary and intersectoral) groups for community-based (mental) health, to include the fields of health, education, social security and the family, societies and associations, social care programmes, municipalities, etc.) with the aim of improving (mental) health in the community" (8, p. 29). Sections 1.4.1 and 1.4.2 will therefore also describe the current situation on intersectoral cooperation.

1.4.1 Community-based mental health care in the pilot area of Nova Gorica

The NG pilot area does not include hospital based psychiatric facilities, but there are protocols that cover the collaboration of primary and specialised (psychiatric hospitals outside the region) care. In 2021, the number of annual admissions to mental hospitals per 10.000 adults whose habitual residence is in the pilot area was 43.3 for women and 62.1 for men. The rate of discharges from mental hospitals for children and adolescents whose habitual residence is in the pilot area was 14.6 per 10.000 minor population.

Table 6: Total number of MH workers in the area of CMHC NG (11)

	In MH services (all)		In child & adolescent MH services	
	Total number	Rate per 100.000 total population	Total number	Rate per 100.000 minor population
Psychiatrists	4	0.5	----	----
Child psychiatrists	---	---	1	0.7
Mental health nurse	9	1.1	0	0.0
Psychologists	9	1.1	0	0.0
Social workers	2	0.2	0	0.0
Speech therapists	5	0.6	0	0.0
Occupational therapists	2	0.2	0	0.0
Others	1	0.1	0	0.0
Total	32	3.8	0	0.0

There are two NGOs in the area that provide community residential facilities for adults and one youth crisis centre that can provide temporary housing for child and adolescent population - not necessarily due to mental health reasons. Outpatient community-based services for adults are provided by three facilities – one of them is situated in a health care centre and two are private outpatient clinics. Outpatient services for children and adolescents are provided in a health care centre, as well as in schools and kindergartens, where there are counselling services with trained psychologists and social workers who provide psychosocial support and counselling.

The broader region of NG where the pilot project is being implemented has a "Regional council for public health" and a "Mayor's council". The former has a large number of public health stakeholders but is relatively inactive. The second is composed of the mayors of the municipalities in the region. Among the topics discussed at their meetings are public health issues of concern to the region. Both structures cover a wider region than the area of the MHN are planned for the current pilot project. There were also "local health promotion groups" in the region, which were set up at municipality level, but ceased to function during the pandemic.

There is an organised patient support group hosted by CMHC for adults, but more support groups and other forms of participation are needed.

1.4.2 Community-based mental health care in the pilot area of Murska Sobota

There are no mental hospitals in the pilot area of MS. Primary and specialised care services collaborate mainly on a case-to-case basis. The level of collaboration (in some services) is based on interpersonal relationships between professionals working in different services. In 2021, the number of annual admissions to mental hospitals per 10.000 adults whose habitual residence is in the pilot area was 46.1 for women and 50.6 for men. The rate of discharges from mental hospitals for children and adolescents whose habitual residence is in the pilot area was 14.6 per 10.000 minor population.

Table 7: Total number of MH workers in the area of CMHC MS (11)

	In MH services (all)		In child & adolescent MH services	
	Total number	Rate per 100.000 total population	Total number	Rate per 100.000 minor population
Psychiatrists	6	0.8	----	----
Child psychiatrists	---	---	1	0.9
Mental health nurse	13	1.7	0	0.0
Psychologists	25	3.3	0	0.0
Social workers	3	0.4	0	0.0
Speech therapists	6	0.8	0	0.0
Occupational therapists	3	0.4	0	0.0
Others	59	7.9	0	0.0
Total	115	15.4	0	0.0

* There are also two health professionals (1 child and adolescent psychiatrist and 1 resident in psychiatry) who work part time (1 day per week) and are not included in the table.

The pilot area has one mental health community residential facility for adults run by an NGO and one youth crisis centre that can provide temporary housing for child and adolescent population - not necessarily due to mental health reasons. Outpatient community-based services for adults are provided by one health care centre, two private outpatient clinics and one private outpatient clinical psychology clinic. Outpatient services for children and adolescents are provided in three health care centres in the region, as well as in schools and kindergartens, as is the case nationwide.

In the MS region, "local health promotion groups" were established on municipal level, but they ceased to function during the pandemic and there are currently no network or community-based approaches in the region. The relevant stakeholders are therefore working together on individual basis and according to existing protocols. Such collaborations usually start at the initiative of one of the stakeholders and end when the needs of the stakeholder who initiated the work have been met.

Collaboration between public institutions and NGOs is a rare case. There is also a lack of participatory elements for users and relatives (there is an NGO that supports service users in their needs, but no service user associations).

2 Needs Assessment (NA)

Semi-structured individual interviews were conducted with different staff profiles involved in mental health services in the pilot areas. Based on the interviews, SWOT analyses were prepared.

2.1 SWOT Analysis in the pilot area of Nova Gorica

In the area of NG, we conducted 12 interviews with stakeholders from different services: CMHC for children and adolescents, CMHC for adults, social work centre, municipalities, day centre Ozara, patronage and reference practice.

Table 8: SWOT Analysis for the pilot area of Nova Gorica

STRENGTHS	WEAKNESSES
1. Everyone working together makes for better patient care and therefore better mental health. 2. Good existing cooperation between different services. 3. Multidisciplinary cooperation allows better treatment of the patient. 4. Network developed for both adults and children. 5. Integration takes place at the level of health and social care as well as at the level of NGOs, municipalities and companies.	1. Long waiting times before a person gets involved in another service they need. 2. The problem of services not being included in integrated treatment (e.g. an occupational therapist in a CMHC for adults who would like to go to the patient's housing group, DSO, home, etc.). 3. Lack of the necessary stakeholders (occupational rehabilitation providers). 4. Poor knowledge of the tasks of the professionals involved in the network.
OPPORTUNITIES	**THREATS**
1. Involvement of professionals in multidisciplinary treatment. 2. Optimized task allocation among professionals for enhanced accountability and streamlined operational efficiency. 3. Involvement of relatives in the network and in the overall communication. 4. Regular multidisciplinary meetings according to patients' needs. 5. Protocols for cooperation in place (when, how, what). 6. Specific telephone lines set up (separate telephone numbers for collaboration). 7. Good existing network allows earlier identification of mental health problems especially in more vulnerable populations.	1. Lack of experts' time to network and interact with each other. 2. The inferiority of some services to other services. 3. Protection of personal data. 4. Location distribution (hills and displacement). 5. Limited resources. 6. Maintaining interpersonal relations and regular communication between all stakeholders is challenging. 7. Interest in cooperation only on one side and not with all services. 8. The flow of information about the patient between professionals is not coordinated 9. Lack of professionals.

2.2 SWOT Analysis in the pilot area of Murska Sobota

In the area of MS, we conducted nine interviews with stakeholders from different services: day centre Zavod Vitica, social work centre, Mozaik - association for social inclusion, day centre and residential facilities Ozara, Pomurska Chamber of Commerce, CMHC for children and adolescents and CMHC for adults.

Table 9: SWOT Analysis for the pilot area of Murska Sobota

STRENGTHS	WEAKNESSES
1. Cooperation established where the needs exist. 2. Exchange of good practices, cooperation ideas, solutions to problems and actions. 3. Collaboration means putting together the services the user needs more quickly. 4. Cooperation allows for faster adjustment of the quality of services also according to the satisfaction of the user. 5. Better user experience with the system (due to collaboration) reduces prejudices about mental health. 6. Reduction in hospital admissions (because the user is treated in a holistic way and deterioration of problems is detected earlier by different services). 7. If professionals are linked, the user is also more motivated to participate.	1. Lack of knowledge of the role of all services and the skills that each service has. 2. Lack of general knowledge of mental health among the general population and among some professionals.
OPPORTUNITIES	**THREATS**
1. Regular team and multidisciplinary meetings, and peer presentations. 2. Raising awareness of the tasks and roles of other services. 3. Upgrading of knowledge on the field of mental health at different levels through various topics. 4. Cooperation tailored to needs (cooperation is even more important where experts do not otherwise work in a multidisciplinary team).	1. Lack of experts' time to network and interact with each other. 2. Lack of resources in certain services (especially NGOs). 3. Formally mandated participation could act as a constraint. 4. Important to think of cooperation as a long-term system and not just an opportunistic way of working (seeing that cooperation is not only important when patient's health deteriorates). 5. Lack of professionals. 6. Uncoordinated cooperation protocols (cooperation is therefore individually conditional).

3 Reflection on SANA results

In both pilot areas, cooperation is only established between some services that concern mental health. Also, the quality of cooperation varies from service to service. Some of them have established cooperation protocols with each other according on their needs, while some work together without established referrals and without protocols. Overall, the practice of community cooperation is better developed in the Nova Gorica pilot area – both between and within different municipalities.

The CMHC for adults and the CHMC for children and adolescents have been established in both pilot settings, representing a new service with involved and engaged local stakeholders. both pilot areas are still facing a shortage of staff or even specific stakeholders. In implementing MHN, we will need to be attentive to their needs and to making connections that will benefit them and not create additional obligations.

In addition, the SANA results show a clear need for more user involvement in mental health care – either through more support (support groups) or through the creation of user associations.

Box 1. Prioritized measures for pilot implementation

Strategic area 1 – Substrategic area 2: Building and sustaining networks based on intersectoral, multidisciplinary and recovery-oriented approach

Activities at both pilot areas:

- Identify relevant stakeholders
- Approach stakeholders with an invitation to participate in MHN
- Identify possible actions and feasibility of actions to address needs
- Establish core MHN teams
- Define roles and responsibilities of MHN at a local level
- Establish protocol on cooperation within the MHN and governance
- Develop mental health needs assessment tool and report
- Collect data on the visibility and perceptions of the MHN
- Improve participation of users/families
- Prepare MHN action plan for the period after the end of the project
- Organise communities/municipalities with plans to implement MHN after the end of the project

Strategic area 3: Training & capacity building programme of stakeholders (in support of the reform & cultural change in service provision)

Activities at both pilot areas:

- Provide capacity trainings, seminars and workshops for MHN team

Strategic area 5: Data collection, monitoring & evaluation

- Use the dashboard developed within WP5

POTENTIAL SUCCESS FACTORS

- ✓ Stakeholders are engaged and motivated
- ✓ Actors in the network perform their roles as planned
- ✓ Financing is secured
- ✓ Country teams remain committed
- ✓ Mental health networks do not duplicate existing processes, structures

There is an awareness, that better and systemized collaboration between services could help to improve the flow of information, better understand and delineate the tasks of each service and help overcome some of the barriers faced by individual services.

4 Priorities & Next steps

In both pilot areas, we define next priorities and steps:

- Establish MHN core teams.
- Provide trainings, seminars and workshops for MHN to attend to build capacity.
- Establish protocols of cooperation within the MHN and governance.
- Prepare MHN action plans for the period after the end of JA ImpleMENTAL.
- Organise communities/municipalities with plans to implement MHN after JA ImpleMENTAL.

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