Depression scorecard: SLOVENIA

This report is based on a user guide and template that were produced by The Health Policy Partnership as part of the Words to Actions initiative. The user guide and template were initiated and funded by Janssen Pharmaceutica NV. No experts involved in the original depression scorecard work for Belgium, France, Italy and Romania, other than The Health Policy Partnership, were paid for their time. The same is true for experts involved in developing the scorecards in Slovakia, Czech Republic, Hungary, Slovenia, Croatia, Serbia, Bulgaria, Estonia, Latvia, Lithuania.

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About this scorecard

The depression scorecard is a tool that aims to support the assessment of national-level performance in key aspects of policy, delivery and care for people with depression. The framework that underpins the scorecard was developed based on an international literature review and consultation with an expert advisory group.

The idea for the depression scorecard came from collaborative discussions between The Health Policy Partnership and Janssen Pharmaceutica NV as part of the Words to Actions initiative. For full details about the Words to Actions initiative, please see wordstoaction.eu/about.

The scorecard framework was developed and applied initially by The Health Policy Partnership, in collaboration with experts, to four countries: Belgium, France, Italy and Romania, with findings summarised in individual scorecard reports. National-level findings were developed based on in-depth literature review and interviews with leading national experts in depression.

The scorecard framework has now been made publicly available for advocates to use in their own countries, following the template and instructions provided in an accompanying user guide.

This scorecard report is based on that framework to assess depression care in Slovenia.

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Depression: why it matters

Depression is a common mental disorder that affects people of all ages worldwide.

According to WHO estimates, over 300 million people, or nearly 4% of the global population, suffer from depression.[1]

A large number of patients with depression (though not all) have a distinct episodic course of their disorder, with periods of good mental health in between.

Depressive disorders affect 40 million people in Europe, with individual country rates ranging from 3.8 to 6.3 percent of the population.[1]

These figures are even higher today, as a result of the psychological impact of the COVID pandemic.[1]

14.7

psychiatrists per 100,000 inhabitants in Slovenia[4, 5, 6]

4.3%

of people in Slovenia [aged over 15] are living with depression[1]

19.8 per 100.000

per 100,000 inhabitants in Slovenia died from suicide or self-harm in 2019. Global estimates indicate depression may have contributed to up to 60% of these deaths.[3, 2]

Depression causes mental distress and can impair an individual's ability to perform even the most basic daily tasks. It can have a devastating effect on relationships with family and friends, while also preventing an individual from participating in work, education, family, and community.

Depression significantly reduces a person's quality of life, exacerbates existing chronic diseases, increases the likelihood of new ones, and is one of the most important risk factors for suicidal behavior. According to international estimates, depression is present in up to 60% of suicides, and up to 15% of people with untreated depression commit suicide.[2]

Stigma is strongly linked to depression, and people who suffer from depressive symptoms often suffer in silence for a long time and put off seeing a doctor in order to receive quality care.

Depression also has a significant impact on the country's socioeconomic situation, status, or position.

EUR 177 million

cost of mental health (direct and indirect) annually in Slovenia[6, 7]

5.8%

of Slovenia's health spending on mental health[6]

4.1%

cost of mental health to Slovenia's GDP (direct and indirect expenditure) [8]

[1, 3, 4, 5, 7] Data from 2021

[2] Data from 2017

[6] Data from 2020

[8] Data from 2018

Depression scorecard for Slovenia

According to the Global Health Data Exchange[1] approximately 85,000 people, or 4.3% of the population, suffered from depression in Slovenia in 2019. Every sixth person suffers from depression at some point in their lives, and every twentieth Slovene is depressed at the moment, with many of them going without a diagnosis or receiving proper professional help.

A significant number of patients with depression (though not all) have a distinct episodic course to their disorder, with periods of good mental health in between.

Suicide is a major public health issue in Slovenia, and the country is one of the countries with the highest suicide rates. In 2019, the suicide quotient was 19.8%, which was higher than the European average (13 per 100,000 people). Suicide claims the lives of nearly four times as many men as it does women, and the elderly are particularly at risk. It is concerning that suicide is the second leading cause of death among adolescents aged 15 to 19 (after deaths due to road accidents).[9]

Access to mental health services varies by geographical area in Slovenia, and it is also characterized by significant socioeconomic and demographic differences.

Slovenia does not have a separate national program for the treatment of depression. However, the treatment of depression in conjunction with other mental disorders is included in the National Mental Health Program.

Slovenia is in the process of renewing its mental health system and developing new services in this area.

The Mental Health Act[10] was adopted in 2008. The adoption of the Resolution on the **National Mental Health Program (2018–2028)**[5] marked a significant transition.

The National Mental Health Program 2018–2028 (MIRA)[11] is the Republic of Slovenia's first comprehensive mental health strategy document. The program integrates existing structures and adds much-needed new ones to create an integrated, interdisciplinary, and cross-sectoral promotion, prevention, treatment, and rehabilitation organisation.

In 2021, the Association of Psychiatrists of the Slovenian Medical Association adopted **Guidelines for the Treatment of Depression**[12] which mention psychotherapy, psychoeducation, and other psychosocial approaches, as well as biological approaches to treatment, in addition to pharmacological treatment of depression.

In Slovenia, compulsory health insurance covers the care and treatment of people with mental health issues (psychosis, bipolar disorder, and depression). Individuals do not pay for services, nor hospital or outpatient care.

The National Institute of Public Health (NIJZ)[13] monitors, collects, and analyzes data and activities in the field of mental health, but the main flaw in the mental health system's control and monitoring is the indicator of quality and outcome of care for the user.

Slovenia has developed many initiatives and participated in international projects addressing stigma, discrimination, and the protection of mental health (depression, stress, alcohol) of specific groups—children and adolescents, adults, and the elderly, etc.

In Slovenia, there are a number of non-governmental organisations (NGOs) that focus on mental health prevention and rehabilitation (education, accommodation, and employment) for people with mental issues, as well as support for their caregivers.

Stigma exists in Slovenia, and it should be addressed at various levels with the cooperation of various ministries, such as empowering patient advocates, introducing social and emotional learning programs in schools, and implementing effective prevention and support programs for families, to name a few examples.

People suffering from depression can seek help in a variety of counseling centres throughout Slovenia, or they can call the confidential phone line at any time (24 hours a day, 7 days a week) and speak with someone who can assist them. There are also available websites, such as www.nebojse.si, www.tosemjaz.net, www.zivziv.si, and others.

About this scorecard

This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Slovenia. It is our hope that this document may galvanise policymakers to work in close partnership with all stakeholders to reverse the course of depression in Slovenia, taking a comprehensive and preventive approach to address depression in all its complexity.

It focuses on four key areas, identified as priorities for improvement:

1

Joined-up and comprehensive depression services

Integrated care – that is, a patient-centred system that supports the person with depression throughout their lifetime and with continuity across the health system – is essential to delivering adequate support and treatment. Integrating mental health services into wider health and social care services is convenient and can increase treatment rates, improve comprehensiveness of care and reduce overall costs.[a]

2

Data to drive improvements in depression care

Collecting and analysing robust and up-to-date data on depression is essential for ensuring the right services are available for everyone who needs them. Monitoring patient outcomes helps to identify and inform good practice, and may give hope to service users that their mental health can improve.[a] Data on services can support clinicians, policymakers and people with depression to better understand what treatment options are available and accessible. More transparent data will also facilitate shared learning across all domains of depression care. New digital tools may have the potential to facilitate documentation for transparency and research purposes while retaining the anonymity of the user.[a]

3

Engaging and empowering people with depression

It is essential that people with depression – along with their families, friends and carers – are actively empowered to participate in depression care plans at all stages. Empowerment involves a person gaining information and control over their own life as well as their capacity to act on what they find important, which in turn will allow them to more optimally manage their depression.[b] Peer support, whereby a person who has previously experienced depression offers empathy and hope to others in the same position, can assist both people with depression and their peer supporter in their recovery.[c] Social systems, patient advocacy groups and other civil society organisations with access to underserved communities are critical in ensuring that mental health services reach everyone, including those who have 'slipped through the net.'[a]

4

Harnessing technology to improve access to care

Digital platforms such as those which facilitate remote therapy sessions and online prescription requests, as well as other depression-focused software, smartphone applications and virtual platforms, can allow greater choices of treatment for people with depression while supporting them to take more control of self-managing their condition. While virtual sessions cannot replace in-person therapy, they may be a flexible option to support people with depression between regularly scheduled visits. Health and social services may also use digital tools to facilitate data collection and monitor care.[d, e] In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[f]

Summary scorecard for Slovenia

Joined-up and comprehensive depression services

Is depression included in either the national health plan or a specific plan for mental health?

Is there a government lead on mental health, with cross-ministerial responsibility to support a 'mental health in all plans' approach?

Is collaboration between primary care and mental health services supported and incentivised/encouraged/facilitated?

Are there guidelines on depression care developed jointly by primary care and psychiatry?

Is a range of therapeutic options reimbursed and available to people with depression, such as psychotherapy, counselling and cognitive behavioural therapy?

Are depression services available and tailored for at-risk groups?

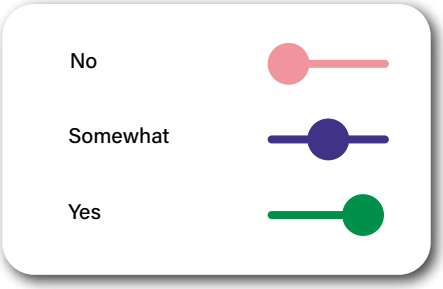
- Young people 
- Older people 
- People in the workplace 
- Homeless people 

Data to drive improvements in depression care

Are data on people with depression systematically collected by the health system?

Are data on mental health services being used for planning?

Are patient-reported outcomes being measured systematically?



Engaging and empowering people with depression

Do guidelines or care pathways for depression recognise the importance of patient empowerment?

Were patient and carer representatives involved in the most recent national plan or strategy covering depression?

Is peer support recommended in depression care guidelines?

Do guidelines on depression recognise the role of families and carers in making decisions on the planning and delivery of care?

Do carers have access to financial aid to help them support their loved ones with depression?

Are peer support roles reimbursed?

Are there national associations advocating for the rights of:

- people living with depression?
- carers of people living with depression?

Harnessing technology to improve access to care

Can patients access depression support remotely (via telephone or the internet) in addition to services delivered face-to-face?

Do professional societies or guidelines recommend the use of remote services alongside face-to-face services?

Is remote support for depression reimbursed?

Are people with depression able to use telephone or online platforms that allow them to renew their prescriptions from home?

Joined up and comprehensive depression services

Since 2005, initiatives in Slovenia have been underway to identify depression in a timely manner and to include depression treatment at the primary level.[14]

Systematic depression screening[15,16] is now included in the program of Reference clinics[17,18] which have over 880 stations throughout Slovenia. If depression is suspected, the individual is referred to a general practitioner (family medicine specialist). The general practitioner diagnoses depression and initiates treatment with antidepressants. Any licensed physician, both at the primary and secondary levels, can prescribe antidepressant medication. As a result, there is no bottleneck in the introduction of treatment. Psychoeducational workshops are also available at the primary level to assist with coping with depression.[19,20] These workshops are included in the Centres for Health Promotion (Center za krepitev zdravja - CKZ).[21]

Slovenia has psychiatric outpatients clinics within the framework of public health and the newly established Mental health centres (Center za duševno zdravje - CDZ)[22] at the primary level. Access to a psychiatrist is possible without a referral (for consultation and basic treatment). If treatment at the primary level is unsuccessful or too complicated, the patient is referred to the secondary or tertiary level.

Slovenia is in the process of renewing its mental health system and is planning new services in this area.

Slovenia does not have a separate national program for the treatment of depression, but it is included in the **National Mental Health Program**[4], along with other mental disorders.

In 2008, the **Mental Health Act**[10] was passed, and in 2018, the **Resolution on the National Mental Health Program 2018-2028**[5] **(Resolucija nacionalnega programa za duševno zdravje - RNPDZ)** was passed, which marked a significant shift. The **National Mental Health Program 2018–2028 (MIRA)**[4] is Slovenia's first strategic document that comprehensively addresses the field of mental health.

The Resolution establishes management structures for professional leadership, interdisciplinary and interinstitutional coordination, monitoring, and evaluation of the Resolution's implementation. The coordination of the implementation of the MIRA Programme is led by the NIJZ. The National **Council of the Government of the Republic of Slovenia for Mental Health**[23] which is the government's consultative body in the supervision and management of the Resolution, was established in the middle of 2021. It brings together representatives of ministries, national professional bodies of the medical profession, social welfare, and education, providers, professional associations, and non-governmental organisations in the field of mental health with the status of a humanitarian organisation.

The program integrates existing structures and adds much-needed new ones to create an integrated, interdisciplinary, and cross-sectoral promotion, prevention, treatment, and rehabilitation organisation. It is based on the participation, collaboration, and cooperation of all services and stakeholders in the mental health care of individuals and groups in the local community at all levels of treatment.

The national program's **three main challenges** are: reducing mental health problems and burdens, as well as burdens due to poor mental health, increasing literacy and awareness in the field of mental health and destigmatization, and better organising mental health services.

Priorities include: providing a community-based approach to mental health, promoting mental health, preventing and destigmatizing mental disorders, establishing a network of mental health services for various age groups, alcohol and mental health, suicide prevention, education, research, monitoring, and evaluation.

The National Mental Health Program aims to move Slovenia's mental health care population in the direction of mental health strengthening, preventing the development of mental health problems in all environments, and bringing accessible and connected mental health services for people with mental disorders to the primary level and the community.

To that end, it intends to establish 28 centres for the **mental health of children and adolescents**, as well as 25 centres for the **mental health of adults**. Slovenia currently has 16 children's and adolescent mental health centres (CDZM) and 14 adult mental health centres (CDZ). CDZ treatment (for children and adolescents, as well as adults) is interdisciplinary.

The main obstacle to implementing the planned network is the severe scarcity of experts in this field (pedopsychiatrists, clinical psychologists, and psychiatrists). Slovenia has fewer psychiatrists, pedopsychiatrists, and clinical psychologists than the EU average.

Three ministries are responsible for mental health management (Ministry of Health; Ministry of Labour, Family, Social Affairs, and Equal Opportunities; and the Ministry of Education, Science, and Sport).

The mismatch between them prevents the National program from being implemented successfully. The total cost of mental health is also difficult to assess because costs are shared among various ministries, which is why the Resolution calls for a shift of resources (financial and human) to community care. The majority of funds are now allocated to psychiatric hospitals and long-term care facilities. Regrettably, these funds are often insufficient. However, it is necessary to control and coordinate the distribution of funds.

In 2021, the Slovenian Medical Association's **Association of Psychiatrists** adopted **Guidelines for the Treatment of Depression**, which include psychotherapy, psychoeducation, and other psychosocial approaches, as well as biological approaches to treatment, in addition to pharmacological treatment of depression. The guidelines also address the treatment of depressive disorders in specific populations, such as children, adolescents, and the elderly, as well as the treatment of postpartum depressive disorders.

In Slovenia, compulsory health insurance covers the care and treatment of people with mental health issues (psychosis, bipolar disorder, and depression). Individuals do not pay for services, either hospital or outpatient. Treatment is available to all, including those who do not have basic health insurance, in the event of a psychiatric emergency (citizens without regulated health insurance, the homeless, refugees, and foreigners). Other services are also included, such as social services and the Ministry of Health, who coordinate all necessary follow-up care.

In Slovenia, according to the recommendations of the Guidelines for the Treatment of Depression, there are various options for the treatment of depression, in addition to pharmacological treatment also psychological support, psychotherapy, and cognitive behavioural therapy (vedenjska kognitivna terapija - VKT), but unfortunately to a limited extent in public services. When a patient is hospitalised, psychological support, VKT, and psychotherapy are provided in a hospital setting as well as in mental health centres. Patients are left to the market of service providers in outpatient treatment. Psychotherapy is a field that is not systematically regulated, understaffed, and self-funded.

In Slovenia, a Psychosomatic outpatient clinic is being established that will include the treatment of pain syndromes, pain conditions, and depression. A psychiatrist will be able to refer patients to this clinic.

Case Study 1 - What is OMRA?

The acronym OMRA stands for Greater Mental Health Literacy to Cope with Mood Disorders. The innovative OMRA program's primary goal is to educate the public about mental health and how to deal with and manage mood disorders. The program is aimed at everyone in general, but especially at more vulnerable groups, such as children, adolescents, the elderly, people with mental health problems and their relatives, the Roma, early school leavers, and people from various rural backgrounds, who may be even less informed and motivated to act in the event of mental distress. The expanded OMRA program was upgraded with content in the field of personality disorders in 2020. Initially, the program was delivered through live workshops across Slovenia; however, during COVID-19, they prepared an online version.[24]

Data to drive improvements in depression care

The absence of data on depression, such as demographic trends in prevalence and incidence, use and effectiveness of services and treatment, patient-reported indicators, and long-term outcomes, represents a missed opportunity to better understand depression trends in Slovenia.[25]

Regular health and other statistics, as well as regular and periodic surveys, are used to record indicators in the field of mental health, but they do not provide all of the required data. In order to meet the needs of mental health monitoring, an internationally comparable data set that allows for comparable mental health monitoring must be defined.

All of the experts interviewed agreed that there is no well-organised data on mental health in Slovenia.

The National Institute of Public Health (Nacionalni inštitut za javno zdravje - NIJZ) is the collection manager in charge of monitoring all hospital treatments.[13] It costs money to acquire this data. This data, however, is often useless. The data available is fragmented (at various levels of health care), unrelated (the same person may appear in multiple databases depending on visits to different services), and less accessible (data must be requested separately).

Every year, the NIJZ publishes the Health Statistical Yearbook of Slovenia, a comprehensive publication that presents data and information on various aspects of the population's health status, the health care system, health financing, and the role of the environment in influencing population health in a broad sense.

Each hospital has its own set of data that it needs to run and plan its operations. There is no established link between these hospital health statistics.

The Health Insurance Institute of Slovenia (Zavod za zdravstveno varstvo Slovenije - ZZZS) collects data on medicine consumption.

According to some, the data could be incorporated into the **Central Register of Patient Data (CRPP),** which allows for the electronic exchange of health data between healthcare providers so that all of them would have access to it. Due to the sensitive nature of mental health issues, it is especially important to ensure privacy protection and controlled access.

Data collection on suicidal behavior has a long history in Slovenia, with the most progress being made in this area with the establishment of the Register of suicide[26,27] and suicide Attempts in 1970.

The Resolution specifies how outpatient care will be monitored. On a primary level, it is supposed to connect family medicine, CDZ, and psychiatrists.

The responsible expert group of the RNPDZ manager has been determined within the Action Plan of the National Mental Health Program MIRA (2021-2023)[28] to monitor the success of the implementation of individual goals and measures from the priority areas of the Resolution. The group's top priority is to develop a set of internationally comparable indicators for monitoring men and women's mental health across all age groups and in vulnerable populations, as well as the establishment and implementation of appropriate ongoing monitoring and research of men's and women's mental health, as well as the efficacy of interventions in all age groups and vulnerable groups.

Case Study 2 – This is me

The National Institute of Public Health's program for the promotion of mental health among young people, which has been running since 2001 with the support of the Ministry of Health, assists young people in developing a positive self-image and life skills. The This Is Me program is founded on two modes of communication. The first is based on online communication with young individuals. The online counseling service at www.tosemjaz.net provides Slovenian youth with public, free, anonymous, and easy access to professional advice.

The second part of the program focuses on teacher education and the delivery of preventive workshops in the school setting based on the concept of the „10 Steps to Better Self-Esteem." Two practical manuals are useful tools for working with young people in a preventative capacity. The first handbook is for professionals who work with young people (teachers, youth workers, social pedagogues, social workers, etc.), and the second is for young people themselves. 10 Steps to a Better Self-Image: 10 Preventive Workshops for Working with Youth.[29]

Engaging and empowering people with depression

Mental health is a concern not only for the health sector but for many other sectors and policies as well. Mental health is a national asset that requires the combined efforts of the entire community, including users, their associations, and relatives' groups.

In Slovenia, there are a number of non-governmental organizations (NGOs) and associations (Ozara, Šent, Altra, DAM) that focus on mental health prevention and rehabilitation (education, housing, and employment) for people with mental disorders, as well as support for their caregivers.

Association representatives play a part in the planning and implementation of mental health care. They are invited to various working groups at the Ministries of Health and Social Affairs, Labour, Family, and Equal Opportunities. A relative representative is also present in the Mental Health Council[30] which was established in 2021.

Patients and caregivers do not have their own representatives at the Health Insurance Institute of Slovenia (ZZZS), which is the central institution for ensuring the availability or financing of individual methods of treatment and rehabilitation, and thus do not have the opportunity to participate in introducing new treatment approaches.

All of their suggestions were taken into consideration when the National Mental Health Program was adopted. In management structures, interdisciplinary working groups, and the professional program council for the National Program's implementation, representatives from associations, relatives, and patients are involved. However, there is still much that can be done to improve cooperation in practice. The most important aspect in this area is to empower patient organisations so that they can function and look like organisations from other disease areas that are already more involved in policymaking.

Stigma exists in Slovenia, and it should be addressed at various levels with the cooperation of various ministries, such as empowering patient advocates, introducing social and emotional learning programs in schools, and implementing effective prevention and support programs for families, to name a few examples. Many famous Slovenes have joined the public awareness group in recent years, speaking openly about depression.

Only one organisation in Slovenia focuses solely on depression and anxiety disorders: the DAM association, which provides peer-to-peer support and self-help groups to members and others in need. In Slovenia, such assistance is not funded. Experts agree that peer support is beneficial in the treatment of depression, and that more should be done in this area.

Financial support is not provided to relatives or caregivers of people suffering from depression. Societies provide them with emotional support as well as educational opportunities.

People suffering from depression can seek help in mental distress at various counseling centres throughout Slovenia, or they can call the confidential phone line at any time (24 hours a day, seven days a week) and similar Slovene websites are www.nebojse.si, www.tosemjaz.net, www.zivziv.si, www.telefon-samarijan.si, and Posvet.org.

Harnessing technology to improve access to care

The COVID-19 pandemic has paved the way for the use of digital technology. Prior to that, the profession was hesitant to adopt these solutions because psychiatry is based on the personal approach.

Treatment and re-examination services for depression are now available online. The service is governed by ZZZS rules and is compensated as such. The doctor's choice of remote method is based on the individual patient. These are mostly phone conversations, a few less video reviews (Zoom, Skype). This brings up the issue of security. However, there are currently no national guidelines or financial support in place to implement additional security options.

Digital devices are extremely important because they allow for faster treatment. Most doctors use the Mediately application for doctors, which is a medicine register with various tools for disease monitoring. These tools can be used by both the patient and the doctor, and they can also be printed. For the time being, there are no such options for people suffering from depression. In an ideal world, such information would be entered into a patient's digital file in the hospital's computer system.

Before the pandemic, there were no digital tools available for people suffering from depression. OMRA[31], a program that educates patients, relatives, and professionals in the field of depression and anxiety disorders, has been transformed into „online" workshops that took place during the epidemic. Previously, the workshop could only be held in person (example 1).

The Ozara Association created the **„Overcome Depression“** application,[32,33] which is freely available to anyone suffering from depression (example 3). However, due to a lack of financial resources, the promotion was insufficient to adequately inform the public. The Association is considering upgrading the application.

The digital system solution for depression and other mental disorders could be found in the **central register of patient data (CRPP, eZdravje)**[34] which is a comprehensive system for collecting and exchanging health data on patients who live in Slovenia permanently or temporarily, as well as other patients who receive medical care in Slovenia.

A Summary of Patient Information (Summary) and **medical records** are both included in the **CRPP**. The CRPP‘s aim is to allow the electronic exchange of health data between healthcare providers so that all of them have access to their patients‘ data. The patient becomes acquainted with the data collected about him through the zVEM portal.[35] Registration on the **zVEM** portal necessitates the use of a digital certificate.

The **e-Recept**[36] tool also allows for remote prescribing and renewal of prescriptions for depression treatment, so that a patient can order an extension of his prescription from home with his doctor and pick it up at a nearby pharmacy.

Case study 3 – Overcome depression – application

Users of the Overcome Depression application will be able to learn more about depression, its symptoms, risk factors, and treatment and management options. They will be able to conduct a self-assessment of their mental state or more easily identify signs that may indicate depressive or anxious behavior and seek professional help faster with the help of a questionnaire which was created based on a diagnostic questionnaire known as the Health Questionnaire or PHQ-9. The application also contains a number of specific guidelines that its users can use to help themselves deal with depressive symptoms. The application also includes a number of specific guidelines that users can use to assist themselves in dealing with depressive symptoms. This chapter was co-written by people who live with or have suffered from depression on a daily basis.

The Ozara Slovenija association spearheaded the development of the Overcome Depression application.[32,33]

Conclusion and recommendations

Individuals in Slovenia have unlimited access to psychiatrists 24 hours a day, seven days a week, without the need for a referral.

Depression is covered by compulsory health insurance, and most antidepressants can be prescribed by a general practitioner or any doctor licensed at the primary and secondary levels.

For several years, depression screening has been implemented in reference clinics.[37,38] Reference clinics[18] are located in all health centres and are part of public health.

Slovenia is updating its mental health system and developing new services in this area.

The National Mental Health Program[4] aims to shift the population of Slovenia's mental health care in the direction of strengthening mental health, preventing mental health problems from developing in all environments, and bringing accessible and connected services for people with mental health problems to the primary level and the community.

Slovenia also focuses on two public health problems – harmful alcohol use[39] and suicide[9] which should be specifically addressed – alcohol as self-medication of depression[40] and suicide as a result of depression, in addition to transient mental distress plaguing the adult population, as well as stress, anxiety, and depressive disorders in adults and dementia in the elderly.

Priority recommendations

Joined-up and comprehensive depression services:

- The Mira program is establishing a network of mental health centres staffed by interdisciplinary teams of experts. The guiding principle of mental health centres is to ensure that all groups of people in a given area have equal access to services and programs. Although access to psychiatric care in Slovenia is good, it varies by region. Equal access is not currently guaranteed for all regions, and some areas are underfunded, which must be addressed in the future.
- There is a severe shortage of mental health professionals in Slovenia (psychiatrists, clinical psychologists, psychotherapists, and pedopsychiatrists). It is imperative that sectoral policies be linked and coordinated (education, health, social services). As a result of the foregoing, the field of resolving mental health issues in various vulnerable groups, such as children, adolescents, and the elderly, remains neglected, particularly at the primary level. Because this is an interdisciplinary approach (nurses, social workers), coherence between ministries and coordinated implementation are critical. It is critical to maintain the fluidity of these systems in order to provide the best possible assistance to the individual.
- Work at the secondary and tertiary levels of depression management should be coordinated with mental health centres.
- The Guidelines for the Treatment of Depression recognise psychotherapy as an appropriate treatment next to pharmacological treatment for depression. Since there is a shortage of psychotherapists in Slovenia, it is necessary to regulate this field on a systemic level (financially and in terms of human resources) and to pass a psychotherapy law.

Data to drive improvements in depression care:

- Creating a comprehensive and integrated Mental health information system (Informacijski sistem duševnega zdravja - ISDZ) can help with monitoring service implementation and quality from both the population and individual perspectives.
- The Resolution's Action Plan (RNPDZ) envisions the establishment and implementation of appropriate continuous monitoring and research on men's and women's mental health, as well as the efficacy of interventions in all age groups and vulnerable groups. It makes sense to connect all those who deal with the treatment of people with depression or mental health issues at the primary level – pediatricians, family physicians, outpatient psychiatrists, and CDZ.
- Because of concerns about data security and confidentiality, most psychiatric institutions are hesitant to submit data to the CRPP. We could have allocated space within this interoperable backbone, in collaboration with the NIJZ, where data would be entered on a regular basis if there was a will and financial support.

Engaging and empowering people with depression:

- The professionaly recognised well-being of self-help and peer support groups in Slovenia, both in adults with depression and in children and adolescents and their caregivers, needs to be strengthened (case study 2).
- Patients and caregivers do not have their own representatives at the Health Insurance Institute (ZZZS), which is the central institution in charge of ensuring the availability or financing of individual treatment and treatment methods. As a result, they are unable to participate in the introduction of new treatment approaches. Involvement of patients and caregivers associations in policymaking is still insufficient. The most crucial aspect in this area is the empowerment of patient associations.
- Adult mental health associations have been present in Slovenia for a long time. However, there are no associations dedicated to children's and adolescents' mental health.

Harnessing technology to improve access to care:

- A variety of digital tools should be used to raise public awareness of depression, educate the general public about it, and help depressed people cope with it.
- During the COVID-19 pandemic, new approaches to dealing with people suffering from depression and other mental disorders (telephone, video chat) emerged, but the issue of security and confidentiality arises. Several systems that provide such treatment are already available due to the development of these services during the aforementioned time period. Financial investments in such digital technology should be considered in accordance with time and needs.

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