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Child and adolescent psychiatry in Slovenia in comparison with other European countries

Slovenia is a small European country facing rapid changes that also impact child and adolescent psychiatry (CAP) in the country. Looking back, Slovenia had been a part of the Austro-Hungarian Empire for almost 600 years. After its collapse at the end of WWI, the country gained its independence as part of the Kingdom of Serbs, Croats, and Slovenes. After WWII, Slovenia became a constituent republic of Yugoslavia and remained part of Yugoslavia until 1991 when it gained its independence. In 2004, Slovenia joined the European Union.

Political, social, and economic shifts that Slovenia was facing after the breakup of Yugoslavia were dramatic. Loss of social security and growing unemployment, which was at the time above 15%, changed family dynamics in a very dysfunctional way. The situation improved only 10 years after the breakup of Yugoslavia when Slovenia's economy finally managed to reach other European counties. However, it worsened again with the world economic crisis in 2008. Today, Slovenia's economy is growing again. In terms of demographics, Slovenia has 2.1 million inhabitants, 15% of which are aged 0–14 [1]. Ljubljana is the country's capital city.

History of child and adolescent psychiatry in Slovenia

Before WWII, Slovenian psychiatry had relied heavily on German tradition. Following WWII, the Anglo-Saxon tradition was gradually introduced. Until the 1950s, the professional care of mentally disturbed children and adolescents was carried out rather unsystematically, dispersed among different specialities.

In 1954, the first out-patient clinic for child psychiatry was established at the Psychiatric Dispensary of the Ljubljana Psychiatric Hospital. The credit for this goes primarily to Prof. Bazilija Pregelj who was the beginner of CAP in Slovenia. She specialised in neuropsychiatry and received training in CAP in London. She is the author of the first Slovenian book addressing CAP topics, published in 1969, and the co-author of the first Slovenian psychiatric textbook published in 1978.

After 1960, more out-patient clinics were set up in Slovenia. In 1970, a Department for Child Psychiatry was established at the Ljubljana Paediatric Hospital and a Unit for Child and Adolescent Psychiatry and Neurology emerged at the Maribor Paediatric Hospital. In 1975, a Department for Adolescents was established at the Mental Health Centre of the Ljubljana Psychiatric Hospital.

Today's child and adolescent mental health services architecture

Slovenian CAP health care system is organised on three levels. Primary care is provided mostly by a network of community-based health care centres, owned, and managed by municipalities. There are altogether eighth child and adolescent mental health services (CAMHS) in Slovenia. CAMHS are multidisciplinary services offering medical, psychiatric, and psychosocial intervention for children and adolescents with mental health problems and disorders. Unfortunately, there are still some regions in Slovenia without CAMHS. Slovenia has four guidance out-patient clinics, where mainly allied CAP professionals work. They are mostly part of the school system, and only one out of four has also CAP specialists in the team. As a part of the school system, counselling services with social workers and/or special pedagogues are provided at

every primary and secondary school throughout the country. They are often the first ones to identify children in need of help and can refer them to the right professional.

For hospital care, altogether, 44 beds are available in the three Slovenian hospitals. Apart from the general CAP in-patient treatment, these hospitals also provide some specialised hospital programmes, i.e., for schizophrenia, eating, and emerging personality disorders. Highly specialised ambulatory care is organised for disorders such as ASD, psychotic, transgender, eating, and emerging personality disorders. However, Slovenia is lacking rehabilitation programmes. There is only one rehabilitation programme for emotional and eating disorders at the Rakitna Youth Health Resort [2]. Currently, there are altogether 30 CAP specialists working in Slovenia.

Slovenia's mental care in comparison with other European countries

Signorini et al. [3] published data on mental health care in 28 European countries from 2013. According to this data, Slovenia ranks in the middle, regarding the number of CAP specialists and in the second half regarding the CAMHS per 100,000 young persons [3, 4], Table 1. These numbers have probably changed for many countries in the last 5 years. For the neighbouring country Croatia, for instance, for the worse, since their CAP specialists are leaving the country and for Slovenia for the better. Approximately 3–5 trainees finish CAP specialisation every year in Slovenia and fortunately the brain drain is not so frequent as in counties in the region. Slovenia ranks also in the middle of European countries regarding the number of CAP beds [3], Table 1. It is expected that a new ward with 10 new beds under special supervision will be opened. This will be an important step forward, since currently, children and adolescents who need treatment under special supervision are hospitalised at closed adult psychiatry wards throughout Slovenia.

Today's psychopathology

Slovenian National Institute of Public Health has just published e-publication on mental health of children and adolescents in Slovenia, 2008–2015 [5]. According to the data published, the out-patient appointments increased for 71% (57% in case of boys and 43% in case of girls) in the surveyed period. This enormous rise can be explained by better service and diagnostics, more awareness, and knowledge of CAP psychopathology, but also with increased prevalence of certain mental diseases, as will be described later.

Table 1 Number of CAP specialists, CAMHS, and in-patient beds according to Signorini et al. [3]

Country	*N* of CAP specialists per 100,000 YP in 2013	*N* of CAMHS per 100,000 in 2013	*N* of in-patient beds per 100,000 in 2013
Finland	87.0	12.9	32.3
Sweden	23.0	1.0	NA
Italy	20.0	2.1	3.2
Germany	8.0	4.1	64.0
Croatia	6.3	1.3	8.8
Slovenia	6.0 (7.8 in 2018)	2.1	13.1
Austria	6.0	0.7	21.0
UK	4.5	7.0	9.4
Hungary	3.4	3.1	7.7
Romania	3.1	NA	17.9
Bulgaria	1.9	0.5	4.0

CAP child and adolescent psychiatry, *CAMHS* child and adolescent mental health services, *NA* not applicable

The top three most frequent diagnoses for boys in out-patient treatment, diagnosed according to the 10th International classification of diseases (ICD-10), are behavioural and emotional disorders (F90–98), disorders of psychological development (F80–89), and neurotic, stress-related, and somatoform disorders (F40–48). Behavioural and emotional disorders are also the most frequent disorders for girls in out-patient treatment, while the situation has been changing for the second three most frequent diagnoses for girls. Until 2012, eating disorders had been the second most frequent diagnosis, but after 2012 neurotic, stress related and somatoform disorders became the second most frequent and disorders of psychological development the third most frequent diagnosis [5].

The top three most frequent discharge diagnoses for the boys were the same throughout the surveyed 7 years: behavioural and emotional disorders, mental and behavioural disorders due to psychoactive substance use (F10–19), and neurotic, stress-related, and somatoform disorders. The top three most frequent discharge diagnoses for the girls changed a lot during this time. Neurotic, stress-related and somatoform disorders were the most frequent discharge diagnoses in 2010, but in 2015, they fell to the third place and were replaced by disorders of psychological development, including autism [5].

The diagnosis of behavioural and emotional disorders is not only the most frequent diagnosis in both sexes in out- and in-patient treatment, but it is also the most misused diagnosis in Slovenia, covering very different mental states, problems, crises, and disorders. It is frequently used for emerging personality disorders, adolescent crisis, and for various brief anxious/depressive/psychotic symptoms not lasting long enough to fulfil any other diagnostic criteria.

The situation is no different than in other European countries. Similarly, in Croatia, Denmark, Finland, Poland, and Portugal, behavioural and emotional disorder according to ICD-10 is the most frequent diagnosis [3]. In Czech, Republic disorders of psychological development including autism are the most frequent diagnoses. In those European countries that are using the 5th diagnostic and statistical manual of mental disorders (DSM-5), neurodevelopmental disorders are the most frequently diagnosed disorders (Belgium, Ireland, Netherlands, and Spain), while mood disorders are the most frequent diagnosis in Romania [3].

It is noteworthy that anxiety, hyperkinetic, and eating disorders are increasing, while suicide is decreasing in Slovenia. According to the report of Slovenian National Institute of Public Health, the most concerning data are particularly those related to anxiety [5]. From 2008 until 2015, there was a 4.6-fold increase of anxiety in girls and 2.4-fold in boys in out-patient treatment. The increase in anxiety disorders is reflected also in the number of prescriptions and doses on prescriptions for antidepressants. There is a substantial 73% increase in number of prescriptions for antidepressants and in average doses prescribed by one prescription. The girls received on average two times more prescriptions for antidepressants as boys (absolute and in daily doses) [5]. Since the diagnosis of depression was stable throughout the observation period, the huge increase in the number and dosages for antidepressants is probably related to the anxiety disorders.

As expected, hyperkinetic disorder is the most frequently diagnosed in the age group of 6–14 years in both boys and girls. However, only in boys, the defined daily dose (DDD) and the number of prescribed prescriptions for psychostimulants doubled in those 7 years. Of particular concern is that 15–19-year-old girls reported frequently about hyperactivity and attention problems, but were rarely diagnosed as hyperkinetic disorder and were even more rarely properly treated [5]. Hospital treatments for all eating disorders as well as for anorexia nervosa show an increasing trend. The same applies to the out-patient visits for unspecified eating disorders. Anorexia nervosa is the most frequent eating disorder in boys. On the other hand, there is a decreasing trend regarding suicide, which could be probably attributed to the national programme for suicide prevention. In absolute numbers, this means altogether 13 suicides in 2008 and 6 suicides in 2015 in the age group of 12–19 years. However, suicide is still one of the top three causes of death in the respective age group and is three times more frequent in boys than in girls [5].

Availability of treatment

The situation regarding psychotherapy treatment availability in Slovenia is an area of particular concern. Slovenia is lacking psychotherapists in general and especially those specialised in children and adolescent treatments. Psychotherapists are mostly educated in cognitive-behavioural, systemic, and psychodynamic therapy. A group of 17 young CAP trainees and specialists as well as psychologists has been just recently educated in adolescent identity treatment (AIT). The situation could be compared to the availability of treatment methods in other European countries, where family psycho-education, learning assistance, speech/language training, and parental guidance are the most frequently used help for patients and their families. Cognitive-behavioural therapy is available only forth in a row [3].

Pharmacotherapy is well advanced in Slovenia. Practically, any CAP medicine is available and reimbursed by insurance. The first line of drugs for depression is SSRI, atypical antipsychotics for psychosis, psychostimulants, and atomoxetine for hyperkinetic disorders. Among psychostimulants, immediate-release methylphenidate (IR-MPH) and methylphenidate–osmotic release oral delivery system (OROS-MPH) are available. However, amphetamines, other forms of methylphenidate and guanfacine, have not been registered in Slovenia to date.

Clinical perspective

Increasing numbers of adolescents who are suffering from a complex psychological problem related to identity issues are referred to hospital treatment. Nearly, ¾ of all inpatients in the last years in Slovenia have had emerging personality disorders (most frequently borderline), and have been many times readmitted. The majority of them have been girls. These patients are hard to deal with in the out-patient treatment frame because of suicidal ideations, repeated suicide treats, and attempts. They are sent to hospitals repetitively as urgent cases and the vicious circle of out-patient therapy—hospitalisation—out-patient therapy is repeating. To address this circle adequately, some therapists have been just trained in AIT. Unfortunately, there is long waiting time for the first appointment for CAP specialists (4–6 months). Urgent referrals are often misused to skip this. It should be highlighted that Slovenia is facing psychiatrisation of society. It looks as if there is a common agreement that every crisis, problem, minor/normal stress, upbringing problem ought to be seen, advised, and solved by a CAP specialist. Other professions (pedagogues, social workers, and psychologists) underestimate their knowledge and possible solutions they could offer. Schools, teachers, and parents are without authority, which brings huge upbringing problems resulting in many mental problems and disorders, among them also in personality disorders.

Strengths of mental health care in Slovenia

CAP and allied professions specialists have high-quality work standards and excellent knowledge in Slovenia. Since funds for education are limited, workshops and seminars are regularly organised locally. They cover and bring new treatment approaches (such as incredible years, infant monitoring, and AIT). The advantage of a small county could be seen in a good patient follow-up and referral to other specialists, since practically every patient could be personally referred to other specialists. Counselling services in every primary and secondary school are a good foundation of community-based help. It is crucial that social workers and special pedagogues, who work in these counselling services, have good knowledge of mental health problems. There is an initiative to introduce more mental health topics to the curriculum in undergraduate level at respective faculties and to introduce the WHO Mental health gap action programme (mhGAP) to allied professions.

Slovenian-training requirements for the CAP specialty have been just recently changed following the European union of medical specialists (UEMS-CAP) recommendations. Specialty training in CAP lasts 3 years and complementary training (general psychiatry and paediatrics) lasts 2 years. Theoretical knowledge in psychotherapy is included in the training, but medical chamber of Slovenia cannot cover the costs for supervision and self-analysis, so these must be paid by trainees. Students at both medical faculties in Slovenia get good theoretical and practical insight in CAP during their studies and there is a growing interest in CAP specialisation. There are 26 CAP trainees in Slovenia at the moment. Many students are engaged in CAP research already at faculty and there are a growing number of CAP trainees who are committed in the research.

CAP problems in Slovenia

Slovenia has centralised mental help with one-third of CAP specialists working in the capital city of Ljubljana. Unfortunately, there are still regions without any CAP specialists. The lack is also huge when it comes to allied professions. Slovenia is lacking highly specialised out- and in-patient programmes. The waiting time for the first specialist appointment is much too long, 4–6 months. Although the plans for 24/7 urgent CAP help are prepared, help from general/adult psychiatry in urgent situations is still needed due to the lack of CAP specialists. There is a growing pharmacotherapy trend, while psychotherapy is undernourished. Waiting time for psychotherapy is longer than for the first CAP specialist appointment and is available sooner when self-paid. Not many therapists are educated in specialised approaches, as Dialectical Behaviour Therapy (DBT) or mentalization-based treatment (MBT).

National programme for mental health, 2018–2028

Following more than 10 years of preparations and many versions, national programme for mental health was accepted at the last government meeting in March 2018 [6]. It defines six priority fields in mental health for the period 2018–2028: community-based mental help; promotion, prevention, and destigmatisation; network of services for mental help; alcohol and mental health; suicide prevention and education; and research, monitoring, and evaluation. Crucial for CAP are the following areas: early diagnostic of somatic and mental problems in children, accessibility to multidisciplinary teams, new highly specialised out- and in-patient programmes, special help for children with aggressive behaviour/conduct disorder and providing CAP urgent help in two centres in 2018 and extending it to each region by the end of the programme in 2028. The programme has a clear action plan and funds provided. According to the programme, altogether, 25 new CAMHS will be established throughout Slovenia. Existing CAMHS will be expanded by additional staff. A CAMH team will—according to plans—consist of: one CAP specialist, four clinical psychologists, one psychologist with special education (different psychotherapeutic schools), two special pedagogues/occupational therapists/social pedagogues, one social worker, medical nurses, and administration staff. One CAMHS should cover an area of 16,000 persons aged 0–19. Slovenia has just established a new government which will be responsible to bring the programme to life. Slovenian CAP and allied professionals strongly believe in it and will give their best to help the programme to be implemented.

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Compliance with ethical standards

Conflict of interest The authors declare that they have no competing interests.

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