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MARIJA BRECELJ AND ANDREJ MARUŠIČ

Psychiatry in Slovenia

A high suicide and cirrhosis rates country

Although considerable changes have taken place in Slovenia since it became independent in 1991, the psychiatric services face further challenges for their future. Among these, the two main priorities are a further development of the already proposed Patients Advocacy Act and Protection of Rights of Mental Patients Law, and a development of presently almost non-existent community psychiatric services (World Health Organization, Regional Office for Europe, 1999). The developing services should become needs-oriented as Slovenia is a country with extremely high suicide rate and has high rates of alcohol misuse and alcohol-related disorders, with both problems interacting significantly throughout the country.

History of Slovenia

With a population of nearly 2 million and an area of about 20 000/km^2, Slovenia is a heterogeneous European country that extends from the Mediterranean Sea to the Alps and the Panonian Plane (see Fig. 1). Independence of the Republic of Slovenia was declared in 1991 after the short war with the army of the Yugoslav Federation – 1100 years since breakdown of the last independent state of Slovene Slavs. More recently, Slovenia was a part of the Austrian–Hungarian Empire. In the years between the two world wars, Slovenia was separated into a western part, which was given to Italy, and an eastern part, which, together with the other South Slavic nations, came to constitute Yugoslavia. For 48 years (from 1943) the two parts of Slovenia formed the North Republic of the Yugoslav Federation. As well as the war of independence, Slovenia has undergone other significant political, economical and social changes in the last decade.



Fig. 1. Republic of Slovenia in Europe

Psychiatric services in Slovenia

The need for special care for the mentally ill was first mentioned in Slovenia in 1786 when a general hospital was built on the site of an abandoned monastery. Milestones in the development of psychiatry in Slovenia were reached in 1827 when the first special department for the mentally ill was set up in the general hospital, and in 1881 when the first psychiatric hospital was opened. Until the Second World War the psychiatric tradition and practice in Slovenia were German-based. Afterwards, the Anglo-Saxon psychodynamic view gradually entered Slovene psychiatry (Ziherl, 1997).

At present, Slovenia has six regional psychiatric hospitals, including the University Psychiatric Hospital, which is the only teaching hospital and also serves as a tertiary referral centre. The hospitals are unevenly distributed across the country, none of them are located in the south. All hospitals have general and old age psychiatry wards, as well as wards for the treatment of alcohol dependency. Beside these, the University Psychiatric Hospital also has wards for adolescent psychiatry, drug dependency and psychotherapy. The latter is psychodynamically oriented and, interestingly, has in-patients beds. A child psychiatry ward is provided by the University Children's Hospital for children aged below 14 years. The needs of north-east Slovenia are met by the general paediatric department of the Children's Hospital in Maribor. Facilities for people with learning disabilities are not yet connected to the psychiatric services. To date, consultative psychiatry has not

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developed into liaison psychiatry, with four out of the six regional psychiatric hospitals remaining separate from the general district hospitals.

The number of psychiatric beds has decreased in the past three decades. In 1997 there were 1583 hospital beds altogether, with a bed occupancy rate of 0.8 per 1000 inhabitants, the average length of stay was 48.5 days (Ministry of Health & Institute of Public Health of Republic of Slovenia, 1998). Additionally, in 1988 about 1800 people lived in homes for people with mental disorder (Vovk, 1993). The biggest among those are two specialised social institutions, each providing about 200 beds for patients with chronic psychiatric disorders and eight departments with psychiatric beds in local homes for older people. In the same period, a strong emphasis was placed on out-patient psychiatry, provided by the hospitals and regional health centres. All these institutions were included in the public health service, but recently, partly because of the enormous changes in the health insurance system, some psychiatrists have started to work as private practitioners. There are about 150 psychiatrists in Slovenia, each of them potentially covering a population of 13 000.

Community mental health care has not developed yet. There are a few organisations outside the psychiatric services that offer rehabilitation in the community by way of self-help groups and shelter homes. However, these initiatives are only an indicator of the public's intention to reduce the adverse health impact of mental health problems, but a clear plan for community psychiatric services in Slovenia has not been formulated yet.

Psychiatric disorders, suicide rate and rate of cirrhosis

The most prevalent diagnosis in the hospital is schizophrenia, followed by alcohol-related psychiatric disorders and affective disorders. If one compares the health indicators in *Health for all by the year 2000* (World Health Organization, Regional Office for Europe, 1999) for Slovenia with those of the European Union, two of the most striking differences are those for standardised death-rate for chronic liver diseases and cirrhosis and for suicide. As far as the former is concerned, Slovenia has more than 30 deaths per 100 000 per year due to liver disease, which is more than double the European rate (Ministry of Health & Institute of Public Health of Republic of Slovenia, 1998). Along the same lines, the alcohol consumption in Slovenia is one of the highest in Europe (Andersen, 1994). In relation to the latter, Slovenia has had a very high suicide rate, one of the highest in the world – more than 30 suicides per 100 000 inhabitants per year in the past decade. Interestingly, Marušič (1998) investigated regional differences in suicide rate in Slovenia and found the prevalence of alcohol-related psychiatric disorders to be the best predictor of regional suicide rates. In the past 10 years, 79 suicides occurred at the University Psychiatric Hospital, which had 605 beds and approximate bed occupancy of 90% (Šteblaj *et al*, 1999).

The Involuntary Commitment Law

The procedure of involuntary admission to psychiatric institutions is described in Section 7 of the Involuntary Commitment Law, which has been in place since 1986, during the Socialist Republic of Slovenia era. Grounds for detention of people with mental disorders include: putting his or her life, or life of others, in danger and causing great damage to himself, herself or others. The psychiatric institution should inform the local court about the detention within 48 hours and the court must visit and interview the patient during the 3 days after they have received the notice about detention (except when this is impossible owing to the health status or when this would damage the course of treatment). The court decides on the duration of the commitment, which cannot be longer than 1 year. A complaint can be made by the patient, but this must be made in the first 3 days of commitment. The complaint, however, does not stop the execution of the decree. The psychiatric institution can propose to the court to extend the commitment.

The law, however, does not differentiate whether the compulsory admission is urgent or planned, and whether the admission is for an assessment or for treatment, neither does it clarify which of the psychiatric treatments requires consent or a second opinion. It is also worth noting that electroconvulsive treatment has not been used at the University Psychiatric Hospital, Ljubljana, since 1991. Interestingly, it has not been used at all in Slovenia for the past 4 years.

Much more contemporary law can be expected soon because the Patients Advocacy Act and Protection of Rights of Mental Patients law has been proposed to the parliament and is, at the time of writing, being discussed by all the parties involved.

Training in psychiatry

A comprehensive overview of training in psychiatry in Slovenia has been given by Ziherl (1997). Initially, the Ministry of Health of Slovenia prescribed a national training programme and recognised training institutions and mentors. Most recently, the Medical Chamber of Slovenia has taken over these functions.

Psychiatric training takes place in all six hospitals, although it is compulsory to complete 1 year of this training at the University Psychiatric Hospital, Ljubljana. Overall, training lasts 3 years and is organised in a rotational system, designed to cover every aspect of psychiatry. There are two obligatory courses: one in psychopathology and one in psychotherapy. Both courses run for a year, with a total duration of about 400 hours. The course in psychopathology covers theoretical issues of psychopathology, treatment approaches, ethical and legal issues and research. The course in psychotherapy is predominantly psychodynamically oriented and includes didactic groups, where trainees participate in role-plays 'as patients'. Cognitive–behavioural therapy training has recently been offered outside the University Psychiatric Hospital. The final examination consists of a practical (psychiatric interview, diagnosis, case management and

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prognosis), a written exam (a theoretical essay on a chosen topic) and an oral exam. After successfully completing the training and the examination, the trainee is officially recognised as a specialist in psychiatry, which is equivalent to the consultant psychiatrist grade in the UK.

A new programme of training has been prepared by the Slovene Medical Association in cooperation with the Department of Psychiatry of the Medical Faculty. Its main aim is to adjust the training to the proposals of the European Board of Psychiatry. Slovenia is already an associate member of this board.

Research in psychiatry

There was time when it was almost impossible to find a paper published by Slovene psychiatrists in an international peer-reviewed journal. This is no longer the case; one of the requirements for becoming a university teacher is to be the main author of at least three articles published in a journal with the SSCI (Social Sciences Citation Index) or SCI (Science Citation Index) impact factors higher than 0.5. Nevertheless, basic and applied research in the field of mental health should be strengthened further in order to establish culturally-specific strategies for psychiatric disorders and suicide prevention.

Comment

There appear to be marked differences in the prevailing doctrines of psychiatric care between western and eastern Europe. In eastern Eruope large psychiatric hospitals prevail, with community psychiatric services being underdeveloped. In this respect, Slovenia fits into the eastern Europe model. Beside that, the underdeveloped community psychiatric services and the high suicide rate make Slovenia an ideal candidate for implementation of the new targets for improving mental health in Europe by the year 2020 (World Health Organization, Regional Office for Europe, 1999).

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***Andrej Marušič** Clinical Lecturer in Psychiatry, SGDP Research Centre, Institute of Psychiatry, De Crespigny Park, London SE5 8AF, **Marija Brecelj** Trainee in Psychiatry, University Psychiatric Hospital, Ljubljana, Slovenia

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