NIJZ National Institute of Public Health

JAImpleMENTAL

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Country Profile "Slovenia"

Suicide and Suicide Prevention: 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 6 Work Packages (WPs), 4 horizontal WPS and one for each best practice. **WP6 on suicide prevention** aims to support improvement in knowledge and quality of suicide prevention services. Defined elements of SUPRA should be transferred and pilot implemented at national/regional level, suicide prevention strategies in participating countries developed i.e. revised.

The present country profile is one of the major deliverables of the JA, presenting national priorities for suicide prevention embedded in contextually relevant facts. It summarizes results of the national Situation- and Needs Assessment (SANA), lists lessons learned, recommendations and prioritized measures for suicide prevention. It includes challenges and opportunities as well as outlining next steps necessary to scale-up i.e. promote national/regional suicide prevention activities. The country profile is a basis for strategy formulation, for decision-making and a declaration of commitment to suicide prevention.

1 Context

1.1 Country, Health and Social System

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)

			Sex
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 centers 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 System

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 18 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). 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. One of six priority areas is suicide prevention, which includes raising of mental health awareness and literacy, particularly in relation to suicide; early identification of people at risk; access to help and mental health provision for people at risk of suicide; reduction in alcohol use; and restriction of access to the means of suicide (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).

Table 2: Facilities, number of beds and hospital admissions related to mental health, 2019 (10)

Indicator at national level		number	rate per 100 000 adult/minor population
Mental health hospitals	Facilities	5	0.25
	Beds	1163	55.95
	Admissions	9402	452.31
Psychiatric wards/units in general hospitals	Wards/units	1*	0.05
	Beds	198	9.53
	Admissions	1546	74.38
Mental health inpatient facilities specifically for children and adolescents	Facilities	3	0.80
	Beds	46	11.36
	Admissions	/**	/**

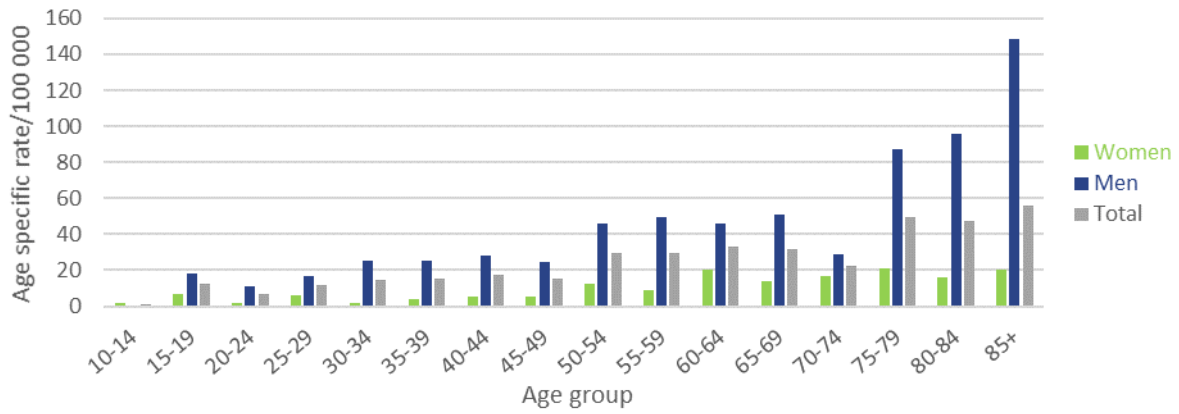
* We have one psychiatric ward in general hospital - that is a psychiatric clinic of the University Clinical Centre Maribor.
**No data available.

2 Suicide and Suicide Prevention

2.1 Situation Analysis (SA)

2.1.1 Suicide mortality statistics

Figure 1: Suicide rate: 2021, by age groups and sex (11; age specific rates calculated by authors)



The suicide mortality rate in Slovenia has decreased by more than 30% over the last two decades, but Slovenia still has a higher suicide rate than the European average (12). Men in Slovenia die from suicide 3 to 4 times more often than women, and this ratio increases with age. Report on suicide mortality (including trends and other relevant contextual information) is prepared every year on the world suicide prevention day.

Figure 2. Suicide deaths trend, 2001–2020, by sex (11; age standardized rates calculated by authors)

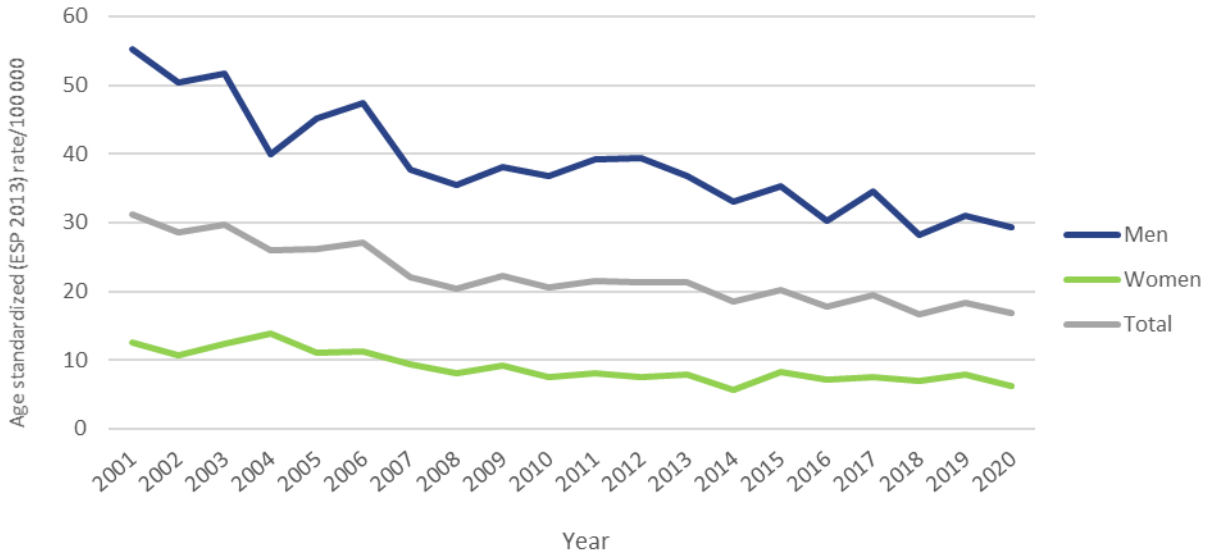


Table 3: Most common methods of suicide: 2001–2020, by age group and sex (11)

Sex/Age	0-19	20-39	40-59	60-79	80+
Women	1. hanging 2. jumping or laying before moving object 3. jumping from height/prescription drugs	1. hanging 2. jumping from height 3. prescription drugs	1. hanging 2. drowning 3. prescription drugs	1. hanging 2. drowning 3. jumping from height	1. hanging 2. drowning 3. jumping from height
Men	1. hanging 2. jumping or laying before moving object /jumping from height	1. hanging 2. firearm 3. jumping from height	1. hanging 2. firearm 3. drowning	1. hanging 2. firearm 3. drowning	1. hanging 2. firearm 3. jumping from height

Note. Symbol / indicates shared place by two or more methods

Based on international research and expert opinion, elderly men, LGBTQ+, drug use (alcohol included) disorder patients and victims of violence are the groups of Slovenian population that are most vulnerable to suicide. People face barriers when seeking psychosocial help, especially long waiting times, stigma of help seeking, low accessibility (geographical), low mental health literacy (knowledge on available services) and insufficient coordination among service providers; health care, social care, education and stigmatising attitudes by gatekeepers (13, 14).

2.1.2 Self harm statistics

In Tables 4 and 5, we present data on self-harm. However, data on self-harm is incompletely collected (no distinction is made between deliberate self-harm with intention to die or without) and therefore probably does not reflect the true situation.

Table 4: Hospitalization due to self-harm: 2018, by age group and sex (15)

	10-19		20-39		40-59		60-79		80+	
	N	rate	N	rate	N	rate	N	rate	N	rate
female	57	62.40	40	16.35	37	12.59	16	6.89	7	9.55
male	15	15.41	36	13.45	49	15.85	35	16.89	6	17.16

Table 5: Most common methods of self-harm with or without a suicidal intent: 2018, by age group and sex (15)

Sex/Age	10-19	20-39	40-59	60-79	80+
female	1. sharp object 2. prescription drugs - psychotropic 3. unspecified drugs	1. prescription drugs - psychotropic 2. sharp object/nonopioid, antipyretics and antirheumatic drugs	1. prescription drugs - psychotropic 2. sharp object 3. unspecified drugs	1. prescription drugs - psychotropic 2. unspecified drugs 3. sharp object/ nonopioid, antipyretics and antirheumatic drugs	1. prescription drugs - psychotropic 2. unspecified drugs/sharp object/narcotic and psychodiscleptic drugs/unspecified means
male	1. prescription drugs - psychotropic 2. alcohol 3. sharp object	1. sharp object 2. prescription drugs – psychotropic/unspecified drugs/strangulation	1. prescription drugs - psychotropic 2. sharp object 3. unspecified drugs	1. sharp object 2. prescription drugs - psychotropic 3. unspecified drugs	1. prescription drugs - psychotropic 2. unspecified drugs/sharp object/strangulation/alcohol

Note. Symbol / indicates shared place by two or more methods

2.1.3 Suicide prevention activities

Suicide prevention strategy is integrated into National mental health programme 2018–2028. Evaluation of suicide prevention activities is an integral part of the National mental health programme evaluation.

Targeted suicide prevention activities are available at different levels of health care system and also provided by NGO's. There are voluntary trainings for community and professional gatekeepers on the primary health care level on recognition and management of suicide individuals. Emergency psychiatric services (24/7) are in place for both children and adolescent and adult population. Regarding standardised follow-up care, there are case management plans in certain services (community mental health care centres, community psychiatric management by social protection centres), but they are not present across (health) case system. Programmes for drug users, preventive programme on early identification of at-risk users of alcohol are present in the health care system (https://www.sopa.si/en/). Programs for specific population groups that are most vulnerable to suicide are offered mainly by NGOs with programmes for vulnerable populations (LGBTQ+, victims of violence etc.). There are also nationwide hotlines for crisis interventions, some operated by NGO's, others by the health care system: a 24/7 hotline for psychosocial support (Samarijan, http://www.telefon-samarijan.si/), 24/7 hotline for children and adolescents (TOM telefon, https://www.e-tom.si/), both run by NGO and 19.00 to 7.00 hotline operated by University Psychiatric Clinic Ljubljana (https://www.psih-klinika.si/koristne-informacije/klic-v-dusevni-stiski/).

The aftermath of suicide is an area still underdeveloped in Slovenia. At the moment, postvention activities are developed only for school-aged children. There are no dedicated suicide prevention measures or standards in Slovenia for restricting the means of suicide. Collaboration on media is established, guidelines on responsible reporting on suicide were developed in 2010 which was accompanied by amendments made to the Ethical codex of Journalists. The suicide prevention

professionals and the media work together regularly (press releases on world suicide prevention day etc.).

2.2 Needs Assessment (NA)

A group of national experts conducted SWOT analysis on the basis of the guiding questions on strengths, weaknesses, opportunities and threats. Results are presented in Table 6.

Table 6: SWOT Analysis

STRENGTHS	WEAKNESSES
• Good expertise in suicide prevention in Slovenia • Centralised governance • National Mental Health Programme 2018-2028 (priority area: suicide prevention) • NIJZ holds a mortality database that is reasonably up-to-date • Experience in working with the media	• Stigma towards suicidal behaviour • Data on suicide and suicide attempts are very limited and underused for research porpuses • Insufficient human resources for intensive focused work in suicide prevention • Insufficient integration of institutions and programmes involved in suicide prevention
OPPORTUNITIES	**THREATS**
• Small country (more manageable, less fragmented) • Political support for mental health • Space/opportunity to develop postvention (e.g., support for relatives) • Public health approaches (in suicide prevention) are gaining importance • Opportunity to disseminate results at national level	• High proportion of suicide methods (hanging in particular) that are difficult to prevent • Infrastructure of railway lines is not optimal • Alcohol culture • Threat of inflation, economic recession

3 Reflection on SANA results

Based on SANA, we have derived two implementation areas: cooperation with the media and reducing access to means. We have already worked with the media, which will help us to strengthen our cooperation with them and work on media guidelines for reporting on suicide. Access to mortality database gives us information on suicide methods in Slovenia. More in depth information on methods of suicides (e.g. place of suicide, accompanied circumstances) is hard to obtain and we will try to overcome this obstacle by studying reports on suicides gathered by the police. Hence, a crucial step here will be collaboration with the criminal police. The obtain information will help us develop next steps towards reduce access to means.

Box 1. Prioritised measures for implementation

OVERARCHING MEASURE: Revision of the existing suicide prevention strategy

Strategic Area 1: Coordination and Organization

- Revision and update of suicide prevention strategy, embedding it within the action plan 2024-2028 of the National Mental Health Programme

Strategic Area 2: Reducing access to means

- Access police reports on suicide and analyse data on means of suicide (QUICK WIN)
- Mapping preventable means of suicide and their respective interventions
- Engage relevant stakeholders in the task of restricting access to means

Strategic Area 3: Awareness and Knowledge - Cooperation with media

- Getting feedback on existing media guidelines through questionnaires (QUICK WIN)
- Revision of media guidelines
- Engage universities to include responsible reporting on suicide (and other related topics) in the curriculum

4 Next steps

Next steps on the revision of the suicide prevention strategy:

- The interdisciplinary working group on suicide prevention prepares a list of prioritised actions for the new action plan of the National Mental Health Programme
- The intersectoral governmental working group evaluates proposed actions, addresses concerns, and provides feedback from government representatives to refine the plan
- The list of prioritised actions is presented at the expert board of the National Mental Health Programme, feedback is gathered and actions refined accordingly

Next steps on cooperation with the media:

- Engage additional journalist association and other stakeholders (i.e., editors)
- Develop interactive workshops with journalists to evaluate the usefulness, barriers to the usage of the guidelines
- Conduct guidelines evaluative workshops and analyse the results
- Engage universities to include responsible reporting on suicide (and other related topics) in the curriculum
- Recommendations on improvements of the guidelines (based on the feedback from the workshops)
- Increase awareness of the guidelines

Next steps on reducing access to means:

- Agreement with the Criminal Police on access to reports on suicide
- Analysis of data on means of suicide
- Mapping of interventions to reduce access to means of suicide
- Relevant stakeholders/organisations in prevention of suicide by chosen method are involved in the task
- Collaboration with the stakeholders/organisations on reducing access to means

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