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THE ROLE OF EFFECTIVE TREATMENT OF MENTAL ILLNESS IN THE FIGHT AGAINST POVERTY

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ABSTRACT

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In Slovakia, one in five people experiences mental disorder. Mental illness tends to start early in life, which makes it the most prevalent disease among people of working age. It accounts for a third of expenditures on disability benefits, increases unemployment and deepens poverty. There is a substantial gap in psychological care for patients who receive adequate treatment and those who need it, but do not get it. Provision of appropriate psychological therapy early on could prevent and reduce much of the negative impact of mental illness. The experiences from IAPT initiative in England where evidence based psychological therapies are made widely accessible can serve as a guide. IAPT initiative operates stepped care model with emphasis on starting with low intensity interventions. By using these principles, we can fill the gap between primary care and highly specialized treatment of mental disorders in Slovakia. Early psychological intervention can help people with depression, anxiety disorders and long-term psychological conditions to get well, improve quality of life and reduce unemployment and poverty.

key words:
mental illness,
poverty,
early psychological interventions,
low intensity therapy

kľúčové slová:
duševné ochorenia,
chudoba,
včasné psychologické intervencie,
terapia druhého stupňa nižšej intenzity

INTRODUCTION

Generally, the income is perceived as one of the most important factors of poverty determined by education, experience, skills, health and further quantifiable factors (Zelinsky, 2014). Despite rapid economic growth, Slovakia has struggled with poverty and is known as the Eurozone's second poorest member state. The government policy to help people overcome poverty is mostly focused on specific populations (e.g., Roma communities), older people, or students. But a large group of people threatened by poverty due to their mental illness is overlooked.

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THE GAP IN MENTAL HEALTH CARE

Mental illness can lead to deprivation of basic human needs due to deterioration of ability to complete day to day tasks (e.g., in psychotic disorders) or difficulties in maintaining healthy functioning at work (e.g., in social phobia, or agoraphobia). If not treated, mental health problems can lead to unemployment, long term sickness or reduction of productivity at work. Mental disorders, such as psychotic disorders (schizophrenia), neurotic and depressive disorders are linked with a substantial degree of impairment and difficulties in life (Jacobi et al., 2014; Bandelow & Michaelis, 2015). Up to 33.7% of the population experiences an anxiety disorder at some point in their life (Bandelow & Michaelis, 2015). Depression is also common with its lifetime prevalence currently estimated at 10.8% (Lim et al., 2018). Moreover, the number of sufferers continually rises (World Health Organisation, 2017). Schizophrenia spectrum disorders, which affect approximately 1% of the population, are considered especially severe and disabling (Gur et al., 2014; Xia, Merinder, & Belgamwar, 2011).

According to the official Health Statistic yearbook of the Slovak Republic (National Health Information Centre, 2016) the prevalence of mental diseases treated at a first contact in psychiatric inpatient and outpatient services was as follows: 1) the number of examined persons by diagnoses according to ICD-10 F 30.0–39 was 14,930 cases or 27.5 per 10,000 population; 2) the number of examined persons by diagnoses according to ICD-10 F40.00–48.9 was 21,928 cases or 40.3 per 10,000 population. Bražinová, Hašto, Levav and Pathare (2019) found that there are hundreds of thousands of people in Slovakia who have symptoms of depression, anxiety disorders and addiction but are not being treated. She estimates that 67% of people who are most likely to suffer from depression are not currently in treatment. Up to 80% of people with symptoms of alcohol dependency do not get psychological support either. The proportion of people with untreated anxiety disorders is as high as 84%. These numbers demonstrate the size of the gap in mental health care in Slovakia.

According to Pathare, Brazinova and Levav (2018), mental health care gap refers to the percentage of persons who require treatment, but do not receive it, either due to non-availability of facilities, stigma or poor access to appropriate care. Treatment gap seems to be frequently seen by policymakers, researchers and non-professional stakeholders as exclusively relating to clinical psychiatric interventions. The result is the exclusion of a range of effective psychological and psychosocial interventions available today. Typically, measurement of the gap focuses on the mental health needs that are to be met by either highly specialized or primary care health services, while those addressed by related sectors using stepped care and lower intensity interventions are usually not included (World Health Organization, 2009).

THE BURDEN OF MENTAL DISEASE

Vos et al. (2012) estimated overall morbidity of mental disease in most developed countries at 28% and the musculoskeletal complaints at 25%. World Health Organization (2017) investigated the degree of disability due to depression and compared it with that caused by the four most common chronic physical diseases – diabetes, asthma, angina and arthritis. The results demonstrated that depression is in fact 50% more severe and disabling than any of the above physical illnesses. Depression and anxiety disorders together account for more than half of all mental diseases. (Layard & Clark, 2014). Mental illness is the most significant single cause of suffering in modern societies. According to Layard and Clark (2014, p. 63) “Mental illness causes more of the suffering in our society than physical illness does, or than poverty or unemployment

do. It reduces life expectancy as much as smoking does. It accounts for nearly half of all the disabled people on disability benefits, and nearly half of all days off sick. It affects educational achievement and income as much as pure IQ does. And nine out of ten prisoners have mental health conditions when they enter prison."

According to Robins (1991), people with mental disorders are four times more likely to be unemployed or partially employed. The problem tends to begin in childhood. Commonly, children and adults with mental disabilities are discriminated against in school, rejected and bullied (Astbury, 2008). Due to the strong relationship between mental illness, poverty and lack of education (Bor & Dakin, 2006; Patel & Kleinman, 2003), insufficient treatment of mental disorders in children is likely to negatively affect their learning outcomes and limit their employment and other income generating opportunities later in life. Since the quality and performance of the work force is currently an essential element in achieving enterprise competitiveness, untreated mental health problems can contribute to reduced socioeconomic status in those struggling with mental ill health. According OECD (2018)) a large part of these expenses are due to lower employment rates and productivity of people with mental health issues (1.6% of GDP or EUR 260 billion) and greater spending on social security programmes (1.2% of GDP or EUR 170 billion), with the rest being direct spending on health care (1.3% of GDP or EUR 190 billion). Unemployment disrupts normal daily routine, negatively affects relationships, and reduces one's ability to contribute to family life.

People with untreated mental illness are often forced to rely on financial support from their families to get their basic needs met and cover the cost of their treatment (Magliano, McDaid, Kirkwood, & Berzins, 2007). Unmet psychological and physical needs often result in frustration with one's inability to work and its consequences, unsuitable living conditions, lack of dignity and personal fulfillment as well as lack of acceptance by others. There may be fear of the future, low self-confidence, loss of self-esteem, even suicidal thoughts and behaviors. Sufferers can experience negative changes in cognitions, emotions and bodily functions and engage in maladaptive patterns of behavior. Mental disorders can have diverse negative social consequences including homelessness, imprisonment and others (see Layard & Clark, 2014). Lack of material resources to meet one's basic needs and to afford appropriate treatment can lead to further deterioration of health and premature death. Thus, a vicious cycle of human suffering is developed.

Burns, Tomita and Kapadia (2014) in his review of incidence rates for schizophrenia disorders, found that between 1975 and 2011 countries with a large rich-poor gap have increased risk of schizophrenia. In Slovakia and the Czech Republic, the situation is similar in that high percentage of patients from different diagnostic groups are either unemployed or receive incapacity benefits and their income is below the poverty line. There are several studies to show that.

Slepecky et al. (2018) studied the research sample consisting of 380 in-patients suffering from alcohol dependence, 282 men and 98 women. The patients were from OLUP Predna Hora (n=212) in Slovakia, Wotuw Cracow (n=117) in Poland and psychiatric hospital in Jemnice (n=51) in the Czech Republic. Almost half of the patients (46.5%) were unemployed, 36.4% had stable employment, 6.9% were receiving incapacity benefits, 9% were retired and 1% were students. The high level of unemployment (58.2%) was also found in another Slovak study of hospitalized alcohol-dependent patients (Benkovič, Mišurdová, & Grossman, 2012).

Holubova et al. (2018) studied 82 out-patients, who met diagnostic criteria for depressive disorder. She found that 39% of the sample were unemployed. The study

identified specific negative coping strategies such as a tendency to give up and escape for stressful situations in this patient group. Vrbova et al. (2018) studied 48 schizophrenic out-patients in stable condition (without a need for changes in treatment). She found that 26 of the patients were employed, 22 patients were unemployed, 17 patients were receiving full pension and 5 patients a partial pension. Grambal et al. (2016) studied a sample of patients with various diagnoses. The result is showed in the Table 1. Holubova et al. (2018) studied 153 out-patients with neurotic spectrum disorders (panic disorder, agoraphobia, social phobia, generalized anxiety disorder, mixed anxiety-depressive disorder, adjustment disorder, somatoform disorders and obsessive compulsive disorder; 88 patients were employed and 64 patients were unemployed.

Table 1 Sample of patients with various diagnoses

Categories	All	BPD	SCH	MDD	BAD	AD
Number (%)	184 (100)	35 (19.0)	49 (26.6)	33 (17.9)	30 (16.3)	37 (20.1)
Age (year) (mean ± SD)	38.29±12.0	29.97±9.6	37.49±10.5	45.52±11.3	39.77±11.9	39.57±12.2
Rent (n) no	103	26	19	18	14	26
Rent (n) partial	40	3	23	5	5	4
Rent (n) full	30	6	7	6	7	3
Old-age pension	23	11	6	1	1	4
Employment (n) Yes	84	8	18	18	16	23
Employment (n) No	100	27	31	15	14	14

Note: AD: anxiety disorder; BAD: bipolar affective disorder; BPD: borderline personality disorder; MDD: major depressive disorder; SCH: schizophrenia spectrum disorder

The above studies show the high percentage of unemployment and those in receipt of incapacity benefits across the diagnoses of mental diseases. Although the rate is the highest in psychotic disorders, the proportion of unemployed and incapacitated people with anxiety disorders and major depressive disorders is alarming. The findings are in line with Hendriks et al. (2015) who argued that the association between psychopathology and functioning is not restricted to severe mental illness. It has been noted that anxiety and depressive disorders were associated with work disability and absenteeism compared with healthy controls. Long-term work disability and absenteeism were most prominent in comorbid anxiety and depressive disorders, followed by depressive disorders and lowest in anxiety disorders.

Substance-related disorders are also a global problem affecting people of any nationality, race, social environment, education or gender. It is estimated that about 50 million people are suffering from substance related problems worldwide. The adverse use of alcohol results in 3.3 million deaths each year (World Health Organization, 2014). Alcohol use disorders are among the ten leading causes of Years Lost due to Disability (YLD) in low-income, middle-income as well as high-income countries (World Health Organization, 2014).

In Slovakia, Social Insurance System monitors the official data on incapacity benefits paid for selected diagnoses (Džado, 2018). The analysis of the data on new incapacity benefits in 2017 showed the following spending. Diseases of the muscular,

skeletal system and connective tissue is 25%, tumors (neoplasms) 17%, mental disorders and behavioral disturbances 15%, diseases of the circulatory system 10%, neurological disorders 7%, the other diseases 26%.

Table 2 shows selected diagnoses of new disability benefits in 2017 in Slovakia.

Table 2 Selected diagnoses in new disability benefits in 2017 in Slovakia

Category/age	19-29	30-39	40-49	50-60	60 and more	total
Diseases of the muscular, skeletal system and connective tissue	61	400	1329	3098	433	5321
Tumors (neoplasms)	93	342	796	1993	435	3659
Mental disorders and behavioral disturbances	273	561	771	1313	150	3068
Diseases of the circulatory system	14	73	317	1344	314	2062
Diseases of the nervous system	65	185	306	759	179	1494
Total 2017	506	1561	3519	8507	1511	15604

The data demonstrate that mental disorders and behavioral disturbances are the third major cause of new disabilities. The most striking is the finding that they are a leading cause of new disabilities at the age of 19 to 39. This suggests that an early onset of mental disease can result in disruption of a healthy life cycle and poor quality of life as individual's final pension depends on the number of years worked and their income. The data are a reflection of human suffering of those affected by mental illness too. Unfortunately, the policymakers are predominantly concerned with the level of national income rather than the life satisfaction of the population (Layard & Clark, 2014). This is where researchers can help by investigating how satisfied people are with their life, which could in turn inform future policy making process. In order to know how to change policies, we need to understand what factors affect people's life-satisfaction and to what degree. Studies of the population demonstrate considerable influence of people's mental health on their life satisfaction but also its links with their physical health, income, work, family, age and gender.

Table 3 illustrates finding about life satisfaction from Britain, Germany, and Australia (Layard & Clark, 2014). In each country, it is showed who is unhappy (defined as the bottom 10%) and who is not. The factors causing people to feel miserable are discussed and their significance is measured. The results show that mental ill-health explains more of the misery in the population than physical illness does. Moreover, mental ill-health also explains a lot more misery than is explained by poverty or unemployment (Layard & Clark, 2014).

Since mental illness is the most significant cause of misery in adults (as shown in Table 3), we need a new concept of deprivation, which includes much more than just financial hardship. Financial resources do not create life satisfaction if people lack the psychological means to enjoy their life. For this reason, mental health must be acknowledged in the development of public policy (Layard & Clark, 2014).

INABILITY TO WORK

According to Layard and Clark (2014), mental illness causes over a third of all disability in Britain, the USA and Continental Europe as it is shown in Table 4.

Table 3 Mental illness is the biggest cause of misery (adults)

	Partial correlation coefficients *		
	Britain	Germany	Australia
Mental ill health (1 year earlier)	.30	.21	.21
Physical ill health (now)	.12	.10	.15
Household income per head (log)	-.05	-.06	-.05
Unemployment	.04	.06	.05
Number surveyed	103,00	50,000	57,000

*These numbers show the strength of the relationship between misery and each variable after controlling for the influence of all the other variables shown. According (Layard & Clark, 2014).

Table 4 Percentage of people of working age on disability benefits

	Due to all causes	Of which due to mental illness
Britain	6.1	2.5
USA	6.6	2.0
6 other OECD countries (average)	6.4	2.4

Altogether, approximately 6% of working-age adults are on disability benefits (1/3 of these attributable to mental illness). Moreover, we need to add many people who report physical illness, like back pain or headache and medically unexplained symptoms of psychosomatic origin. Thus, the proportion of disability benefits caused by mental diseases is closer to 50%. Further, people with mental disorders who are employed often struggle to perform well at work. They are much more likely to take days off work due to sickness. Psychiatric disorders account for between a third and a half of all days off work. Sometimes, the absence is caused by the problematic relationship or the atmosphere in workplace. However, in at least 80% of cases work absences are due to an unresolved mental health problem (Layard & Clark, 2014). Another work related problem caused by mental illnesses "presenteeism". This term refers to the situation where people are at work, but their performance is below expected standard. When people start receiving welfare benefits due to mental illness, it is likely that they will continue to do so for a long time. In Britain, the average time on welfare benefits is four years. The most surprising is the fact that less than half of them receive any form of treatment (Layard & Clark, 2014).

LACK OF PROPER TREATMENT

Despite strong research support for effectiveness of psychological therapy, most people suffering from depression and anxiety disorders in Slovakia are not treated according to evidence-based medicine (EBM) recommendations. In Slovakia, out of all F diagnoses to the ICD-10 (1996), 38.2% of the patients are treated by general practitioners (GPs), 45.5% by the secondary psychiatric care and only 9.5% are treated by clinical psychologists. The main method of treatment by GPs and psychiatrists is through prescribing psychotropic medication (Source: Ministry of Health 2018, requested information). The survey of the 50 most prescribed medications shows that the fifth in the rank is Stilnox 10 mg, the 23rd Neurol 0.5 mg, the 34th is Neurol 0.25

mg, 39th Oxazepam 10 mg, 45th Hypnogen (National health information center, 2018). It is likely that these have been prescribed for sleep problems and anxiety. As far as psychotherapeutic treatment is concerned, the preferred psychotherapeutic intervention in 2017 by psychiatrists was short term, rational, insight-oriented therapy (term used by insurance catalogue) offered 65,801 times. The second one was individual psychotherapy offered 16,041 times. Clinical psychologists offered individual psychotherapy 81,257 times and short-term, rational, insight-oriented therapy 39,235 times. There are 448 registered outpatient psychiatric practices and 221 outpatient psychological practices in Slovakia. (Source: data from Ministry of Health Slovak Republic, 2018, requested information). So most people with mental health problems are treated by GPs and psychiatrists, mostly by psychotropic medication or simple forms of psychotherapy.

There are currently no clinical guidelines for treatment of mental disorders in Slovakia (these are presently being developed at the Slovak Ministry of Health). Various forms of psychotherapy originating from different psychotherapeutic orientations are being provided, not taking into account EBM scientific approach. The situation in Slovakia is characterized by low access rates and insufficient quality of care for people with mental health problems. One of the best guidelines for treating mental disorders was developed in England by The National Institute for Health and Care Excellence, or NICE. NICE was created by the National Collaborating Centre for Mental Health (NCCMH). NCCMH guidelines have been translated and adopted by healthcare systems in Italy, Australia and Slovenia (The NCCMH has also supported NICE International to aid the Netherlands, Georgia, Turkey, the USA and others in establishing their national guideline treatment programs in collaboration with the American Psychological Association).

NICE (2011) stepped-care model provides guidance for organizing mental health problems, as well as helping their families and carers. NICE guidelines help healthcare professionals to identify and choose the most effective interventions for specific mental disorders. The model presents an integrated overview of the key treatment interventions. NICE guidelines recommend delivery of mental health care in a stepwise manner in order for the intervention to be the most effective and least burdensome for the patient. Please see Figure 1 for the illustration of the stepped-care model: a combined summary of common mental health disorders.

WHAT WE NEED TO DO

In 2008 in the UK, British government had made a decision to start a major national program to deliver evidence-based psychological therapies through the National Health Service. This initiative is called the Improving Access to Psychological Therapies (IAPT) (Layard, 2017). We are of the view that Slovakia needs to go through a similar process. IAPT is an example of how to enable access to EBM therapies for wider populations in need of psychological help and how to organize the delivery of these psychological therapies. Under the IAPT initiative, new treatment centers with well-trained therapists working under regular supervision were established. In IAPT center, patients' progress is measured session by session. This approach offers valuable information for care providers about how effectively their money is spent. All data from the system (other than personally identifiable patient data) are regularly published. Three essential features characterize the IAPT model (Layard & Clark, 2015):

Stepped care approach ensures that treatment is provided on the basis of patients' needs. This ensures that everyone gets the most effective and least burdensome treat-

Focus of the intervention	Nature of the intervention
Step 3: Persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention; initial presentation of moderate or severe depression; GAD with marked functional impairment or that has not responded to a low-intensity intervention; moderate to severe panic disorder; OCD with moderate or severe functional impairment; PTSD.	Depression: CBT, IPT, behavioural activation, behavioural couples therapy, counselling, short-term psychodynamic psychotherapy, antidepressants, combined interventions, collaborative care, self-help groups. GAD: CBT, applied relaxation, drug treatment, combined interventions, self-help groups. Panic disorder: CBT, antidepressants, self-help groups. OCD: CBT (including ERP), antidepressants, combined interventions and case management, self-help groups. PTSD: Trauma-focused CBT, EMDR, drug treatment. All disorders: Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions.
Step 2: Persistent subthreshold depressive symptoms or mild to moderate depression; GAD; mild to moderate panic disorder; mild to moderate OCD; PTSD (including people with mild to moderate PTSD).	Depression: Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes, non-directive counselling delivered at home, antidepressants, self-help groups. GAD and panic disorder: Individual non-facilitated and facilitated self-help, psychoeducational groups, self-help groups. OCD: Individual or group CBT (including ERP), self-help groups. PTSD: Trauma-focused CBT or EMDR. All disorders: Support groups, educational and employment support services; referral for further assessment and interventions.
Step 1: All disorders – known and suspected presentations of common mental health disorders	All disorders: Identification, assessment, psychoeducation, active monitoring; referral for further assessment and interventions.

Figure 1 Stepped-care model: a combined summary for common mental health disorders

ment adequate for their needs. Most people begin with 'psychological wellbeing practitioners' or PWPs, the therapists trained in low-intensity approaches delivered through telephone contact, self-help books, computerized therapy, group therapy or low-intensity one to one therapy. People who suffer from more severe anxiety and depression, all patients with PTSD, and patients with milder symptoms who do not recover with PWPs are referred, or 'stepped-up', to receive more intensive treatments to be delivered by therapists trained in high-intensity therapies that require additional training, knowledge and skills. All therapies offered by IAPT are evidence-based with predominant but not exclusive use of CBT. People can be referred to IAPT either by their GP or other professionals involved in their care but people can also self-refer. IAPT initiative in England started in late 2008 and since then has continued to grow steadily. Similar initiatives were developed in Australia and Canada (Gratzer & Goldbloom, 2016). Clark (2017) summarized the results achieved by IAPT in his presentation at CBT congress in Cluj, Romania. The program transformed treatment of common mental health disorders of depression and anxiety. Psychological therapy services based on stepped-care model were established in every area of England. As a result, approximately 16% of local prevalence of mental disorders (950,000 per year) was seen in IAPT services. Around 60% of these cases were treated (approximately 575,000 per year) and treatment outcomes were recorded in 98.5% of all cases. The effectiveness of therapeutic interventions in IAPT is monitored through regular use of two questionnaires, PHQ-9 and GAD-7, which are completed for every therapy ses-

sion. The criteria for recovery are rigorous – both scores for depression and anxiety have to be under the clinical cut-off point. Data collected between January and March 2017 showed that 51% of patients in IAPT reached recovery and 16% of them were improved. The substantial pre-post effect size was 1.4 for depression (PHQ-9) and 1.5 for anxiety (GAD-7).

Since the model has worked so well and is so important, it has generated significant interest in other countries. At least seven countries expressed their interest, and Norway and Sweden have already started to introduce their versions of the system. The model is an inspiration for Slovakia, too.

According to Layard and Clark (2014), there are six main criteria which a service has to satisfy if it is to be an IAPT service.

- It has to deliver only evidence-based, NICE-recommended therapies. This includes not only CBT but interpersonal therapy, brief psychodynamic therapy, couples therapy and counseling for depression.
- It has to employ therapists who are fully trained in how to deliver the relevant treatment.
- It has to measure patient outcomes on a session-by-session basis, with at least 90% of completeness of data.
- Each patient receives a professional assessment when he/she arrives and is then allocated to high- or low-intensity treatment, as appropriate. About 46% get low-intensity only, 34% get high-intensity only, and 20% get both – having been stepped up to high-intensity after low-intensity failed.
- Each therapist must have weekly supervision, and each trainee must have a well-qualified supervisor.
- The service must be open to patients who refer themselves, without going through their general practitioner (GP). This breaks with all conventional arrangements in the National Health Service. When it was proposed, some people argued that it would attract the 'worried well'. On the contrary, it was found that patients who self-refer are as ill as those coming through their GP-referred. They have also been ill longer, and recover as well (often with fewer sessions, reflecting their high level of motivation). They also include a higher proportion of people from black and minority ethnic groups than patients referred by GPs, and this helps to ensure that IAPT patients have a more similar ethnic balance to their population at large.

CONCLUSION

So why is it important to introduce the new model of mental healthcare in order to fight poverty? As explained above, mental diseases cause low income, low quality of life and poverty. Most mental diseases are treatable in their early stages. However, the most effective modern psychological treatments are not widely available nor delivered by mental health professionals in Slovakia. The reform of the system for mental healthcare is long overdue in our country, and the development of the missing steps of care for treatment of common mental disorders such as depression and anxiety, as well as anxiety or depression related to long term health conditions is a worthwhile goal.

In order to achieve this goal, there are several steps to be completed. First, it is necessary to develop clear practice standards for treatment of specific mental disorders based on scientific evidence. The Ministry of Health of the Slovak Republic has already taken a positive stance toward this initiative by setting up professional groups of psychiatrists and clinical psychologists and is supporting their activity inspired by the work of NICE and IAPT models.

Secondly, it is important to address the current lack of monitoring system in order to understand and measure effectiveness of presently used treatments for mental disorders. It is crucial to be able to provide feedback to policy makers and providers about the effectiveness of individual treatments used in clinical practice. The lack of transparency about effectiveness of specific treatments has contributed to the current state of our clinical practice where the majority of people suffering from mental health problems are treated by medication, or by very specialized psychotherapies (many of these have insufficient evidence base), while psychological therapies with good evidence base are scarcely used. However, the recent initiative of conversion to electronic healthcare records could provide an opportunity for integrating the measurement of effectiveness of mental health interventions within this new system.

Thirdly, we need to introduce further 'steps' into the current system of care for treatment of common mental health disorders based on severity of patients' needs. In the new proposed care system, initial support can be provided by GPs at Step 1 and mild to moderate mental health problems can be addressed at Step 2 using low-intensity, evidence-based psychotherapeutic interventions following an adequate initial assessment. The low-intensity interventions can be delivered through phone consultations, internet-based psychotherapy, guided self-help and group treatment by therapists appropriately trained in these forms of interventions. More severe manifestations of mental health problems, or those who haven't responded to lower-intensity treatments should be referred to an appropriately trained therapist certified for providing adequate disorder-specific psychotherapy. The overarching aim is for anyone suffering with mental illness to receive appropriate evidence-based and disorder specific treatment.

Apart from adequate diagnosis and treatment of mental disorders, we also consider strategies for prevention of mental illness as very important. The revised National Mental Health Program dated 6th October 2004 (Úrad verejného zdravotníctva, 2004) based on the recommendations of the World Health Organization, emphasizes it. It states that not enough attention is paid to the support of mental health and prevention of mental disorders in the society. According to the program, there was an important difference between real and declared mental healthcare. Moreover, the level of care for those with mental disorders fell behind the care for those with physical illness. As such, the issue with mental health is becoming a political priority in all its complexity. At the same time, there are significant differences noted in current mental health and physical health between urban and rural areas. Unfortunately, options for psychological support are given minimum attention in this material. Within this framework, the EU has set the following priorities:

- Prevention of depression and suicides
- Mental health of youth and education
- Mental health in the workplace
- Mental health of older people
- Tackling social exclusion

Lack of appropriate training and education in the field of mental health results in an insufficiently informed society. Poorly developed care for people with mental disorders and low awareness of the population about mental health issues leads to persistence of mental disorders and sometimes to stigmatization and discrimination of those who suffer with mental health problems. The current situation does not promote better quality of life for people with mental illness, nor does it help to prevent mental disorders.

Educating society about how to prevent psychological problems and how to promote mental health in an essential aspect of mental health policy. We believe that the interventions and services for improving mental health should be aimed at the society as a whole. Raising general awareness of mental health is a duty of every individual as this awareness is critical for maintaining our psychological wellbeing.

The program points out the need to devote adequate resources and decisive powers to those involved in mental healthcare while taking the service users' needs into account.

The implementation of changes into the mental healthcare system is expected to bring the following benefits:

– More professional specialist services and better quality of life for recipients of care and their families.
– The highest possible number of current passive recipients of state support to become active contributors to the society.
– Positive economic impact for the individual (higher financial self-sufficiency, better access to resources, increased personal freedom, responsibility and self-respect, lower family burden) and the society as a whole (reduction of expenditure on welfare as the recipients of appropriate care should be able to return to productive economic activities and pay taxes, pension contributions and insurance) (NPDZ, 2017).

In Slovakia, more than 400 psychologists graduate from universities every year. Some of these graduates could be trained in delivering low-intensity treatments after one year of training based on the experiences from England. For the project of transformation of mental healthcare, we will be looking for support from politicians, ministry of health, patient organizations and all professionals supporting people suffering with mental illness. The importance of a combined strategy for tackling the mental health burden is recognized by WHO (2013) in its objectives and targets of the Comprehensive Mental Health Action Plan for 2013-2020.

Currently we are at the very beginning of a long journey hoping that our joint efforts will eventually succeed.

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SÚHRN

Úloha účinnej liečby duševných chorôb v boji s chudobou

Na Slovensku trpí duševným ochorením jeden z piatich ľudí. Tieto ochorenia začínajú obvykle vo včasnejšom veku, a preto sú v produktívnom veku najčastejšie. Odhaduje sa, že sú zodpovedné za tretinu sociálnych výdavkov, zvyšujú nezamestnanosť a prehlbujú chudobu. Prítomný je tiež značný nepomer v psychologickej liečbe u pacientov, ktorí sú liečení primeranou liečbou, a tými, ktorí túto liečbu potrebujú, ale ju nedostávajú. Poskytnutie vhodnej psychologickej liečby včas môže zabrániť alebo obmedziť väčšinu negatívnych vplyvov duševných ochorení. Podnetom, na zlepšenie tohto stavu sú skúsenosti „Iniciatívy na zvýšenie prístupu k psychologickej liečbe (IAPT)“ v Anglicku, kde sa podarilo sprístupniť dôkazmi podloženú liečbu významnému počtu pacientov. IAPT iniciatíva používa model postupnej starostlivosti s dôrazom na začiatok liečby pomocou menej intenzívnych intervencií. Ak by sme postupovali podľa tohto modelu, mohli by sme vyplniť medzeru medzi primárnou starostlivosťou o duševné ochorenia a ich vysoko špecializovanou liečbou. Včasné psychologické intervencie môžu pomôcť uzdraviť sa ľuďom s depresiou, úzkostnými poruchami a pomôcť aj pacientom s chronickým ochorením, a takto zlepšiť ich kvalitu života, znížiť nezamestnanosť a chudobu.