Editorial/Uvodnik

Mental health and nursing: Current needs and development challenges

Duševno zdravje in zdravstvena nega: potrebe časa in razvojni izzivi

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Mental health has become a key public health priority in Slovenia and worldwide, particularly since the COVID-19 pandemic, which significantly reshaped and worsened the fundamental social and economic determinants of mental health (Clemente-Suárez et al., 2021; Kola et al., 2021; Lange, 2021). Negative mental health trends are evident in several indicators showing an increasing prevalence of mental health problems. Globally, two indicators are particularly significant: 'Disability-Adjusted Life Years' (DALY), which shows that 5% of the total global burden of disease is linked to mental health problems, and 'Years Lived with Disability' (YLD), which shows that mental health problems account for as much as 15% of all years lived with disability (GBD 2019 Mental Disorders Collaborators, 2022).

Statistically, Slovenia ranks among the European countries with the highest prevalence of depressive symptoms in the population (La Torre et al., 2021), and shows a rapid rise in mental health problems among young people, with increased rates of depression, anxiety, and other mental health problems (Piao et al., 2022; Sacco et al., 2022). During the COVID-19 pandemic, Slovenian youth reported lower levels of anxiety, depression, and suicide attempts than their German and Polish peers, yet experienced notably high perceived stress (Benatov et al., 2022). However, a recent study by Vinko et al. (2024) indicates that health statistics do not capture the full extent of the problem: the study found a persistent gap between perceived mental health problems and recorded cases. This gap may be due to several key factors: delayed recognition of mental health problems, persistent social stigma surrounding mental disorders, and inadequate accessibility of mental health services (ReNPDZ18–28, 2018; Vinko et al., 2024). As these are well-established and recurring issues, there is a clear need for systemic solutions in mental health care at the cross-sectoral level, with an emphasis on accessible promotion and prevention programmes and timely identification of mental health problems at the individual level.

Slovenian strategic documents in the field of mental health

Mental health is shaped primarily in family environments, early childhood education settings, schools, workplaces, and healthy local communities, rather than within healthcare institutions. Sustainable strengthening and maintenance of mental health at individual and community levels, focused on prevention rather than treatment, can be achieved only through integrated cross-sectoral approaches that require collaborative engagement across multiple domains: health care, education, social care, culture, workplace settings, local communities, the judiciary, home affairs, and media (Van Ginneken & Waitzberg, 2025; WHO/Europe, 2025). Achieving these objectives requires implementation through national legislation, as this is the only mechanism capable of reaching all social groups and strata.

Slovenia began moving in this direction in 2008 with the adoption of the Mental Health Act (ZDZdr, 2008), later supplemented by the Resolution on the National Mental Health Programme 2018–2028 (ReNPDZ18–28, 2018). The Resolution is the first document to set out a development strategy for mental health care, with fundamental objectives to strengthen the mental health of the Slovenian population, prevent mental disorders from birth to old age, destigmatise and combat discrimination against people with mental disorders, and organise accessible mental health services through a community-based approach in the local environment (ReNPDZ18–28, 2018).

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As a result of this resolution, Slovenia has in recent years undertaken a fundamental transformation of the organisation of mental health services, shifting from a distinctly conservative, institution-based and curative model to an open model that emphasises prevention and provides users with access to mental health services within their local communities. The accessibility of mental health services is now being developed through the operation of adult mental health centres, child and adolescent mental health centres, as well as through a network of mental health services that are not confined to the health sector, but also involve all socially significant structures capable of sustainable mental health promotion, prevention and treatment. Despite these changes, responsibility for mental health care cannot rest solely with the state and legislators.

Social responsibility for mental health care

Mental health and resilience are shaped by dynamic interactions among biological, psychological, and social factors (Porter, 2020). This biopsychosocial framework therefore requires coordinated action from all these services from birth onwards. As individuals typically engage with the healthcare system only when their distress exceeds their daily capacity for coping, self-regulation, and adaptation, health care plays a limited and generally secondary role in determining mental health outcomes (Bolton et al., 2023). To prevent the institutionalisation of individuals with mental health difficulties, mental health care must prioritise strengthening psychological resilience at the individual level. This requires societal investment, through multiple systems, in individuals' mental and psychological development from birth, with emphasis on the development of emotional competencies, adaptive behavioural patterns, self-regulatory capacities, social skills, and a sense of security and belonging.

Shifting from curative to preventive approaches requires investment in childhood mental health, parenting support, and education as prerequisites for healthy self-development (Castillo et al., 2019; Hoover & Bostic, 2020). Individuals who have developed these foundational competencies are better equipped to respond resiliently to stressful life situations and will require clinical intervention only under significant psychological strain. However, prioritising prevention should not lead to the opposite extreme, namely denying the need for mental health care within institutional settings.

Development of mental health and psychiatric nursing staff

Given the inevitability of curative care, the development of qualified healthcare professionals at all levels is, and will remain, crucial in mental health care. Only qualified nursing staff can ensure high-quality care and uphold the highest professional and ethical standards, both for less complex mental health conditions and for those requiring the most complex psychiatric treatment. The development of mental health and psychiatric nursing staff – the largest group of healthcare professionals – has therefore become an urgent necessity.

International studies indicate that mental health and psychiatric nursing staff are trained in mental health relapse prevention (Wazzan et al., 2025) and play a key role in the early identification, support, and prevention of suicide, depression, and anxiety disorders (Tamanna, 2024; Tushe, 2024). Nevertheless, they are insufficiently trained to carry out mental health promotion at the population level (Aguiar et al., 2012). As no systematic competency assessments of mental health and psychiatric nursing staff have been conducted in Slovenia to date, there is a lack of reliable data regarding the preparedness of nursing staff for work in mental health treatment, promotion, and prevention, which poses serious problems for workforce planning and educational policy development.

ReNPDZ18–28 (2018), which addresses this gap, highlights the following among its six strategic priorities: 1) promotion of mental health, prevention, and destigmatisation of mental disorders; and 2) education, research, monitoring, and evaluation. The Resolution states that appropriate knowledge and skills must be ensured for all professionals and support staff who come into contact with people experiencing mental health problems (ReNPDZ18–28, 2018). The introduction of an undergraduate degree programme in nursing and social work, or a specialisation in mental health for nursing, has direct implications for health professionals. A comparative analysis of educational programmes by Mancheri et al. (2025) also shows that many higher education programmes remain strongly focused on the treatment and management of already established disorders. Consequently, educational reforms in this field should prioritise several key areas: defining core competencies for mental health treatment, prevention, and promotion; strengthening practical and simulation-based training; incorporating content on public mental health, leadership, and research; developing interprofessional learning opportunities; and ensuring alignment with national strategic documents.

Specialisation field offering opportunities to transform the culture of care for individuals with mental health problems

In 2025, after decades of systemic efforts, Slovenia adopted the Regulations Amending the Regulations on the Types, Content, Duration and Course of Specialisations for Healthcare and Midwifery Practitioners (*Pravilnik o spremembah Pravilnika o vrstah, vsebini, trajanju in poteku specializacij izvajalcev v dejavnosti zdravstvene in babiške nege,* 2025) introducing a specialisation programme in mental health and psychiatric nursing. This formally

established a structured approach to advanced clinical training in this specialised field as a key objective of the Resolution (ReNPDZ18–28 2018). The aim of the specialisation is to ensure that healthcare professionals possess the theoretical and clinical competencies required for professional and autonomous practice in mental health and psychiatric care. The programme will equip specialists with competencies in preventive care, recovery-oriented care, guideline-based therapeutic interventions, and evidence-based management of complex health care. It emphasises interdisciplinary collaboration, critical reflection on clinical work, and the application of modern and technological methods in practice.

A core component of the specialisation programme focuses on supporting recovery and working with patients with chronic mental disorders, based on a recovery-oriented model of care and consistent respect for human rights. International documents such as the United Nations Convention on the Rights of Persons with Disabilities (CRPD, UN CRPD, 2006), the WHO QualityRights initiative (Mion & Ventura, 2024), and the WHO Action Plan on Mental Health (World Health Organization, 2021) unequivocally emphasise the right of people with mental health disorders to dignity, autonomy, freedom of choice, and community living. The QualityRights model highlights that institutional culture is often permeated by paternalism, restrictions on decision-making, and the removal of personal control, which is contrary to contemporary human rights standards.

A recovery-oriented approach therefore requires a fundamental shift in the professional attitude of health professionals: the patient is no longer a passive recipient of care, but an equal partner who actively shapes the goals of their own recovery (Jaiswal et al., 2020; Subandi et al., 2023). Recovery is not limited to the stabilisation of symptoms, but involves the re-establishment of identity, social roles, meaning, and quality of life. Such a model presupposes respect for the individual, support for peer advocacy, family involvement, and the systematic measurement of treatment outcomes. This shifts responsibility from the institution to the individual and the community. Only through such an approach is it possible to develop integrated care that coordinates health, social, and community services around the individual's needs, rather than the administrative structures of the system. Otherwise, there remains a risk that institutional culture will maintain control over the individual, rather than enabling genuine recovery and social inclusion.

At a time of growing and increasingly complex mental health needs, health professionals have the opportunity to strengthen their professional roles. Although mental health and psychiatric nursing staff bear a significant share of direct and indirect responsibility for caring for people with mental health problems, national authorities have so far failed to provide tangible solutions in the form of specialist training programmes, while master's degree programmes remain under-recognised and underutilised in clinical settings. Consequently, professional knowledge has developed empirically within individual clinical settings and through the informal transfer of experience from senior to junior professionals.

Such a model uncritically transmits and reinforces existing practices without adequate reflection, while simultaneously reinforcing power relations and deliberately maintaining a paternalistic, institutional culture of care for both patients and health professionals. In this environment, the needs of individuals are often subordinated to the rules and authority of the institution. With the development of specialisation programmes in mental health and psychiatry, both clinical practice and those in need of help can benefit from a new model of care. Scientifically grounded and human rights-oriented education can become a key mechanism for transforming clinical practice. Although changes are likely to be gradual and may encounter resistance from existing structures, education offers significant opportunities to achieve genuine and lasting transformation of institutional culture towards integrated, community-based, person-centred care.

Slovenian translation/Prevod v slovenščino

Duševno zdravje postaja ena ključnih javnozdravstvenih prioritet ne samo v Sloveniji, ampak po vsem svetu, še posebej od pandemije covida-19, ki je pomembno preoblikovala in poslabšala temeljne socialne in ekonomske determinante duševnega zdravja (Clemente-Suárez et al., 2021; Kola et al., 2021; Lange, 2021). Negativne trende v duševnem zdravju razkriva več kazalnikov, ki kažejo na porast težav v duševnem zdravju. V svetovnem merilu sta pomembna dva in sicer »leta življenja, prilagojena invalidnosti« (Disability-Adjusted Life Years – DALY), ki kaže, da je 5 % celotnega svetovnega bremena bolezni povezanega s težavami v duševnem zdravju. Drugi kazalnik so »leta, ki jih posameznik preživi z boleznijo ali zmanjšano funkcionalnostjo« (Years lived with disability – YLD). Ta kaže, da so za kar 15 % vseh let življenja z invalidnostjo vzrok težave v duševnem zdravju (GBD 2019 Mental Disorders Collaborators, 2022).

Slovenija statistično ne samo da sodi med evropske države z najvišjo pojavnostjo depresivnih simptomov med prebivalstvom (La Torre et al., 2021), ampak tudi opažamo hitro rast težav v duševnem zdravju mladih s povečano pojavnostjo depresivnosti, anksioznosti in drugih duševnih težav (Piao et al., 2022; Sacco et al., 2022). Med covidom-19 je bilo na primer stanje duševnega zdravja med mladimi pri nas v primerjavi z

vrstniki v Nemčiji in Poljski obetavnejše, z nižjo stopnjo anksioznosti, depresije in samomorilnimi poskusi, a z visoko zaznano stopnjo stresa (Benatov et al., 2022). Kljub temu pa zdravstvene statistike ne razkrivajo vseh razsežnosti problematike, kot kaže nedavna študija Vinka et al. (2024), ki je razkrila še vedno velik prepad med zaznanimi težavami v duševnem zdravju in evidentiranimi primeri. Poglavitni vzroki za to bi lahko še vedno bili nepravočasno prepoznavanje težav v duševnem zdravju, socialna stigma zaradi duševnih motenj in nedostopnost služb za duševno zdravje (ReNPDZ18–28, 2018; Vinko et al., 2024). Ker gre za znane in ponavljajoče se težave, se kaže jasna potreba po sistemskih rešitvah v skrbi za duševno zdravje na medsektorski ravni s poudarkom na dostopnih programih promocije in preventive ter pravočasnega prepoznavanja težav v duševnem zdravju na individualni ravni.

Slovenski strateški dokumenti na področju duševnega zdravja

Duševno zdravje se ne oblikuje v zdravstvenih ustanovah, temveč v družini, vrtcu, šoli, na delovnem mestu in zdravih lokalnih skupnostih. Trajne in celovite rešitve pri krepitvi in ohranjanju duševnega zdravja tako na individualni kot skupnostni ravni, katerih cilj mora biti preventiva pred kurativo, so uresničljive samo z medsektorskim razvojem in načinom v skrbi za duševno zdravje ter z vključevanjem ne samo zdravstvenih služb, ampak tudi služb na področju izobraževanja, socialnega varstva, kulture, delovnega okolja, lokalnih skupnosti, pravosodja, notranjih zadev in medijev (Van Ginneken & Waitzberg, 2025; WHO/Europe, 2025). Za doseganje teh ciljev je ključna njihova implementacija na državni zakonodajni ravni, ki kot edina lahko doseže vse družbene skupine in sloje.

Prva dejanja v tej smeri je Slovenija naredila leta 2008 s sprejetjem Zakona o duševnem zdravju (ZDZdr, 2008), ki ga je nato nadgradila z Resolucijo o nacionalnem programu duševnega zdravja 2018–2028 (ReNPDZ18–28, 2018). Resolucija je naš prvi dokument s strategijo razvoja na področju skrbi za duševno zdravje, katerega temeljni cilji so krepitev duševnega zdravja prebivalcev Slovenije, preprečevanje duševnih motenj od rojstva do pozne starosti, destigmatizacija in diskriminacija oseb z duševno motnjo ter organiziranje dostopnih služb in storitev na področju duševnega zdravja s pomočjo skupnostnega pristopa v lokalnem okolju (ReNPDZ18–28, 2018). Po zaslugi resolucije Slovenija v zadnjih letih izvaja temeljito preobrazbo organiziranosti služb za duševno zdravje od izrazito konservativnega tipa, ki je temeljil na instituciji in kurativi, k odprtemu tipu s poudarkom na preventivi, s čimer so službe za duševno zdravje uporabnikom postale dostopne tam, kjer živijo. Dostopnost služb in storitev duševnega zdravja se danes tako gradi prek delovanja centrov za duševno zdravje odraslih in centrov za duševno zdravje otrok in mladostnikov ter prek mreže služb za duševno zdravje, ki pa niso le v domeni zdravstvenega sektorja, ampak so vanjo vpete vse družbeno pomembne strukture, ki lahko trajno krepijo, preprečujejo in obravnavajo težave v duševnem zdravju. Kljub tem premikom odgovornost za skrb za duševno zdravje ni in ne sme biti v breme državi in zakonodajalcev.

Družbena odgovornost za skrb za duševno zdravje

Duševno zdravje in odpornost se oblikujeta na podlagi dinamičnih interakcij med biološkimi, psihološkimi in socialnimi dejavniki (Porter, 2020). Ker je njuna zasnova torej biopsihosocialna, je nujno usklajeno delovanje vseh prej naštetih služb od rojstva naprej. Zdravstveni sistem ima pri determinantah duševnega zdravja omejeno in praviloma sekundarno vlogo, saj ima posameznik praviloma stik z njim šele takrat, ko posameznikove stiske presežejo njegove vsakodnevne zmožnosti soočanja, samoregulacije in prilagajanja (Bolton et al., 2023). V izogib institucionalizaciji posameznika s težavami v duševnem zdravju mora biti skrb za duševno zdravje usmerjena v krepitev psihološke odpornosti vsakega posameznika, kar pomeni, da mora družba vlagati prek svojih sistemov v posameznikov duševni oziroma psihološki razvoj od rojstva naprej s poudarkom na čustvenih kompetencah, ustreznih vedenjskih vzorcih, regulacijskih sposobnostih, ustreznih socialnih veščinah, občutku varnosti in pripadnosti itn.

Odmik od kurative k preventivi lahko kot družba osvojimo samo z vlaganjem v duševno zdravje v času odraščanja, zdravega starševstva, izobraževanja itd., kar je predpogoj, da si bo oseba izgradila zdravo identiteto (Castillo et al., 2019; Hoover & Bostic, 2020). Tako opolnomočen posameznik se bo sposoben odporno odzivati na stresne življenjske situacije, zdravstveno obravnavo pa bo iskal le ob visokih obremenitvah. Cilj preventivnega načina pa ne sme voditi v drugo skrajnost, in sicer zanikati potrebo po skrbi za duševno zdravje v institucionalnem okolju.

Razvoj zaposlenih v zdravstveni negi na področju duševnega zdravja in psihiatrije

Ker je kurativa neizbežna, je in vedno bo ključnega pomena v skrbi za duševno zdravje razvoj usposobljenega zdravstvenega kadra na vseh ravneh zdravstvenega varstva. Samo kvalificiran kader lahko zagotavlja visokokakovostno obravnavo ter najvišjo raven strokovne in etične skrbi tako pri manj zahtevnih duševnih stanjih kot tudi pri tistih osebah, ki potrebujejo najzahtevnejše oblike psihiatrične obravnave. Razvoj zaposlenih v zdravstveni negi na področju duševnega zdravja in psihiatrije kot

najštevilnejše skupine zaposlenih v zdravstvenem sistemu je zato postal neizbežna nuja.

Tuje raziskave kažejo, da so zaposleni v zdravstveni negi na področju duševnega zdravja in psihiatrije usposobljeni za preventivo ponovitve duševne motnje (Wazzan et al., 2025) in imajo ključno vlogo pri zgodnjem prepoznavanju, podpori in preventivi preprečitve samomora, depresije in anksioznih motenj (Tamanna, 2024; Tushe, 2024), kljub temu pa so še vedno premalo usposobljeni za izvajanje promocije duševnega zdravja na populacijski ravni (Aguiar et al., 2012). Pri nas dejanske analize usposobljenosti zaposlenih v zdravstveni negi na področju duševnega zdravja in psihiatrije še niso bile izvedene, zato nimamo zanesljivih podatkov o pripravljenosti zaposlenih v zdravstveni negi na delo na področju zdravstvene obravnave, promocije in preventive duševnega zdravja, kar predstavlja resne probleme za načrtovanje kadrovskih ter izobraževalnih politik.

ReNPDZ18–28 (2018), ki se odziva na obstoječo vrzel, med šestimi prednostnimi delovnimi področji poudarja: 1) promocijo duševnega zdravja, preventivo in destigmatizacijo duševnih motenj in 2) izobraževanje, raziskovanje, spremljanje in evalvacijo, da je treba »ustrezna znanja in veščine zagotoviti za vse strokovnjake in strokovne sodelavce, ki se srečujejo z osebami s težavami v duševnem zdravju« (ReNPDZ18–28 2018). Zaposlene v zdravstveni negi neposredno zadeva ukrep o uvedbi dodiplomske smeri izobraževanja na področju zdravstvene nege in socialnega dela oziroma specializaciji s področja duševnega zdravja za zdravstveno nego. Tudi primerjalna analiza izobraževalnih programov Mancheri et al. (2025) kaže, da so številni visokošolski programi še vedno izrazito usmerjeni v zdravljenje in obravnavo že razvite motnje, zato bi morala vsaka reforma izobraževanja na tem področju opredeliti predvsem kompetence za promocijo, preventivo in krepitev duševnega zdravja ter okrepiti praktično in simulacijsko usposabljanje, vključiti vsebine razumevanja razmišljanja javnega duševnega zdravja, vodenja in raziskovanja, razvijati interprofesionalno učenje ter zagotoviti usklajenost z nacionalnimi strateškimi dokumenti.

Področje specializacije, ki ponuja priložnosti spremembe kulture pri obravnavi posameznika s težavami v duševnem zdravju

V Sloveniji smo v letu 2025 tako po več desetletjih prizadevanj na sistemski ravni sprejeli Pravilnik o spremembah Pravilnika o vrstah, vsebini, trajanju in poteku specializacij izvajalcev v dejavnosti zdravstvene in babiške nege (2025) s Programom specializacije s področja duševnega zdravja in psihiatrije v zdravstveni negi, s čimer se prvič formalno vzpostavlja strukturiran način naprednega kliničnega usposabljanja na tem specialističnem področju, kar je pomemben cilj resolucije (ReNPDZ18–28 2018). Namen specializacije je zagotoviti teoretično in klinično usposobljenost zaposlenih v zdravstveni negi za strokovno in avtonomno delovanje na področju duševnega zdravja in psihiatrije. Program bo specializante usposobil za preventivno delovanje, v okrevanje usmerjeno obravnavo, terapevtsko ukrepanje po kliničnih smernicah ter vodenje kompleksne zdravstvene nege na podlagi dokazov. Poudarek je na interdisciplinarnem sodelovanju, kritični refleksiji kliničnega dela ter prenosu sodobnih in tehnoloških načinov v prakso.

Eno ključnih področij specializacije je pomoč pri okrevanju in sodelovanje s pacientom s kronično duševno motnjo, ki temelji na v okrevanje usmerjenem modelu obravnave in doslednem spoštovanju človekovih pravic. Mednarodni dokumenti, kot so Konvencija Združenih narodov o pravicah invalidov (Convention on the Rights of Persons with Disabilities, UN CRPD, 2006), pobuda WHO QualityRights (Mion & Ventura, 2024) in Akcijski načrt SZO za duševno zdravje (World Health Organization, 2021), nedvoumno poudarjajo pravico oseb z duševnimi motnjami do dostojanstva, avtonomije, svobode odločanja in življenja v skupnosti. Model QualityRights posebej opozarja, da je institucionalna kultura pogosto prežeta s paternalizmom, omejevanjem odločanja in odvzemanjem osebnega nadzora, kar je v nasprotju s sodobnimi standardi človekovih pravic.

V okrevanje usmerjen pristop zato zahteva temeljno spremembo strokovne drže zaposlenih v zdravstveni negi: pacient ni več pasivni prejemnik obravnave, temveč enakovreden partner, ki aktivno usmerja cilje lastnega okrevanja (Jaiswal et al., 2020; Subandi et al., 2023). Okrevanje ni reducirano na stabilizacijo simptomov, temveč pomeni ponovno vzpostavitev identitete, socialnih vlog, smisla in kakovosti življenja. Tak model predpostavlja upoštevanje posameznika, podporo vrstniškemu zagovorništvu, vključevanje družine ter sistematično merjenje izidov obravnave. S tem se spreminja težišče odgovornosti od institucije k posamezniku in skupnosti. Le s takim pristopom je mogoče razvijati integrirano oskrbo, ki povezuje zdravstvene, socialne in skupnostne storitve okoli potreb posameznika, ne pa administrativnih struktur sistema. V nasprotnem primeru ostaja tveganje, da institucionalna kultura ohranja nadzor nad posameznikom, namesto da bi mu omogočala resnično okrevanje in socialno vključenost.

V času naraščajočih in vse bolj kompleksnih potreb na področju duševnega zdravja se zaposlenim v zdravstveni negi ponuja priložnost za krepitev njihove strokovne vloge. Čeprav zaposleni v zdravstveni negi na področju duševnega zdravja in psihiatrije nosijo pomemben del neposredne in posredne odgovornosti za obravnavo oseb s težavami v duševnem zdravju, država do zdaj ni ponudila oprijemljivih rešitev v obliki specialističnih izobraževalnih programov, magistrski programi pa so

še vedno premalo prepoznani in v kliničnih okoljih neizkoriščeni. Posledično se je strokovno znanje oblikovalo izkustveno znotraj posameznih kliničnih okolij in skozi neformalni prenos izkušenj od starejših avtoritet na mlajše zaposlene.

Tak model nekritično prenaša in utrjuje obstoječe prakse brez refleksije, hkrati pa utrjuje odnose moči in previdno ter namerno ohranja paternalistično, institucionalno kulturo obravnave tako nad pacienti kot nad zaposlenimi. V takšnem okolju so potrebe posameznika pogosto podrejene pravilom in moči institucije. Z razvojem specializacije na področju duševnega zdravja in psihiatrije se odpira možnost, da obstoječa klinična praksa in osebe, ki potrebujejo pomoč, dobijo priložnost v novem modelu obravnave. Znanstveno utemeljeno in v človekove pravice usmerjeno izobraževanje lahko postane eden ključnih ustrojev preoblikovanja klinične prakse. Spremembe bodo verjetno postopne in bodo naletele na neodobravanje obstoječih struktur, vendar obstaja priložnost, ki jo omogoča izobraževanje, brez katerega ni mogoče pričakovati prave in trajne transformacije institucionalne kulture v smeri integrirane, skupnostne in k posamezniku usmerjene obravnave.

Conflict of interest/Nasprotje interesov

The author confirms that there are no conflict of interest./Avtor izjavlja, da ni nasprotja interesov.

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