European Psychiatric Association (EPA) Report
on
Bulgarian Mental Health Care and Reform Process 2018

The EPA visit to Bulgaria took place from 17-21 July. Programme attached in Appendix 1.

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1. Executive Summary

Background

Mental Health care services in Bulgaria, by common consensus amongst the Ministry of Health, the Bulgarian Psychiatric Association, medical, nursing and other staff, and patients and families, are currently in an unsatisfactory situation and there is a pressing need for reform.

Attempts at reform have stalled due to the complexity of funding arrangements and divergent stakeholder opinions.

There have been two previous WHO missions to advise the government on recommended changes, but these have not led to successful reforms.

The European Psychiatric Association (EPA) was invited in 2018 to send an official team to visit and review mental health services in Bulgaria and advise the Ministry of Health regarding expert recommendations for change needed. The aim of this visit was to provide recommendations to help achieve more consensus and importantly to allow much needed reforms in mental health services to be delivered.

The EPA Panel has consulted widely with stakeholders, policymakers and politicians, visited a range of Bulgarian mental health services, and taken note of written information and previous recommendations.

Information and Documents considered by the EPA Advisory Panel

The EPA Panel considered a wide range of documents and met with many stakeholders, including a panel discussion with more than 20 participants representing most of the Bulgarian mental health stakeholder groups. Full details are listed in Section 3 of this Report.

Summary of the information collected regarding Bulgarian Mental Health Services

Very detailed information was collected and considered under the following headings:

- History of the Bulgarian Mental Health Services: This section provides a broad overview of how services developed and were distributed historically in Bulgaria
- Legal and Policy framework: A brief outline of the evolution and development of current legislation including a summary of key points is included.
- Infrastructure: The nature, extent and services provided in Bulgaria is described, highlighting some of the known challenges (underfunding, lack of provision, geographic location, separation from other medical specialties). Trends in service provision and delivery are also included.
- Workforce: Workforce issues are highlighted, including staff numbers (low by European standards), "brain drain" by emigration, the aging workforce, poor morale, inadequate training programmes, and a lack of strategic national planning.
- Child Psychiatry: This section acknowledges the severe shortage of staff, facilities, training, and treatment in this field.

- Forensic Psychiatry: This section also notes the severe shortage of staff, facilities, training and treatment in this sub-specialty.
- Social Services: The fact that social services are the responsibility of the Ministry of Social Affairs and that there is no effective collaboration with the Ministry of Health regarding the provision of services for people with mental health problems is described.
- Financial resources and Funding: This section notes the challenges of the current funding systems in operation that were identified, including chronic underfunding, confusion regarding the rules, and divided responsibilities. Underinvestment in mental health services is causing significant financial harm to the Bulgarian economy due to both the increased costs of treatment and the loss of economic productivity.
- Site visits in Bulgaria: The Panel was able to visit State Hospital, Mental Health Centre, University Clinic and NGO services in and around Sofia which added to our understanding of the challenges faced in the Bulgarian mental health system.

Challenges and Issues for Bulgarian Mental Health Service Delivery

Human rights violations: The Panel encountered conditions detailed in the main Report below that appear to be in breach of European law (Article 3 of the European Convention on Human Rights) and the United Nations Convention on the Rights of Persons with Disabilities.

Unacceptable conditions: In addition, the panel noted that as a result of chronic underfunding there were unacceptable conditions in many of the facilities visited. Examples included very poor built environments in some, lack of adequate staffing, lack of therapeutic activity, overcrowding, lack of national strategic planning, fragmentation of services, lack of quality control and outcome monitoring, and lack of joined-up working including between the Ministries of Health and Social Affairs that is a particular impediment for achieving timely discharge for many patients who require longer term support in the community and/or supported accommodation.

Lack of joined-up planning and accountability: The EPA Panel found that this is a pervasive problem across the whole mental health care system that has contributed to the current impasse with stakeholders locked in disagreements with one another, with high levels of mutual mistrust.

Staff issues: There are significant workforce issues including inadequate numbers of clinical staff, loss of staff due to emigration, and an aging workforce, lack of investment in training, poor morale and unequal distribution of staff. Salaries are too low, leading to perverse incentives to seek other income sources.

Financial issues: There is longstanding major underinvestment and underfunding in Bulgarian mental health services, especially compared to other medical specialties. Any improvement or meaningful reform will require more investment. However, the economic benefit of reform to Bulgarian society should be considerable with more people off disability benefits, in employment and requiring lower overall healthcare costs. Existing funding mechanisms are not sufficiently coordinated and are complex and confusing. A disproportionate number of people with mental health problems are not covered by the National Health Insurance Fund, which in turn does not pay for many psychiatric investigations and treatments.

Division and lack of consensus amongst Stakeholders: The fragmented and chaotic nature of Bulgarian mental health services is reflected in deep divisions and lack of consensus amongst stakeholders. This is a significant impediment to change, and might contribute to delay, if not avoidance of necessary change. However, the Panel noted that there appears to be consensus regarding the nature of the current challenges faced, and hence the need for change.

Negative public attitudes towards changes in mental health care organization reported as a good reason to avoid change: The Panel was frequently informed that negative public attitudes have prevented or will prevent change, and in particular are an obstacle to establishing community based mental health services. The EPA Panel wishes to challenge this perception. The Global Initiative on Psychiatry has established and runs a successful community-based service and has been able to easily deal with this and has not encountered major difficulty from the local residents or general public.

The Bulgarian Government's "Action plan – National Strategy for Long-Term Care": The EPA Panel is concerned that there may be insufficient recognition of the financial benefit to the country as a whole of investing in mental health services, and the amount of additional investment required including into preventative services.

Marginalisation of Psychiatry as a Medical Specialty:
Psychiatry and psychiatric services are significantly underfunded compared to other medical specialties, often located far away from other medical specialties and are subject to discrimination and complacency including from the authorities regarding all of this.

Recommendations

This EPA Panel Report makes twenty recommendations regarding proposed changes and reforms:

1. **Appoint a national Clinical Leader with executive operational responsibility and decision-making authority for the change programme. The Clinical Leader should be appointed jointly by the Ministries of Health and of Social Affairs and should report directly to the two Ministers.**

2. **Appoint a national Task Force chaired by this national Clinical Leader to advise, lead and implement the change programme.**

3. **Allocate 10% of the health budget to mental health.**

4. **Increase salaries for clinically qualified staff working in mental health care settings; attract trainees and favour the return of those who emigrated to work in more attractive settings.**

5. **Counteract by appropriate campaigns and initiatives the fear that the reform will translate into further reduction of resources allocated to mental health including inappropriate closure of inpatient beds.**

6. **Avoid any attempt to import models wholesale from outside; tailor the development of a more community-based mental health system to the specific context of Bulgaria and make full use of local strengths and experience.**

7. **Implement national action plans to eliminate discrimination and improve attitudes towards people with mental disorders; and improve the image of psychiatrists and the whole mental health workforce.**

8. **Involve patient and family associations; alongside and together with scientific and professional organisations in planning and implementing the different steps of the reform process.**

9. **Establish a collaborative and effective working relationship between the Ministry of Health (MoH) and the Ministry of Social Affairs (MoSA).**

10. **Implement training programmes for existing staff to enhance skills and improve morale, and support best clinical practice including by older staff. Do not accept poor practice, implement a performance management processes to improve practice and, if needed, replace ineffective staff.**

11. **Improve education and training in psychotherapy and psychosocial interventions.**

12. **Improve education and training and significantly increase the number of trainees in all psychiatric specialties including child psychiatry and forensic psychiatry.**

13. **Plan the implementation and coordination of a realistic spectrum of mental health services responsive to population needs.**

14. **Develop and implement the action plan for reform of mental health services in such a way that it can be delivered in a step by step manner based on clinical priority and available resources. First in the priority list must be complete reprovision and relocation of services with severe human rights violations.**

15. **Define and monitor strict criteria for involuntary treatment and supported decision making.**

16. **Provide different but equally humane and high-quality care settings for all patients with mental illness, including old age and child psychiatry, addiction disorders, intellectual disability and forensic psychiatry that are located so as to maximise ease of access for patients and families.**

17. **Define and require an evidence-based method to measure the quality of services and the outcomes of the reprovision program at the service (e.g. lengths of stay, costs of care, service quality) and patient level (e.g. recovery, patient satisfaction, markers of social inclusion). The use of existing standardised quality assessment tools is encouraged (such as the Quality Indicator for Rehabilitative Care which is already translated into Bulgarian and the WHO Quality Rights toolkit).**

18. **Implement an official and publicly accessible (digital) data platform of relevant and up-to-date quality indicators, compliant with European data protection legislation for surveying, planning and monitoring the status and progress of the mental health care reforms.**

19. **Implement an external independent review process to regularly assess progress in implementing change in Bulgarian Mental Health Services.**

20. **Stimulate and fund research for evidence-based evaluation of implementation, maintenance, adoption and further development of the reform process.**

2. Background

2.1 Background and Aims

Mental Health care services in Bulgaria, by common consensus amongst the Ministry of Health, the Bulgarian Psychiatric Association, medical, nursing and other staff, and patients and families, are currently in an unsatisfactory situation and there is a pressing need for reform. Health Reform implemented by the government in 2000 has not led to significant improvement in mental health services.

Achieving reform has been challenging due to divergent opinions within Bulgaria among experts, the Bulgarian Psychiatric Association, the College of Private Psychiatry of Bulgaria and other stakeholders.

A need for external advice has long been felt, and previous advisory reports were commissioned from the World Health Organisation (WHO) Europe and delivered following visits in 2015 (Matt Muijen) and again in April 2018 (Dan Chisholm). These have not led to significant change, apparently because of the complex nature of the challenges involved in reform process.

The European Psychiatric Association (EPA) was invited in 2018 to send an official team to visit and review mental health services in Bulgaria and advise the Ministry of Health regarding our recommendations for change needed. The aim of this visit was to provide recommendations that will allow much needed reforms in mental health services to be delivered and to help achieve more consensus regarding the reforms required.

Bulgaria is a large country of around 7 million inhabitants with a land area of 110,879 km^2 that is divided into six main administrative districts. The official language is Bulgarian, written language uses the Cyrillic script. The ethnicity of the population is about 85% Bulgarian, 9% Turkish and 5% Roma. Bulgaria ranks about 75th in the world by per capita GDP and the currency is the Lev (BGN).

Bulgaria has undergone a number of very significant political and social changes over the past 100 years that has also impacted on the delivery of mental health care including:

- 1878 - 1951 saw the establishment of the modern Bulgarian state culminating in the advent of communist rule
- 1951 - 1974 the period of communism prior to the adoption of the General Law on Public Health
- 1974 - 2005 the period under the Peoples' Health Act included the fall of communism in 1991 and the subsequent democratic governments
- 2005 onwards included implementation of the Health Act 2005 and joining the European Union in 2007
- In 2013 guardianship for people with disabilities was ended, in line with article 12 of the United Nations Convention on the Rights of Persons with Disabilities (Legal World, 2013)

2.2. Methodology

Methodology followed by the EPA Panel in preparing this report included as follows:

- informal discussions between the EPA President and key Bulgarian stakeholders
- a letter from Prof Hinkov (advisor to the Ministry of Health)
- appointment of the EPA Advisory Panel members
- approval by the EPA Board
- approval of a formal contract
- definition of a visit itinerary
- visits to a range of Bulgarian mental health service settings (Appendix 1)
- discussions both formally and informally with a wide range of stakeholders in the Bulgarian mental health system including the Deputy Minister of Health, National Advisors to the Ministry, National Centre for Public Health and Analyses, World Health Organisation, Bulgarian Psychiatric Association, College of Private Psychiatry of Bulgaria, University Professors, Global Initiative for Psychiatry; and psychiatrists, psychiatrists in training, nursing staff, occupational therapists, social workers, support workers and patients from State Psychiatric Hospitals (SPHs), Mental Health Centres (MHCs), University Psychiatric Clinics and non-governmental organisations
- writing and approving this report within EPA

3. Information and Documents considered by the EPA Advisory Panel

Mental health legislation in Bulgaria - A brief overview
(Hristo Hinkov BJPsych International 13:4; p92-3 November 2016)

European Psychiatric Association Procedure of Observation and Evaluation System of Mental

Health Services in Bulgaria: Self Evaluation Report

WHO Brief Assessment of Bulgarian Mental Health Services 28-29 January 2015

WHO Brief Assessment of the Bulgarian Mental Health System: April 2018

Republic of Bulgaria: "National Strategy for Long-Term Care 2017"

Republic of Bulgaria: "Action Plan for the period 2018-2021for the Implementation of the National Strategy for Long-Term Care"

Mental Health Services in Bulgaria (presentation by Dr Vladimir Nakov) 2018

Data on income, expenditures, activities and economic indicators in Bulgarian mental health services - Bulgarian National Centre for Public Health and Analyses 2018

Visits to a number of mental health services and centres in Bulgaria:

- Mental Health Centre "Sofia County"
- University Hospital "Älexsandrovska"
- National Centre for Public Health Analyses
- State Psychiatric Hospital "St. Ivan Rilski"
- University Psychiatric Hospital "St. Naum"
- Daily Centre "Slatina"

Interviews and conversations with staff and patients during the course of our visits.

Meeting with the Deputy Minister for Health Svetlana Yordanova at the Ministry for Health

4. Summary of the information collected regarding Bulgarian Mental Health Services

4.1. History of Bulgarian Mental Health Services

The tradition of mental health services in Bulgaria stretches back in written records for almost a whole millennium to the foundation in 1084 of a refuge for mentally ill people in the Bachkovo Monastery.

In more modern times, 800 years later in 1884, the Alexandrovska Hospital in Sofia began to also admit mentally ill patients.

The first dedicated psychiatric ward was opened in January 1888 by the psychiatrists N. Moskov, B. Chakalov, G. Paiakov and D. Vladov, leading to the founding of psychiatry and psychiatric care as a medical specialty in Bulgaria.

A short while later the first known female psychiatrist in Bulgaria, Anastasia Golovina opened a psychiatric ward in Stalin/Varna and moved in 1895 to the Petropavlovski Monastery.

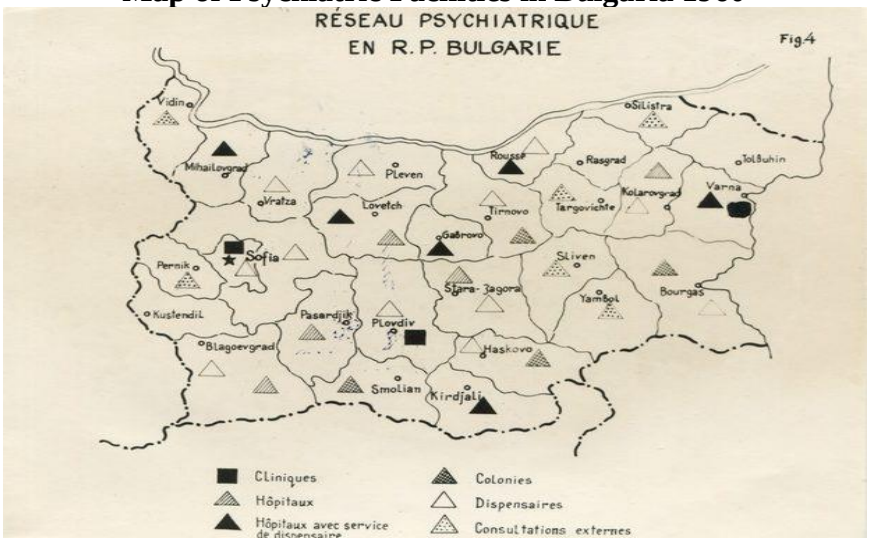
In 1894 the Lovech ward was opened in a specially constructed building, and in 1933 a new building for mentally ill prisoners was opened in its yard.

Rapid expansion in facilities followed over the next few decades leading to the founding of the Medical Faculty in Sofia in 1918 and the opening of a separate Department of Neurology and Psychiatry in 1926.

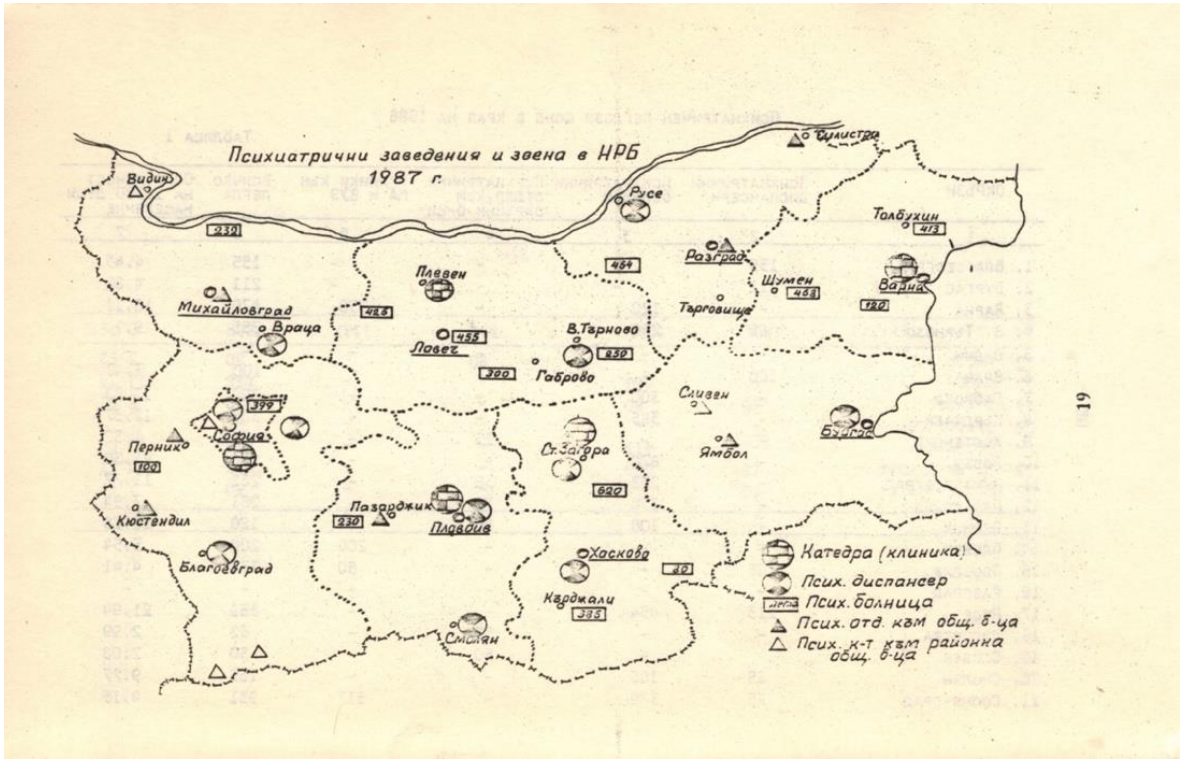
In 1914, Dr Stefan Danadzhiev in *"Hospitals for mentally ill persons in abroad and at home."* wrote that:

> *"The existing two psychiatric wards in Sofia and Lovech, apart from being too small, do not meet the modern requirements of psychiatric science. These words especially apply to the psychiatric ward of the Alexandrovska Hospital, which, as a normal building, does not meet the most elementary conditions of hygiene."*

Map of Psychiatric Facilities in Bulgaria 1960

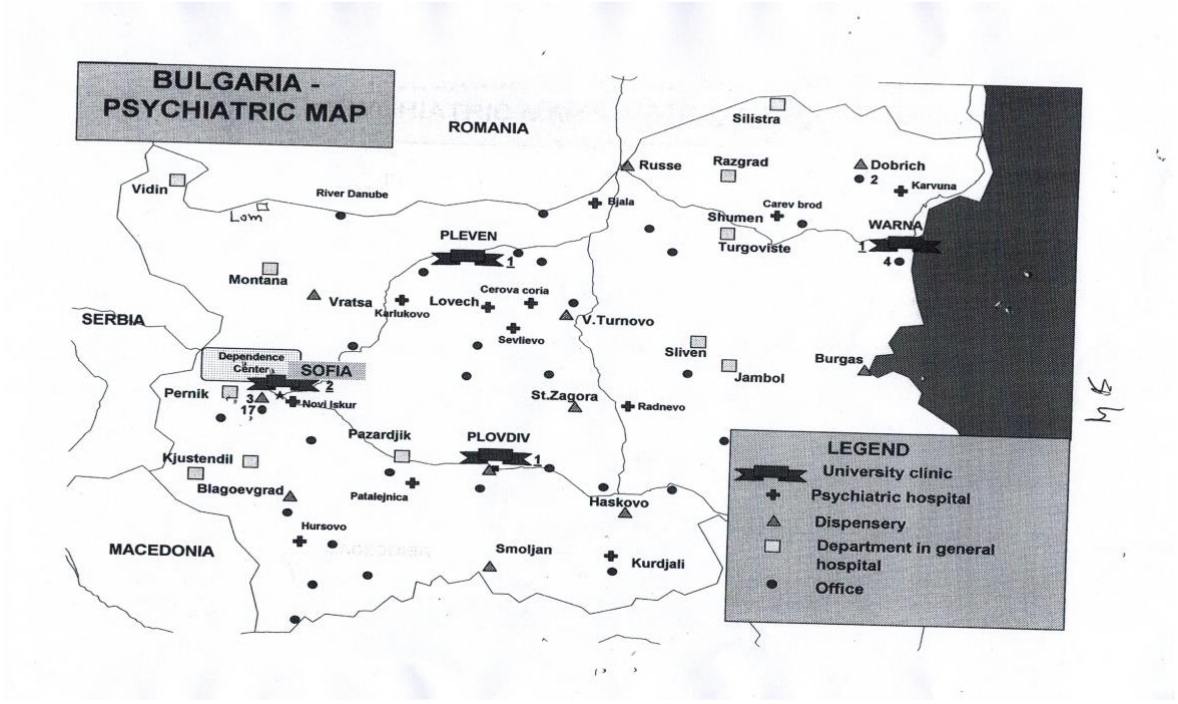


Map of Psychiatric Facilities in Bulgaria 1987



Neurological, psychiatric and neurosurgical care in the People's Republic of Bulgaria in 1986 and 1987. N. Beshkov, K. Milenkov, Sofia, 1989

Map of Psychiatric Facilities in Bulgaria 2000



4.2. Legal and Policy framework

Legislation impacting on mentally ill people dates back to at least 1905 in Bulgaria. However, the main Bulgarian laws now in force date back to the 1960s and 1970s. They correspond to the social and legal doctrines prevailing at that time in the country. Bulgarian psychiatric legislation as a whole essentially followed the European tradition up until that time.

A new era of discussion around mental health legislation was triggered by the EU accession process from 2001 onwards. This included especially the need for improved safeguards for detained patients. There had never been separate mental health legislation, with the older Peoples' Health Act and the subsequent 2005 Health Act (in a separate chapter) both incorporating provisions relating to mental health issues.

Health reforms started in Bulgaria in 2000 established new relationships in the healthcare system and introduced market elements in improving patient care, though to a great extent largely mediated through the new health insurance system. In psychiatry, the new conditions benefited mainly those working in outpatient care, where the processes of market service delivery and decentralization were the same as in most other medical disciplines.

However, psychiatry in hospital inpatient settings remained outside of these processes and thus largely maintained its institutional character. The lack of funding and managerial will to implement the objectives set out in a number of strategic and policy documents appears to have led to distortions and inequality in mental health services. As a result, the principles of continuity of care, comprehensive service provision and ongoing supportive care have been difficult to deliver.

The Health Act is in force since January 2005 and governs much of the public health issues that are not covered by the Acts for Medical Facilities and Health Insurance.

Mental Health is regulated in Chapter Five of that Act with two sections: the protection of mental health and involuntary commitment and treatment. Article 145 describes the institutions and organizations that have responsibilities to protect mental health. Article 146 defines persons with mental disorders who need special care:

- persons with severe mental disorders and severe personality disorders
- individuals with developmental retardation and / or intellectual deficit due to degenerative changes in the brain

The Act explicitly states that these persons are entitled to treatment and care equal with the conditions for patients with other diseases.

There is an important text in the Article 147, paragraph 2, which states that the assessment of the presence of a mental disorder cannot be based on family or professional conflicts, or awareness of a previous mental disorder.

Article 147 (in force since 2009) mandates the Ministry of Health to maintain a register for persons with mental disorders. The register is for use in assessing fitness to carry a weapon or handling of hazardous materials. The Panel was informed that a separate ordinance to detail this requirement and limit any possible abuse and violation of privacy rights of patients is currently under discussion.

The next articles in this section govern the basic principles for treatment of persons with mental disorders, de-institutionalization, re-socialization, combating stigma, and civil society involvement. Services and facilities responsible for the treatment of these persons, the forms and methods of treatment, occupational therapy and other forms of psychosocial rehabilitation and necessary restrictive measures are also defined. The last two articles in this section describe emergency psychiatric care and criteria for temporary treatment in emergency circumstances (no more than 24 hours; and with some exceptions for up to 72 hours).

The second section deals with compulsory treatment which may apply to:

> *"persons with severe mental and / or personality disorders or severe intellectual deficit who, due to their illness may commit an offence, endanger the health of their relatives, families, neighbours and society and/or their own health"* (Art 155 of the Health Act).

Detention and placement may be authorised by the district court and takes place in all types of psychiatric hospitals as well as outpatient medical establishments. A request for compulsory treatment is made by a public prosecutor and the head of the local psychiatric hospital (usually a psychiatrist) in cases of emergency admission (Art. 154 (3) of the Health Act).

The person has the right to object within 7 days except in an emergency. Participation of a legal representative for the patient, a psychiatrist and a prosecutor are obligatory in all stages of the procedure (Art 158 (4) of the Health Act).

The court may order a forensic psychiatric examination for a period not longer than 14 days (exceptionally 24 days). The court may dismiss the case if there is no evidence of an emergency or if psychiatric opinion suggests absence of any mental disorder. This differs from pre-2005 where there was no right of appeal, and the detention was authorised by a prosecutor rather than a court.

Art. 160 Paragraph 1 explicitly states that during the initial assessment no treatment should be administered except in case of emergency or with informed consent. In cases when this capacity is disturbed, a patient's representative may give consent where the patient lacks capacity, which is another change from pre-2005 legislation.

The court determines the form of compulsory treatment - inpatient or outpatient, and the duration of treatment. The medical treatment is decided by the psychiatrist in the hospital. The court reviews the detention every three months and may extend this if needed.

Compulsory outpatient treatment is used less frequently due for example to the living circumstances of the patient or the burden on the family.

Persons placed on compulsory treatment as a percentage of the total number of hospitalized patients in psychiatric hospitals is between 3-5% according reports from human rights organizations. The Panel understands that there is a trend towards a slight increase in detentions.

Forensic cases: The court may order compulsory treatment in an ordinary psychiatric hospital or a specialized hospital with increased oversight where individuals have committed criminal offences due to mental disorder or because some form of dependence (Art. 89 and Art. 92 of the Penalty Code).

In these cases, application for compulsory treatment is made by a prosecutor, after expert assessment (Art. 427 of the Criminal Procedure Code). The subsequent procedure is identical to that for civil compulsory treatment, except that the term is 6 months compulsory treatment, after which the court may suspend or replace the form of the treatment with another measure.

In cases of crime due to drug or alcohol dependency, the court may order compulsory treatment alongside the criminal term. In such cases, involuntary treatment carried out during the period of criminal sentence will be deducted from the term of imprisonment.

Guardianship: Article 5 of the Law of Persons and the Family provides for full and partial guardianship for persons with mental disorders or intellectual deficits that cannot care for themselves and are incapacitated. The procedure for placing a person under full or partial guardianship is described in the Code of Civil Procedure (Art. 336-340). The procedure for the appointment of a guardian is set out in the Family Code (Art. 153 -174).

According to the National Database "Population" in June 2012 there were 6249 persons under full guardianship and 791 under partial guardianship in Bulgaria. Data from the Agency for Social Assistance show that 3679 of these individuals are in social services residential care for children and adults.

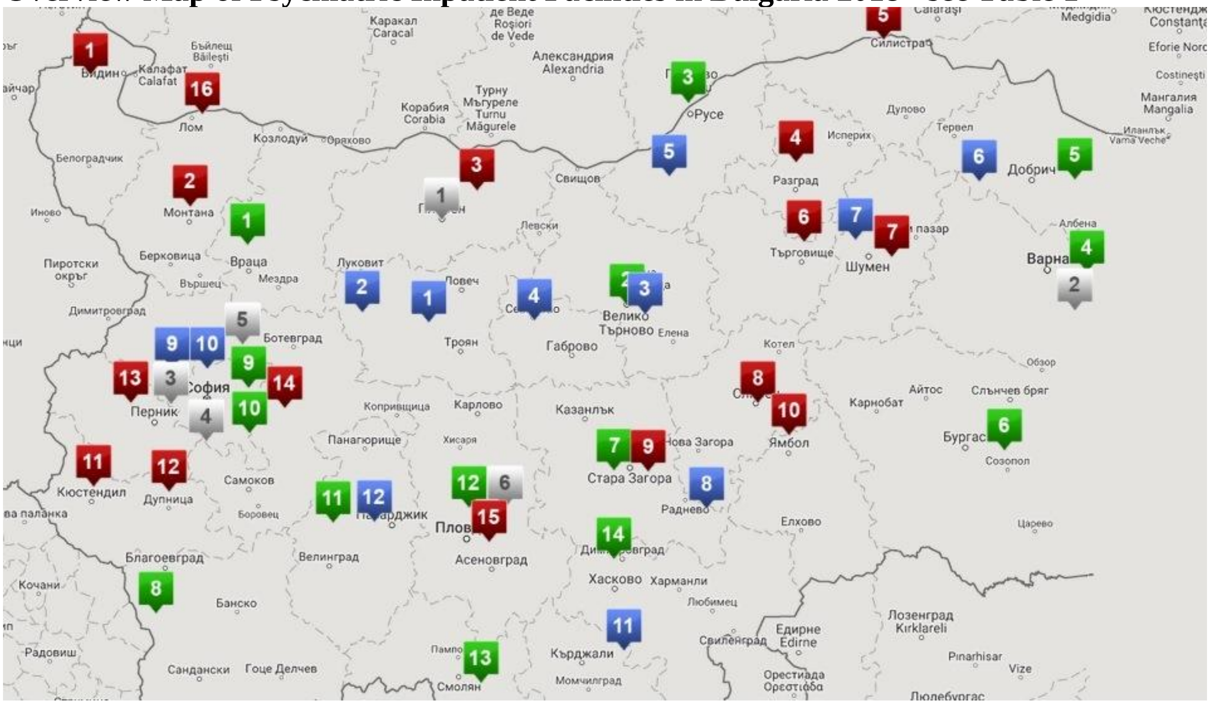
4.3. Infrastructure

There are approximately 68 psychiatric beds per 100 000 population in Bulgaria - roughly the European average, but the service is mainly oriented towards inpatient care with just over 9 beds per psychiatrist which is towards the higher end of European ratios. Eurostat 2015

The Panel understands that there is no national policy regarding admission criteria to the different mental health inpatient facilities, but that the case-mix is comprised largely of people with severe psychoses or severe affective disorders and also some severe addiction disorders.

The Panel was informed that the majority of inpatients are admitted on a voluntary basis, but was unable to obtain data regarding the legal basis for admission.

Overview Map of Psychiatric Inpatient Facilities in Bulgaria 2018 - see Table 1



Annual Regional Health Inspectorate data. NCPHA database

State Psychiatric Hospital | Mental Health Centres | Psychiatry ward in General Hospital | University Psychiatric Clinic

State Psychiatric Hospitals:

There are currently12 state psychiatric hospitals with 2 225 beds and 128 places for day care. Although these are located across Bulgaria, the distribution is not always directly related to local need and has been influenced by historical factors. The number of beds ranges from 40 to 510 per hospital with a median of 170.

State Psychiatric Hospitals are described in the Bulgaria Self Evaluation Report as follows:

> *" State-owned psychiatric hospitals are of an institutional-sheltered type. The territorial distribution of these structures is irregular across the country and does not take into account migration processes that have occurred during the last decade as well as changed socio-economic relations. Most of the hospitals are built on the basis of the isolation principle, typical of the 1950s. The location of these institutions outside the community does not comply with the administrative division of the country and does not follow the naturally created healthcare areas. As a result, the sick, accommodated and treated in these settings, are often at a significant distance from their home, which violates the relationship with their relatives and prevents their resocialization. Hospitals serve several areas, making it difficult to manage and finance them effectively."*

The Self Evaluation Report goes on to state:

> *" The conditions of accommodation and treatment in these facilities are different, but as a whole extremely poor do not meet the requirements for modern services. The building infrastructure of the hospitals is different, but it does not generally take into account the specific needs of the patients accommodated in these establishments."*

The Self Evaluation Report states further:

> *" It should be noted that in all SPHs in the country there are dozens of patients who are not on active treatment and are not discharged. In this way, hospitals are also forced to take on the role of homes for people with mental disorders, a practice that has existed for decades."*

The Panel understands that there have been relatively recent changes in some funding via the Social Assistance Act that are aimed at providing psychosocial rehabilitation for some patients, but that implementation has been very problematic with wide variability in services provided.

Mental Health Centres:

There are currently 12 Mental Health Centres with 1 032 beds and 564 places for day care. Although these are located across Bulgaria, the distribution is not always directly related to local need and has been influenced by historical factors. The number of beds ranges from 40 to 250 per centre with a median of 105.

Mental Health Centres are described in the Self Evaluation Report as follows:

> *"The mental health centres are former psychiatric dispensaries. Above all, psychiatric dispensaries are structured to provide the transition from institutional to outpatient treatment of mentally ill. Until the end of the last century, their activity was limited to the distribution of patients from the community to the institution, maintenance of information basis for the serviced persons from a certain area and provision of out-patient activities. The psychiatric dispensaries were part of the dispensary-hospital complex, which was a basic structural unit of the institutional post-Soviet model. The healthcare reform has given diverse legal status to the healthcare institutions in the country, different forms of ownership and financial management, which led to the dismantling of the dispensary-hospital model. After the decentralization of outpatient care, a large part of the outpatient counselling functions of dispensaries were assumed by private psychiatric offices. Therefore, presumably outpatient mental health centres were transformed into hybrid hospital/outpatient services with unstable legal and economical statute."*

The Panel struggled to develop a clear understanding of the patient pathway through the State Psychiatric Hospitals and the Mental Health Centres. We were given differing explanations by different psychiatrists and were left with the impression that this may well reflect confusion regarding the patient pathway on the part of local stakeholders.

Psychiatry Wards in General Hospitals:

There are currently 16 psychiatric wards in general hospitals with 425 beds and 48 places for day care. Although these are located across Bulgaria, the distribution is not always directly related to local need and has been influenced by historical factors. The number of beds ranges from 10 to 79 per hospital with a median of 23.

The Panel were informed that these wards were seen as a burden by General Hospital administrators due to the funding arrangements for mental health care resulting in comparatively much lower income versus other medical specialty wards. We were informed that this made it difficult to deliver high quality care and also very hard to commission new units.

University Psychiatry Clinics:

There are currently six University psychiatric clinics with 375 beds and 168 places for day care. Although these are located across Bulgaria, the distribution is not always directly related to local need and has been influenced by historical factors. The number of beds ranges from 35 to 199 per hospital with a median of 76.

The Panel noted that the standard of these facilities was much better than the SPHs and MHCs, and that there had often been significant external funding from the EU or NGOs for building the facilities. The Panel was informed of a perception that the University Clinics "cherry picked" or chose their patients; however, we saw no evidence of this, and case mix that we saw appeared similar to those in other types of unit.

Outpatient and Other facilities:

Some outpatient services are run by the State Psychiatric Hospitals, Mental Health Centres and University Psychiatric Clinics. These do not appear to be run according to a national policy or consistent plan, with evidence of great variability in availability, form, reimbursement and service provision - see Table 2.

Outpatient psychiatric care forms a significant component of mental health care delivery in Bulgaria. Funding is by direct payment or by National Health Insurance Fund reimbursement based on single patient consultation (approximately 9 Euros per patient) without consideration of procedures performed by the specialist (such as diagnostic tests, psychological counselling, psychotherapy etc).

There are some other facilities run and funded by non-governmental organisations such as the Global Initiative on Psychiatry in Sofia. There is also a significant psychiatric private sector providing mainly out-patient services. There are a small number of psychiatric beds in other “closed" institutions such as the Psychiatric Clinic at the Military Medical Academy and the Psychiatric Department at the Medical Institute of Ministry of Interior which are not representative of the system.

Table 1: Inpatient Beds by psychiatric specialty:

Beds in psychiatric establishments, clinics and wards by 31.12.[1)]					
Type of beds	**2012**	**2013**	**2014**	**2015**	**2016**
Total	**4 735**	**4 824**	**4 848**	**4 959**	**4057**
For narcology and Intensive Care	-	-	-	-	-
For active/long-term treatment [3)]	4 088	4 051	3 989	4 041	4057
Including: General psychiatric	3 633	3 704	3 661	3 713	3761
Child and adolescent	68	43	34	34	32
Narcological	162	164	154	154	129
Gerontological	120	115	115	115	115
Others	105	25	25	25	-
Forensic-psychiatric	60	60	60	20	20
Day stationary	587	713	799	898	908[2)]
	Psychiatric hospitals				
Total	**2 438**	**2 413**	**2 393**	**2 383**	**2225**
For narcology and intensive care[3)]	2 258	2 238	2 214	2 247	2225
Incl.: General psychiatric	1 963	2 038	2 024	2 057	2060
Narcological / addiction	110	110	100	100	75
Gerontological	95	90	90	90	90
Others	90	-	-	-	-
Forensic-psychiatric	40	40	40	-	-
Day hospital	140	135	139	136	128[2)]
	Mental Health Centres				
Total	**1 358**	**1 480**	**1 506**	**1 585**	**1032**
For active/long-term treatment[3)]	1 044	1 037	1 042	1 047	1032
Incl.: General psychiatric	984	990	995	1 000	1010
Child and adolescent	25	-	-	-	-
Narcological / addiction	20	22	22	22	22
Others	15	25	25	25	-
Day hospital	314	443	464	538	564[2)]
	Psychiatric clinics				
Total	**469**	**479**	**519**	**534**	**375**
For active/long-term treatment[3)]	341	349	341	343	375
Incl.: General psychiatric	243	251	252	254	266
Child and adolescent	41	41	32	32	32
Narcological / addiction	32	32	32	32	32
Gerontological	25	25	25	25	25
Others	-	-	-	-	-
Forensic-psychiatric	20	20	20	20	20
Day hospital	108	110	158	171	168[2)]
	Psychiatric wards				
Total	**470**	**452**	**430**	**457**	**425**
For active/long-term treatment[3)]	445	427	392	404	425
Incl.: General psychiatric	443	425	390	402	425
Child and adolescent	2	2	2	2	-
Day hospital	25	25	38	53	48[2)]

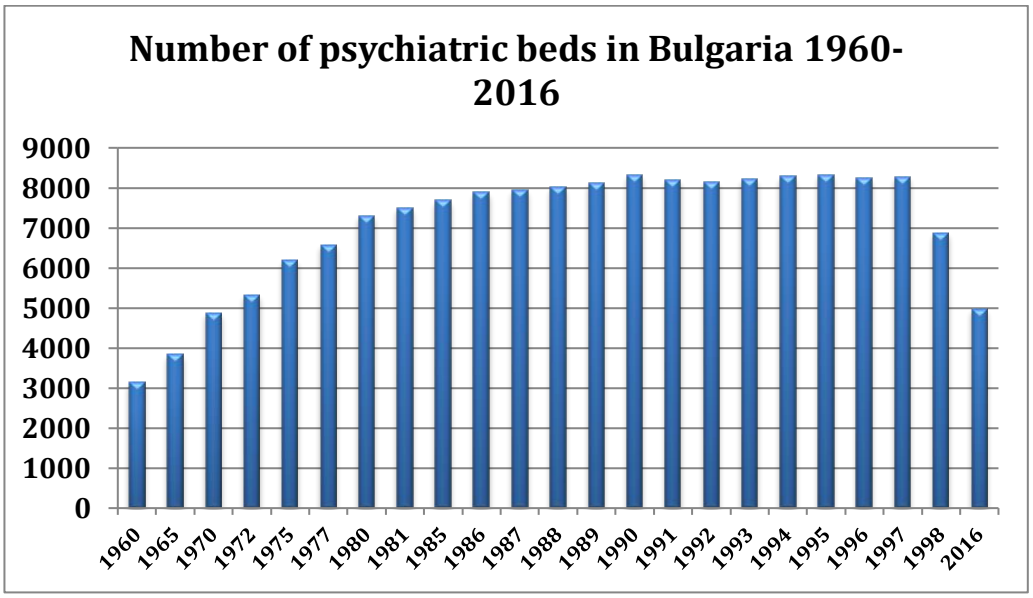
[1)] Incl. covered medical establishments to other institutions

[2)] In 2016, in accordance with the amendments to Ordinance 49 of the Ministry of Health dated 2010, apart from hospital beds, places for short stay are also separately reported.

[3)] For 2016. - for active treatment/long-term care.

Trend in bed numbers:

There has been a 40% reduction in the number of inpatient psychiatric beds in Bulgaria within the past 20 years leading to the current state of approximately European average bed numbers per 100 000 population. This does not appear to have been accompanied by an increased investment in ambulatory / outpatient mental health services.



The panel noted that there has been an overall decrease in the population of Bulgaria since joining the European Union, but there had nonetheless been a disproportionate decrease in the number of psychiatric beds per 10 000 population over the past two decades.

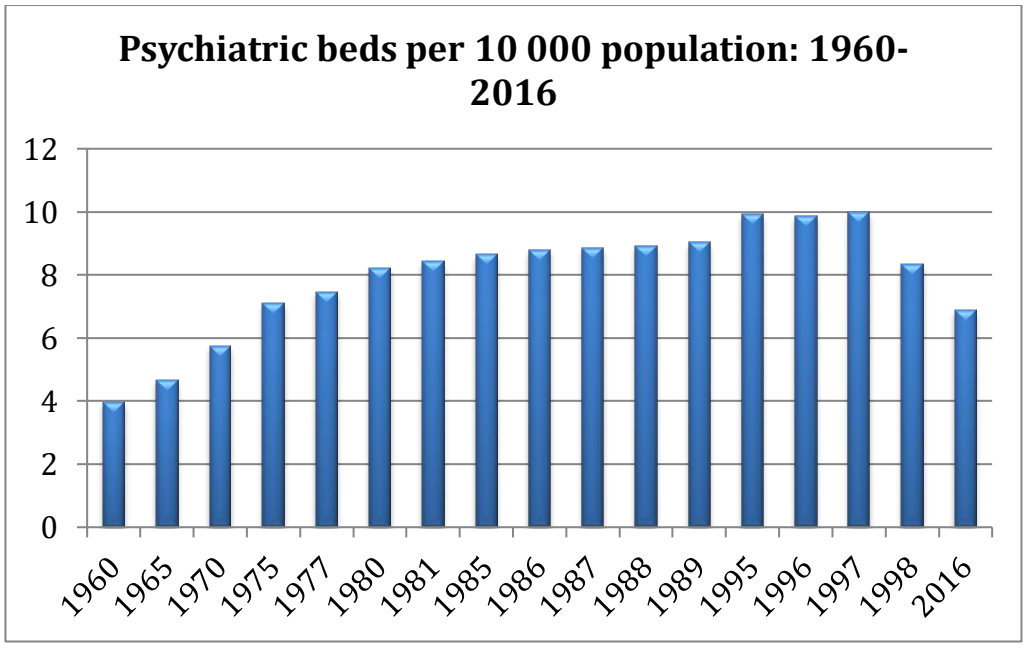


Table 2: Outpatient activity

Outpatient activity in psychiatric institutions, clinics, wards, offices and stationaries

Number

	2012			2013			2014			2015			2016		
	Visits	Including:		Visits	Including:		Visits	Including:		Visits	Including:		Visits	Including::	
		ildren under 1	prophylactic		hildren under 1	prophylactic		children under 17	prophylactic		children under 17	prophylactic		ildren under	prophylactic
	Total														
Psychiatrists	**614533**	**21297**	**11925**	**564598**	**25141**	**76258**	**519706**	**25385**	**65832**	**566124**	**20935**	**86328**	**533518**	**16242**	**86926**
Child	10491	9173	1151	8211	6532	862	18155	6633	1541	8200	4914	1603	8506	6185	2044
Forensic	3944	26	1915	3155	4	1452	3722	-	1109	3290	54	1587	6247	15	-
Narcologists	17112	246	411	17428	48	607	15591	29	-	30992	41	-	10571	-	-
	Including;														
	Psychiatric hospitals														
Psychiatrists	**28085**	**773**	**16496**	**29469**	**554**	**11841**	**27741**	**423**	**11179**	**27326**	**278**	**12208**	**28375**	**134**	**13000**
Child	171	-	-	273	-	-	175	-	-	73	-	-	8	-	-
Forensic	110	-	-	179	-	-	157	-	-	168	-	-	2035	-	-
Narcologists	4820	236	-	4807	47	-	3899	29	-	10326	41	-	2350	-	-
	Mental Health Centers														
Psychiatrists	**185854**	**6770**	**75988**	**140228**	**5706**	**50598**	**123675**	**4450**	**38939**	**150535**	**4272**	**59681**	**147068**	**3696**	**60007**
Child	7333	6186	1151	5428	4022	862	5968	3754	1534	5717	2757	1603	5029	2985	2044
Forensic	3819	11	1915	2976	4	1452	3565	-	1109	2931	-	1587	3837	-	-
Narcologists	2977	-	411	3067	-	607	1856	-	-	1976	-	-	2558	-	-
	Psychiatric clinics														
Psychiatrists	**24764**	**2004**	**-**	**24487**	**2528**	**-**	**20782**	**1913**	**-**	**20270**	**1780**	**-**	**22141**	**1586**	**2503**
Child	1987	1987	-	1752	1752	-	1440	1440	-	1340	1320	-	854	854	-
	Psychiatric wards														
Psychiatrists	**24911**	**302**	**11149**	**22543**	**418**	**7973**	**17955**	**389**	**6796**	**19047**	**314**	**8096**	**19531**	**402**	**5208**
Child	-	-	-	214	214	-	174	174	-	233	-	-	260	-	-
Forensic	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Autonomous psychiatric offices within healthcare establishments														
Psychiatrists	**5799**	**30**	**-**	**4495**	**-**	**-**	**4041**	**18**	**-**	**3720**	**23**	**-**	**3430**	**22**	**-**
	Outpatient psychiatric establishments and structures														
Psychiatrists	**345120**	**11418**	**8292**	**343376**	**15935**	**5846**	**325512**	**18192**	**8918**	**345226**	**14268**	**6343**	**312973**	**10402**	**6208**
Child	1000	1000	-	544	544	-	10398	1265	7	837	837	-	2355	2346	-
Forensic	15	15	-	-	-	-	-	-	-	191	54	-	375	15	-
Narcologists	9315	10	-	9554	1	-	9836	-	-	18690	-	-	5663	-	-

4.4. Workforce

There does not appear to be completely reliable current data on the Bulgarian mental health care workforce available due to the complexity of funding and contractual arrangements. The National Statistical Institute covers all government and municipality-owned inpatient services with basic or dual office contracted psychiatrists.

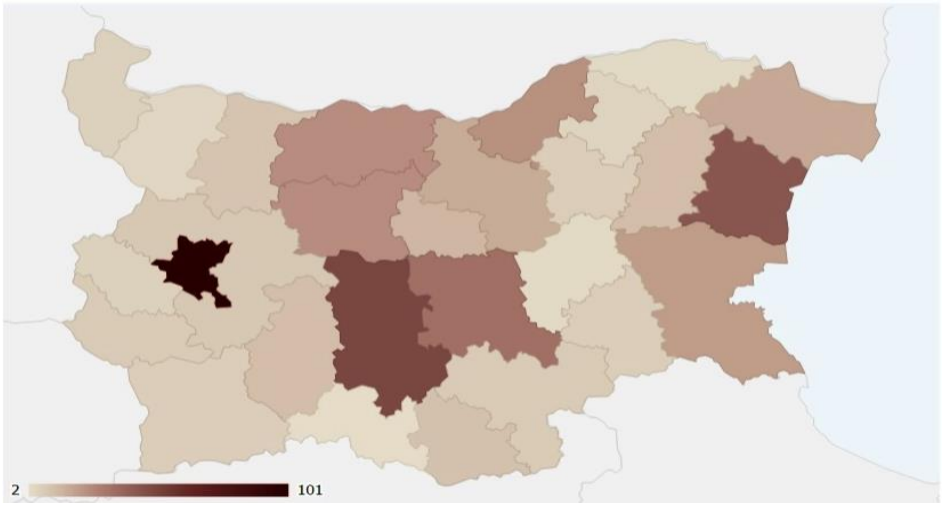
On the other hand, the National Health Insurance Fund (NHIF) reports the total number of contracted outpatient psychiatrists. Not all of the latter have primary appointment in an inpatient unit. There is certain overlap between the two sample sections which is however difficult to estimate.

The mental health care workforce in Bulgaria comprises approximately (National Statistical Institute):

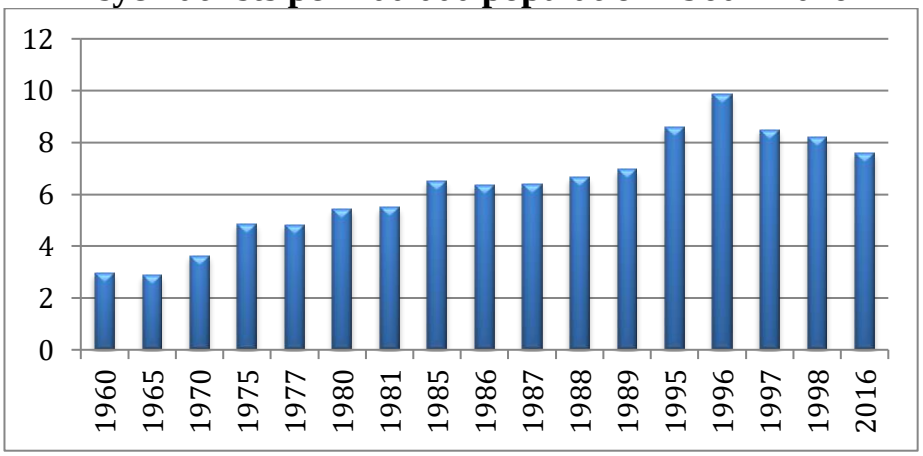
- 518 doctors of whom about 447 are psychiatrists
- 978 mental health nurses
- 89 psychologists
- 50 social workers
- 789 health care assistants

This workforce is unevenly distributed across Bulgaria with up to 60% variation in people per psychiatrist between the six main administrative districts and concentration in urban areas. This represents a severe shortage of clinically trained mental health staff compared to European averages.

Density of Psychiatrists (n=518) in Bulgaria 2018



Psychiatrists per 100 000 population 1960 – 2016



Bulgaria: Self Evaluation Report

Psychiatrists (per 100,000 inhabitants) in other European Countries, 2015

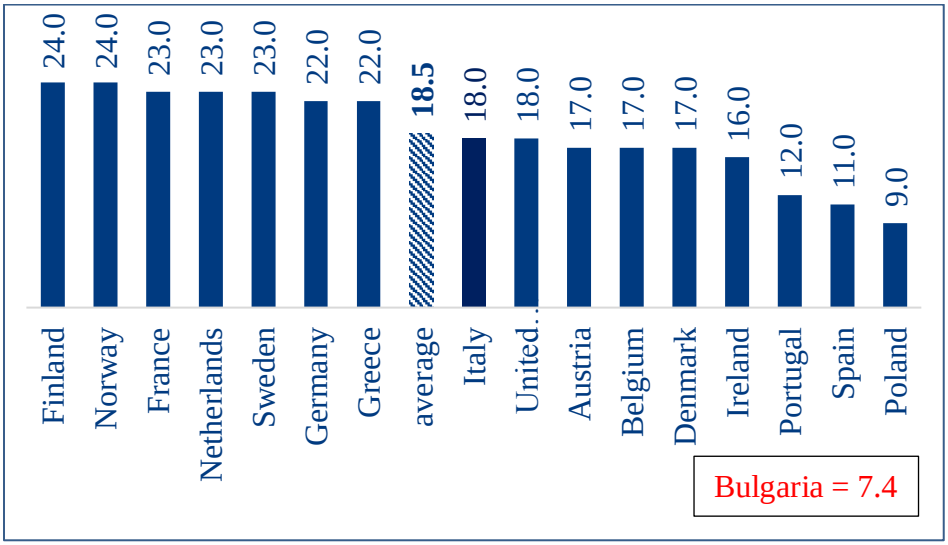


Table 3: Psychiatric workforce

	2012				2013				2014				2015				2016			
	Positions		Natural persons		Positions		Natural persons		Positions		Natural persons		Positions		Natural persons		Positions		Natural persons	
	by pay-roll	employed (including dual office holding)	total	incl. basic employment contract	by pay-roll	employed (including dual office holding)	total	incl. basic employment contract	by pay-roll	employed (including dual office holding)	total	incl. basic employment contract	by pay-roll	employed (including dual office holding)	total	incl. basic employment contract	by pay-roll	employed (including dual office holding)	total	incl. basic employment contract
	Total																			
Psychiatrists	**929.50**	**862.75**	**949**	**587**	**927,00**	**848,50**	**935**	**592**	**916,75**	**852,50**	**936**	**595**	**937,25**	**873,55**	**952**	**596**	**951,25**	**861,05**	**955**	**600**
Child	24.00	21.00	22	19	21,50	20,50	24	19	21,50	20.50	22	20	26,50	25,50	26	23	26,00	24,00	26	21
Forensic	8,00	8,00	9	8	8,00	8,00	10	9	7,00	7,00	8	7	6,50	6,50	8	7	7,50	7,50	8	6
Narcologists	19.50	19.50	20	18	19.50	19.50	20	18	18.50	18.50	20	17	16	16	16	15	14,00	14,00	14	14
	Including:																			
	Psychiatruc hospitals																			
Psychiatrists	**149,00**	**127,00**	**126**	**122**	**152,00**	**130,00**	**130**	**124**	**154,50**	**137,50**	**139**	**134**	**158,50**	**137,00**	**139**	**127**	**159,00**	**130,50**	**134**	**124**
Narcologists	13,00	13,00	13	13	12,00	12,00	12	12	12,00	12,00	12	12	13,00	13,00	13	13	13,00	13,00	13	13
	Mental Health Centers																			
Psychiatrists	**191,00**	**165,50**	**165**	**164**	**185,50**	**160,50**	**162**	**162**	**183,00**	**153,50**	**155**	**151**	**179,50**	**152,50**	**156**	**149**	**182,50**	**152,00**	**155**	**145**
Child	4,00	3,00	3	3	3,00	3,00	4	4	4,00	4,00	4	4	5,00	5,00	5	5	4,00	4,00	5	4
Forensic	3,00	3,00	3	3	3,00	3,00	3	3	2,00	2,00	2	2	2,00	2,00	2	2	2,00	2,00	2	2
Narcologists	3,00	3,00	3	3	1,00	1,00	1	1	1,00	1,00	1	1	1,00	1,00	1	1	1,00	1,00	1	1
	Psychiatric clinics																			
Psychiatrists	**97,00**	**87,00**	**96**	**91**	**96,5**	**81,75**	**92**	**87**	**93,25**	**82,75**	**94**	**90**	**99,50**	**93,50**	**105**	**101**	**112,50**	**105,50**	**116**	**109**
Child	16,00	14,00	15	15	13,5	12,50	15	14	12,50	11,50	13	13	15,50	14,50	15	15	15,50	13,50	14	14
Forensic	3,00	3,00	4	4	4,00	4,00	6	6	3,00	3,00	4	4	2,50	2,50	4	4	3,50	3,50	4	3
Narcologists	1,50	1,50	2	2	2,50	2,50	3	3	3,50	3,50	4	4	-	-	-	-	-	-	-	-
	Psychiatric wards																			
Psychiatrists	**53,50**	**48,25**	**48**	**47**	**61**	**58**	**61**	**56**	**58,25**	**55,00**	**57**	**53**	**62,50**	**56,50**	**59**	**54**	**66,00**	**59,00**	**61**	**56**
Child	1,00	1,00	1	1	1,00	1,00	1	1	2,00	2,00	2	2	2,00	2,00	2	2	2,00	2,00	2	2
	Autonomous psychiatric offices within healthcare establishments																			
Psychiatrists	**8,00**	**8,00**	**8**	**8**	**3,00**	**3,00**	**3**	**3**	**5,00**	**5,00**	**5**	**5**	**3,00**	**3,00**	**3**	**3**	**3,00**	**3,00**	**3**	**3**
	Outpatient psychiatric establishments and structures																			
Psychiatrists	**431,00**	**427,00**	**506**	**155**	**429,00**	**415,25**	**487**	**160**	**422,75**	**418,75**	**486**	**162**	**434,25**	**431,05**	**490**	**162**	**428,25**	**411,05**	**486**	**163**
Child	3,00	3,00	3	-	4,00	4,00	4	-	3,00	3,00	3	1	4,00	4,00	4	1	4,50	4,50	5	1
Forensic	2,00	2,00	2	1	1,00	1,00	1	-	2,00	2,00	2	1	2,00	2,00	2	1	2,00	2,00	2	1
Narcologists	2,00	2,00	2	-	4,00	4,00	4	2	2,00	2,00	3	-	2,00	2,00	2	1	-	-	-	-

4.5. Child Psychiatry

Child Psychiatry is a separate specialty, which does not require any core or common training in psychiatry before specialising. There are 22 child psychiatrists in Bulgaria and three inpatient wards for children in Sofia, Plovdiv and Varna with 29 beds. There are some outpatient facilities for children in Rousse and Sofia.

4.6. Forensic Psychiatry

The Panel was informed that there are 8 forensic psychiatrists in the country with one fully operational forensic hospital service.

4.7. Social Services

Social services in Bulgaria operate under the Social Assistance Act. The types of social services related to the psychosocial rehabilitation of people with mental disorders are:

- day care centres for adults with disabilities
- protected homes (access via a Social Assistance Agency order)
- social assistants
- home care

Day care facilities work independently of the medical services which creates a structural barrier to integration of mental health care. There are 13 homes for adults with mental disorders with a capacity of 1036 people, 27 homes for mentally retarded people and 13 homes for people with dementia. The Panel was not able to visit any of these Social Assistance Act related services nor to obtain more detailed data regarding their available resources nor usage. This appeared to reflect the reported barriers to joined-up service provision relating to the split between Health and Social care.

Table 4: Data on overall inpatient numbers

Hospitalized cases (discharged and dead) in stationaries of psychiatric establishments, clinics and wards

Name of diseases under ICD-10	2012		2013		2014		2015		2016	
	Number	Per 100,000 population	Number	Per 100 000 population	Number	Per 100 000 population	Number	Per 100 000 population	Number[1)]	Per 100 000 population
Total	**50804**	**695,4**	**51971**	**715,3**	**55028**	**761,7**	**52933**	**737,4**	**41995**	**589,2**
Mental and behavioral disorders	48863	668,8	51005	702,1	54239	750,8	52074	725,5	41130	577,0
All other classes of diseases	58	0,8	89	1,2	62	0,9	39	0,5	84	1,2
Epilepsy	57	0,8	43	0,6	60	0,8	35	0,5	17	0,2
Factors influencing the health status of the population and contact with health services	1883	25,8	877	12,1	727	10,1	820	11,4	781	11,0

[1)] In 2016, according to the amendments to Ordinance 49 of the Ministry of Health dated 2010, apart from the hospitalized cases of hospital beds, the persons cared in places for short-term stay are also reported separately.

4.8. Financial resources and Funding (detailed data in Appendix 2)

Funding for inpatient psychiatric care is estimated at about BGN 100 million (50 million euros) or about 2.5% of the total healthcare budget in the country. The latter comprises about 8 % of the Bulgarian GDP which is under the European average; and Bulgaria has one of the lowest spends on health per capita in Europe of slightly more than Euro 1000 per year. European Commission Country Health Profile 2017

The funding of mental health services in Bulgaria is complex and comes from different streams that do not appear to always be co-ordinated or in communication, leading to a confused situation with a lack of joined-up care and an incoherent patient pathway. The Panel noted that even senior clinicians were not always in agreement regarding the rules and mechanisms for funding.

The financing of inpatient psychiatric services is sourced on four levels from:

- the state budget
- contracts with NHIF
- the municipalities
- private payments

Funding from the state budget is according to a formula determined by order of the Minister of Health, which includes inpatient treatment of patients with mental illness according to certain criteria listed in an annex to the formula.

The formula for financing the medical facilities delivering inpatient psychiatric care includes MHCs, clinics and general hospital wards with a "1st, 2nd or 3rd level of competence" according to the medical standard "Psychiatry". Those in effect constitute the smaller segment of the system. The activities covered by this formula are for inpatient treatment for up to one month and duration no less than 20 days, and for each subsequent month of the patient's stay due to a need for further treatment. This in practical terms means an incentive for prolonged inpatient admissions in the absence of an objective assessment of the quality of the treatment leading to discharge.

Payment for a day hospital care is subject to the same requirements. The formula pays for rehabilitation when it is done through occupational therapy in inpatient conditions and with the possibility of extending the stay for longer than one month.

State Psychiatric Hospitals are the largest part of the system but tend not to be funded through this formula. Instead they are funded on historical principles (the number of patients admitted in the last year). This funding system is reported by the Self Evaluation Report as leading to "opposition and tension between different types of medical establishments and affects the quality of medical services. One major concern includes cases of patients who have been admitted for long-term (e.g. 3 months) of involuntary treatment, exclusively in State Psychiatric Hospitals.

Funding for methadone substitution and maintenance programs via the Ministry formula is also available to hospitals other than the State Psychiatric Hospitals (as they do not meet the formula criteria).

National Health Insurance funding (NHIF) is mainly provided for outpatient psychiatric services. Limited income in some medical establishments for inpatient care is provided by the NHIF for dispensary activity.

There are no data regarding direct cash payments for mental health services, but it can be assumed that they are of considerable size taking into account two circumstances. Firstly, most so-called common mental disorders (such as anxiety disorders) are seen in this setting, and secondly, people with severe mental illness (such as schizophrenia) usually cannot afford this service without an NHIF contract.

4.9. Site visits in Bulgaria (see list in Appendix 1)

The EPA Panel were able to visit a range of mental health services in Bulgaria in order to obtain a first-hand view of some of the challenges facing the country regarding mental health service reform.

We had an introductory meeting with Deputy Minister Svetlana Yordanova where she openly explained the challenges faced, and very clearly expressed support, including financially, for evidence-based change, and for the EPA Advisory Panel visit.

Sofia County Mental Health Centre

This centre is on a campus shared with facilities for cardiology and dermatology and was previously used as a "dispensary". The latter are housed in what appeared to be well maintained modern buildings, whereas the psychiatric facilities, both inpatient and outpatient, were severely neglected, dilapidated, poorly maintained, dirty / unhygienic, overcrowded, with minimal or no therapeutic activity programme, and male and female patients housed in the same unit without any staff presence overnight.

Cardiology / Dermatology Unit

Sofia County Mental Health Centre

Toilet for patients

Patient bedroom

University Clinic Alexsandrovska

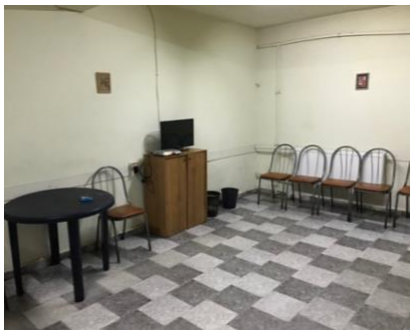
This facility is located in a general hospital alongside other medical specialties but is perceived as unwanted by the hospital management because it does not bring in much income compared to other specialties due to the funding rules for mental health services.

However, the clinic facilities were of a good standard with better staff morale.

State Psychiatric Hospital Noviska Curia

This is the largest psychiatric hospital serving Sofia and is located in a rural area some distance away from the city on the site of a former monastery. There has been some recent renovation to improve facilities, but the site clearly suffers from underfunding with dilapidation, empty posts, lack of therapeutic activities, lack of access to patient transport / ambulances. It is situated some 18 miles away from the nearest general hospital.

The Director is keen to support change, and to move closer to a general hospital in order to improve patient access to other medical care.


University Clinic St Naum

This University Clinic forms part of a larger hospital including Neurology services, and now comprises two units with about 60 beds altogether. This has reduced significantly from the previous 150-200 beds here. It has been renovated with EU funding to good effect and the facilities are of fair quality. However, even here there is evidence of underfunding for example with one toilet for 35 patients and no secure storage for patient possessions. Day Hospital services for 20 patients are provided.

Sofia Central Mental Health Centre

The Panel visited this Mental Health Centre situated in central Sofia in a modernised building over several floors. It contains an Emergency Unit (4 beds), Day Hospital (50 places), Child and Adolescent Service (6 beds), High Secure (25 beds) and Medium Secure (20 beds). There is also a floor run as a Day Centre by the Ministry for Social Affairs, but this is entirely separately administered, and we were not able to visit this despite being on site. Although suffering from the same lack of funding as seen elsewhere, this unit appears to be of a reasonable standard.

The Panel again noted the level of burnout of staff, and severe mistrust regarding possible reforms and changes to the national mental health service system**.**

Global Initiative for Psychiatry Social Recovery Centre Sofia

This is a relatively new and unique project piloted by both the Ministry of Health and the Ministry of Social Affairs and run by the Global Initiative on Psychiatry NGO. It provides a recovery-oriented rehabilitation service for up to 8 inpatients and works with up to 60 patients in the community. Patients are actively reintegrated into the community and employment, including in a laundry business run by the patients in the centre.

Staffing includes administrative, driver, cleaner, psychologists, social workers and expert by experience, but not psychiatrists (although they have negotiated access informally to some psychiatric support).

The Panel was interested to learn that this centre had opened in the middle of a residential area of Sofia. They had directly confronted and pre-empted possible negative attitudes from the general public, for example by speaking with local residents and inviting them to visit. However, they had encountered no significant negative attitude problems at all.

They reported a very successful record in preventing further hospital admission for their patients.

Meetings and activities area

Laundry business

5. Challenges and Issues for Bulgarian Mental Health Service Delivery

Although there are clearly very significant problems affecting many domains of Bulgarian mental health services, the Panel wishes to highlight a selection of examples of good or even excellent practice that was encountered in Bulgaria. We recognise that due to the limitations of a short 5-day visit and available time that this is far from a comprehensive list, and want to also acknowledge those not listed here:

- the Panel were impressed by the open and transparent attitudes that they encountered at all levels from the Deputy Minister through administrators, clinical staff and patients. We believe that this openness is what will make improvements possible
- the Panel were impressed by the passion and commitment of many of the stakeholders whom we met, and in particular their drive to improve services
- the Panel was impressed by the service run by the Global Initiative for Psychiatry in Sofia. This is patient focussed, empowering and has successfully tackled and overcome many of the issues that are perceived to be holding back similar service developments elsewhere

- the Panel was impressed with the high calibre of psychiatry specialist trainees whom we met and believes that retaining them in Bulgaria will be a key part of future service improvements
- the Panel was very grateful for the excellent support provided by Prof Hinkov, Prof Stoyanov, Dr Nakov, Dr Okoliyski; and the Ministry for Health, the National Centre for Public Health Analyses and the WHO Bulgaria office

5.1. Human Rights Violations and Unacceptable Conditions

The Panel was very concerned to discover instances of apparent repeated breach of basic human rights such as the United Nations Convention on the Rights of Persons with Disabilities (ratified by Bulgaria), particularly so since these have already been identified by previous WHO visit reports.

Selected examples include:

- The National Register of people with Mental Disorders established by Article 147 of the Health Act appears to be in breach of Article 5 Paragraph 2 of the Convention:

"States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds."

- Ongoing hospitalisation in State Psychiatric Hospitals of people no longer requiring hospital care due to a lack of health and social care in the community appears to be in breach of Article 19:

"States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community"

- Discriminatory funding and service provision for treating mentally ill people appears to be in breach of Article 25

"Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmed as provided to other persons"

- The lack of habilitation and rehabilitation services and activities for mentally ill inpatients, including the often complete lack of inpatient activities and unacceptably poor facilities with overcrowding and lack of privacy (including men and women sharing accommodation facilities) and hygiene appears to be in breach of Article 26

"States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmed, particularly in the areas of health, employment, education and social services"

The Panel noted that many of the facilities visited suffered from a significant lack of privacy for the patients, and were unsafe environments with, for example, no staff at night and multiple potential ligature points.

Most facilities appeared to have little or no activities available for the patients with the majority of patients seen found sitting aimlessly on their beds regardless of the time of day.

The Panel were alarmed to be informed that facilities in rural areas (not visited by the Panel) were even worse.

Facilities for people with long-term severe disorders were often inadequate with overcrowding, lack of privacy, lack of purposeful rehabilitative activity, poor maintenance, poor cleanliness and understaffing. The culture in some appeared therapeutically hopeless and there was little evidence of community discharge planning.

5.2. Fragmented Care

One of the major problems is the fragmentary nature and lack of continuity of both care and therapy and information about a patient. After discharge from psychiatric hospital, the patient does not routinely have referral for follow-up, maintenance therapy or any psychosocial interventions with a view to their recovery and reintegration again into the community. These activities are undertaken chaotically depending on the particular circumstances of the patient, initiatives from their carers and family, or local service conditions.

Complex systems make it very challenging for patients to successfully obtain and continue use of treatment. For example, in order to use services funded by the NHIF, the patient is obliged to visit a general practitioner (GP), to get a referral to a specialist, to visit that specialist, then to certify the medication protocol, and if it is for costly medications it must be approved by a special committee, after that to go back to the GP and then visit a pharmacy to get the medicines. This is likely to be too complex for many patients to successfully negotiate, let alone if they have impaired insight or cognitive functioning, or poor motivation and drive resulting from their mental disorder. Drugs for schizophrenia and bipolar affective disorder are reimbursed, but no more than three per patient. Anti-depressants are only partially reimbursed after providing evidence of a depressive disorder.

The panel were advised that a national hospital inspection system exists but is woefully inadequate.

There appears to be a lack of a robust national system for reporting mental health service quality outcomes and indicators other than basic bed and patient numbers.

There appears to be a lack of a national system for reporting and learning from incidents including for example suicide, self-harm and medical error.

5.3. Lack of joined-up planning and accountability

Responsibility for mental health service delivery in Bulgaria is divided amongst many stakeholders with little evidence of joint strategic thinking, joint planning, and co-ordinated implementation. These divides appear to encompass national strategy, funding, clinical service delivery and training with evidence of significant practical difficulties for stakeholders when attempting to work together. An example of this was that it was not possible for the Panel to visit facilities falling under the Social Affairs Ministry despite repeated requests.

In effect the Panel encountered a situation where stakeholders were unable to identify clear lines of responsibility for decision making and were left to blame one another for any problems encountered. The Panel were concerned that this situation may have allowed government to avoid and postpone necessary decisions due to the lack of joint consensus and agreement.

The Panel was informed that the Ministry for Social Affairs has just recently decided to create 25 centres on hospital sites for decanting people from State Psychiatric Hospitals - but this does not appear to have been planned with the involvement of all stakeholders and does not form part of an agreed Health / Social Affairs strategic plan.

5.4. Staff Issues

Bulgaria currently has low numbers of psychiatric nurses, clinical psychologists (1.5 per 100 000 population = about 10% of the European average of 13) and social workers (0.36 per 100 000 population) compared to European averages. The number of psychiatrists in Bulgaria is very low (7.4 per 100 000 population) which is less than half the European average of 18.5.

Of particular concern is the high average age of all clinical staff suggesting an entirely predictable worsening of the workforce situation in the next decade. The Panel were informed that the average age of nursing staff is 58 years and that of psychiatrists is 52 years. This has been exacerbated by significant emigration particularly of younger staff, and by inadequate number entering into training programmes.

Whilst accession to the EU may have brought benefits for Bulgaria, it is also the case that it has led to a very significant shift in the Bulgarian population with mainly younger people emigrating and a disproportionate number of older and people with ill health remaining.

Staff morale was almost universally very poor in the sites visited, with a strong sense of hopelessness and helplessness prevailing. This was reflected in patient care attitudes - an example being that staff in most facilities visited would enter patient bedrooms without knocking or asking permission to bring guests (Panel members) inside.

The Panel were alarmed to hear that there appears to be a lack of a clear national strategy and system for recruiting, training and retaining clinical staff. One example of the effect of this apart from the number of trainees is that psychiatry specialist trainees both struggle to get training in an appropriate range of psychiatric specialties, and that they can only be appointed to a hospital in an otherwise vacant regular medical post rather than dedicated training posts. It appeared to the panel that the numbers entering training as psychiatrists, psychologists, psychiatric nurses, social workers and occupational therapists are grossly inadequate to meet the known future workforce requirements in Bulgaria.

5.5. Financial issues

The Panel found a chaotic financial situation with:

- complex different funding systems with no joint planning or strategy
- inadequate investment in mental health services (leading to low staffing, lack of training, lack of multidisciplinarity, inadequate buildings and facilities)
- funding mechanisms that produce perverse incentives (examples: insurance for outpatient treatments leading to inequalities in care; and which subsidises psychiatrists' salaries; that encourage hospitalisation of those who cannot afford private care)
- an appropriate range of evidence-based treatments is not available;
- financial incentives exist for general hospitals to exclude psychiatry by underfunding, closing or not developing mental health services
- **no parity of esteem with other medical specialties** which is very visible, for example with poorly maintained grossly inadequate mental health facilities alongside far better funded general medical buildings and services
- very poor salaries with, for example, a direct incentive for psychiatrists to have a second job in private practice or to make money from recruiting patients into pharmaceutical trials

About 12% of the Bulgarian population is not covered by health insurance, and therefore have no access to state funded outpatient mental health services (and would have to self-pay for this). Their only option is inpatient care, thus creating a perverse financial incentive for admission in order to access care. This **disproportionately** affects people with mental disorders.

The Panel was informed that around 900 000 people in Bulgaria are in receipt of some form of disability benefit, and of these approximately 300 000 were receiving this payment because of mental disorders.

5.6. Lack of consensus amongst Stakeholders

The Panel learned that there has been much discussion and reflection over the past 20 years or more regarding the way forward, but little progress has been made due to the lack of consensus and a lack of clinical leadership.

There are significant splits in professional bodies and little belief that a change programme may deliver improvement. Clinical staff almost universally reported fearing that any mental health reform plan will translate into further reduction of resources allocated to mental health, and that deinstitutionalization from existing inpatient facilities will translate into reinstitutionalization in smaller units providing the same low-quality care, or even worse, a much lower level of care, and higher burden on families and community.

The Panel noted that there had been a bed reduction of about 20% in the late 1990's under a previous government and that this had not been accompanied by investment in or any provision of alternative community-based services for the affected patients. This experience has had a negative effect on senior clinicians' views regarding any proposed future changes.

The Panel encountered a strong feeling amongst clinical staff that government was not prepared to improve funding for mental health services and may even be looking for reasons to reduce funding.

5.7. Negative public attitudes towards changes in mental health care organization reported as a good reason to avoid change

The Panel was repeatedly told by senior stakeholders that negative public attitudes towards people with mental disorders present a major obstacle to change, for example by preventing the establishment of community-based services and sheltered housing.

However, the Panel visited a community facility including inpatient and outpatient provision established by the Global Initiative for Psychiatry delivering a model recovery-based service. Apparently, this had overcome negative attitudes, largely without any outside or official support.

The Panel is therefore concerned about the real possibility of change being avoided due to misplaced and overstated fears of negative public reaction.

5.8. The Bulgarian Government's "Action plan – National Strategy for Long-Term Care"

The Panel broadly welcomes the principles and intention underpinning the Bulgarian National Strategy for Long-Term Care including especially the commitment towards the application of the United Nations Convention on the Rights of Persons with Disabilities.

However, the Panel is concerned that there may be insufficient recognition by the funders of health and social care of the financial benefit to the country as a whole of investing in mental health services, and the amount of additional investment required including into preventative services, and integrated person-centred medical, psychological and social interventions. This additional investment has been shown elsewhere to yield significant savings in health and social care costs and also in improved overall economic productivity.

5.9. Marginalisation of Psychiatry as a Medical Specialty

This is a serious problem that needs to be urgently addressed at a national political level.

It is reflected in many ways, for example:

- chronic and serious underinvestment in mental health services leading almost to the point of collapse in these services
- psychiatrists not authorised even in a University Clinic to directly order necessary investigations such as CT or MRI scans on their patients
- psychiatric facilities are physically located separately from other medical specialties, and often many kilometers apart
- national complacency regarding negative attitudes towards psychiatry and psychiatric patients including within the medical and other health professions

6. Recommendations

6.1. Appoint a national Clinical Leader with executive operational responsibility and decision-making authority for the change programme. The Clinical Leader should be appointed jointly by the Ministries of Health and of Social Affairs and should report directly to the two Ministers.

The appointment of this Clinical Leader is a critical requirement for ensuring the successful delivery of change in the current system that is beset by divisions, disagreements, lack of clarity and lack of accountability.

The Clinical Leader must have the necessary authority, and also the robust support of the two Ministers, that will be required to drive through change.

6.2. Appoint a national Task Force chaired by this national Clinical Leader to advise, lead and implement the change programme.

This Task Force must include representatives of all relevant stakeholders including patients, carers and international experts.

It must be a requirement of the change process that strong efforts are made by the Clinical Leader to achieve consensus on changes required via the Task Force, but also that spurious obstacles to change are not given undue importance.

6.3. Allocate 10% of the health budget to mental health.

There is a longstanding and significant legacy of underfunding of mental health services that has undoubtedly caused significant economic harm to Bulgaria through the avoidable resultant increased health and social care costs as well as the avoidable lost economic productivity.

> *"The total costs of depression alone in the European Economic Area have been estimated to be €136.3 billion (2007 prices). The majority of these costs, €99.3 billion per annum, are linked to productivity losses from employment, but around one third of costs fall on the health care system."*
>
> *McDaid, "Making the Long-term Economic Case for Investing in Mental Health to Contribute to sustainability" European Union 2011*

An immediate significant increase in the budget allocated to mental health and related social care services is required for two important reasons:

- to help redress historic inequity including by raising salaries for recruitment and retention purposes, and for renovating and building improved facilities
- as a clear statement of intent from the government designed to improve staff morale and create real hope for positive improvement in quality of care

The Panel acknowledges that this is a significant amount of money but is very concerned that without a powerful intervention such as this mental health services are at real risk of collapse due to retiring, burnt out and emigrating staff accompanied by lack of recruitment into mental health clinical roles.

Fortunately, there is strong evidence of the economic benefits of this investment in mental health services, for example:

> *"the returns to this investment are also substantial, with benefit to cost ratios of 2·3–3·0 when economic benefits only are considered, and 3·3–5·7 when the value of health returns are also included"* *Chisholm et al, Lancet 2016*

6.4. Increase salaries for clinically qualified staff working in mental health care settings; attract trainees and favour the return of those who emigrated to work in more attractive settings.

This should follow on from 6.3. above, but needs to be vigorously pursued and accompanied by creative use of social media and other marketing tools to promote careers in mental health services in Bulgaria.

6.5. Counteract by appropriate campaigns and initiatives the fear that the reform will translate into further reduction of resources allocated to mental health, including inappropriate closure of inpatient beds.

Clinical staff are very concerned that any reform or change process will be used as justification for reducing investment in mental health services. Given the strong economic incentives for investing in mental health services (see 5.8. above), this should be a quick win.

6.6. Avoid any attempt to import models wholesale from outside; tailor the development of a more community-based mental health system to the specific context of Bulgaria and make full use of local strengths and experience.

However, learning from the experience of others will help in developing and implementing effective changes, for example using WHO guidance such as the The European Mental Health Action Plan 2013–2020.

6.7. Implement a national plan to eliminate discrimination and improve attitudes towards people with mental disorders; and improve the image of psychiatrists and the whole mental health workforce.

Good practice from elsewhere can be adapted to Bulgarian local requirements.

However, the first step is the acceptance and commitment by all stakeholders that negative, discriminatory attitudes can, will and must be changed.

In order to do this effectively full use should be made of patient, family and carer organisations in leading, advising and delivering this programme.

6.8. Involve patient and family associations; alongside and together with scientific and professional organisations in planning and implementing the different steps of the reform process.

This has been mentioned elsewhere already but is so important and central to the future success of any significant change programme that the Panel is listing this clearly as a stand-alone recommendation.

6.9. Establish a collaborative and effective working relationship between the Ministry of Health (MoH) and the Ministry of Social Affairs (MoSA).

This is indispensable for providing appropriately integrated treatment, continuity of care and recovery-oriented care in both hospital and non-hospital settings.
This should involve drawing up agreement about sharing budgets/criteria for funding different components of support to ensure that there are clear agreed pathways of treatment and support available to facilitate recovery and social inclusion for people with acute and longer-term needs.

Specifically, there needs to be clarity about the respective roles and balanced responsibilities of the MoSA and MoH components of integrated services (e.g. the MoH fund clinical team input to people living in supported accommodation, with the supported accommodation service itself being funded by the MoSA).

6.10. Implement training programs for existing staff to enhance skills and improve morale, and support best clinical practice including by older staff. Do not accept poor practice, implement a performance management process to improve practice, and, if needed, replace ineffective staff.

The services currently are heavily reliant on an aging staff cohort and would be severely compromised if there were mass retirements. However, strenuous efforts should be made to boost the morale and skills of these staff members, whilst at the same time making poor practice unacceptable.

6.11. Improve education and training in psychotherapy and psychosocial interventions.

There is an enormous shortage of skilled staff able to provide these that should be urgently addressed by a programme of high-quality training subject to regular independent inspection and quality control.

6.12. Improve education and training for all psychiatric specialties and significantly increase the overall number of trainees including in child psychiatry and forensic psychiatry.

There is a dire shortage of clinical staff and facilities in these areas that should be urgently addressed by a programme of increased recruitment and high-quality training subject to regular independent inspection.

6.13. Plan the implementation and coordination of a realistic spectrum of services responsive to population needs.

Services should include both community and hospital services; they should be interdependent, i.e. provide continuity of care and good communication flow among users and official, as well as unofficial, mental health carers, as well as primary care physicians and social services. Whatever the implemented model, it should encourage the endorsement of the bio-psycho-social recovery model in all steps of care, from prevention, to acute, long-term and rehabilitation settings.

6.14. Develop and implement the action plan for change and reform of mental health services in such a way that it can be delivered in a step by step manner based on clinical priority and available resources. First in the priority list must be complete reprovision and relocation of services with severe human rights violations.

These violations include inadequate or lack of separate facilities for men and women; inadequate space allocated to each person; unavailability of safe and easily accessible storage for personal belongings; good working and clean toilet facilities; lack of structured activities programmes within the facility and inadequate support for patients to access community based activities (including leisure, education and vocational rehabilitation such as supported employment); availability of clear, written information about patients' rights; written protocols, training and monitoring for restraints that includes having to fully justify why a less coercive intervention was not appropriate.

In addition, the national plan might be preceded by a **pilot plan,** involving an urban and a rural area. The purpose of this would be to test the model and build confidence for further implementation. D**ifferent areas might require different models:** for instance, in rural areas there might be a higher need for easily accessible services, close to community, with limited number of beds, but equipped with ambulatory, day care, home visits, rehabilitation programs and fewer supported accommodation places. Models should be adaptable to positively use local strengths and experience.

6.15. Define and monitor strict criteria for involuntary treatment and supported decision making.

These should be consistent with European law and accompanied by training as required for staff involved. The appeal process should be robust and effective and free to use for the patient who should be provided with legal representation for this purpose. Many of these features already exist in Bulgarian law but need to be accompanied by a system of effective monitoring and reporting to ensure that the rights of the patient are in practice fully respected and upheld.

6.16. Provide different but equally humane and high-quality care settings for all patients with mental illness, including old age and child psychiatry, addiction disorders, intellectual disability and forensic psychiatry that are located so as to maximise ease of access including for patients and families.

There is a severe shortage of any facilities for older people, children, addiction and for mentally disordered offenders that should be urgently addressed. The economic case for properly treating people with mental disorders is overwhelming, particularly bearing in mind the life-long costs of treatment and of lost productivity associated with untreated and ineffectively treated mental disorders in this group.

6.17. Define and require an evidence-based method to measure the quality of services and the outcomes of the reprovision program at the service (e.g. lengths of stay, costs of care, service quality) and patient level (e.g. recovery, patient satisfaction, markers of social inclusion). The use of existing standardised quality assessment tools is encouraged - such as the Quality Indicator for Rehabilitative Care which is already translated into Bulgarian, and the WHO Quality Rights Toolkit

There is an urgent need for systematic national quality assessment of clinical services and training in order to drive up quality. Patients and families / carers must be a central part of developing and running this process. There are a variety of established models elsewhere that can be adapted to suit Bulgarian requirements.

6.18. Implement an official and publically accessible digital data platform of relevant and up-to-date quality indicators, compliant with European Data Protection legislation, for surveying, planning and monitoring the status and progress of the mental health care reforms.

Transparency regarding the reforms will be key to ensuring and sustaining stakeholder collaboration.

6.19. Implement an external independent review process to regularly assess progress in implementing change in the Bulgarian Mental Health Services.

The rationale for this is that it would provide sustained ongoing focus on the need for successful changes without being one of the Bulgarian stakeholders.

6.20. Stimulate and fund research for evidence-based evaluation of implementation, maintenance, adoption and further development of the reform process.

This is again esssential for ensuring stakeholder collaboration and support.

Appendix 1:

Itinerary

17 July 2018	15:00	Ministry of Health
18 July 2018	09:00-11:00	Mental Health Centre "Sofia County"
	12:00-14:00	University Hospital "Älexsandrovska"
	14:30-16:00	Hall 2, second floor, NCPHA
19 July 2018	08:00-10:00	State Psychiatric Hospital "Noviska Curia"
	11:00-13:00	University Psychiatric Hospital "St. Naum"
	19:30-	Official dinner
20 July 2018	09:00-10:30	Sofia City Centre Mental Health Centre
	11:00-12:00	Global Initiative on Psychiatry Recovery Centre
	13:00-16:30	NCPHA

Appendix 2:
Income, Expenditure, Activities and Economic Indicators
(provided by National Centre for Public Health and Analyses)

Abbreviations used

VHICs Voluntary Health Insurance Companies

SPHs State Psychiatric Hospitals

MHAT Multiprofile (General) Hospital for Active Treatment

MoH Ministry of Health

NHIF National Health Insurance Fund

NCPHA National Centre of Public Health and Analyses

MHCs Mental Health Centres

The EPA Panel notes the small overall investment in mental health services as discussed earlier in the report. This is reflected in for example low levels of skilled clinical staff, low buildings and facilities investment, low food costs and low investment in any form of recovery, rehabilitation and reintegration services.

Income, expenditures, activities and economic indicators of the state psychiatric hospitals (SPHs) for the period 2010-2016

Income by sources allocated for the State Psychiatric Hospitals for 2010-2016

Lev / BGN	2010	2011	2012	2013	2014	2015	2016
All income	**17 245 349**	**20 023 548**	**21 162 218**	**20 929 250**	**22 497 407**	**21 464 625**	**22 339 125**
Subsidies from the MoH	16 382 032	19 329 823	20 580 045	20 352 821	21 855 565	21 097 549	21 956 739
Financing from Municipality	0	0	58 960	64 860	67 480	73 560	75 770
Funds: NHIF	0	0	0	0	0	0	0
Funds: VHICs	0	0	0	0	0	0	0
Income from services /goods sales	162 606	142 516	156 427	153 879	165 169	116 797	95 713
Income from other sales	4 415	27 851	7 533	11 886	13 619	9 286	6 674
Other financial income	397 332	156 892	81 022	113 283	118 161	65 422	96 845
Fundraising donations	298 964	366 466	278 231	232 521	277 413	102 011	107 384

Expenditures by types in the SPHs for the period 2010-2016
(Including Day Stationary, Diagnostic-Consultancy Unit, etc.)

In BGN

Years	Total expenditures	Staff expenses	Food costs	*Expenses for drugs*	Operating expenses
2010	**17 148 952**	10 142 672	1 279 487	1 237 266	4 489 527
2011	**18 834 814**	10 322 303	1 438 172	1 594 123	5 480 216
2012	**20 740 569**	10 964 731	1 463 905	1 501 617	6 810 316
2013	**21 942 797**	12 368 196	1 651 731	1 300 818	6 622 052
2014	**23 597 553**	14 586 543	1 690 756	1 204 048	6 116 206
2015	**22 540 308**	14 286 600	1 630 675	1 108 689	5 514 344
2016	**23 612 567**	15 102 946	1 580 214	1 103 284	5 826 123

Capital expenditures to acquire long-term assets of the SPHs for 2010-2016

In BGN

Years	All capital expenditures for the group	Overhaul of long-term tangible assets	Acquisition of long-term tangible assets	Acquisition of intangible fixed assets
2010	**28 666**	0	27 226	1 440
2011	**3 661 027**	1 686 806	1 612 795	361 426
2012	**926 700**	791 487	135 213	0
2013	**1 185 946**	1 172 502	13 444	0
2014	**742 541**	419 589	322 952	0
2015	**74 999**	73 759	1 240	0
2016	**226 702**	192 277	34 425	0

Expenditure by types in the day stationaries of SPHs for 2010-2016

Years	Total expenditures	Staff expenses	Food costs	Expenses for drugs	Operating expenses
In BGN					
2010	**16 887 951**	9 950 299	1 278 142	1 232 238	4 427 272
2011	**18 470 518**	10 109 076	1 435 095	1 579 175	5 347 172
2012	**20 179 430**	10 658 076	1 455 515	1 472 338	6 593 501
2013	**21 454 663**	12 069 154	1 641 211	1 286 502	6 457 796
2014	**23 114 782**	14 261 420	1 680 781	1 186 169	5 986 412
2015	**22 101 413**	13 968 756	1 620 866	1 092 783	5 419 008
2016	**23 042 911**	14 644 216	1 572 352	1 082 220	5 744 123
In percentages					
2010	**100.0**	58.92	7.57	7.30	26.22
2011	**100.0**	54.73	7.77	8.55	28.95
2012	**100.0**	52.82	7.21	7.30	32.67
2013	**100.0**	56.25	7.65	6.00	30.10
2014	**100.0**	61.70	7.27	5.13	25.90
2015	**100.0**	63.20	7.33	4.94	24.52
2016	**100.0**	63.55	6.82	4.70	24.93

Activities of the State Psychiatric Hospitals for 2010-2016

Years	Average annual number of beds	Number of treated patients	Average length of stay per patient
2010	2 597	12 391	59.5
2011	2 478	12 413	57.1
2012	2 429	11 615	59.0
2013	2 410	11 673	58.1
2014	2 373	11 335	57.8
2015	2 363	10 997	56.0
2016	2 285	10 887	56.5

Staff by category in the SPHs for 2010-2016

Years	Staff with high school medical education	Ratio: number of patients to staff with high school medical education	Healthcare professionals	Ratio: number of patients to healthcare professionals	Other staff
2010	125	100	451	27	448
2011	133	93	454	27	458
2012	120	97	456	25	460
2013	121	96	455	26	432
2014	127	89	460	25	459
2015	125	88	457	24	464
2016	127	86	448	24	464

Economic Indicators of the activity of SPHs for 2010-2016 *In BGN*

Years	Average cost per patient treated	Average cost per bed	Average cost per hospital bed-day	*Average per day spending on food*	Average drug costs per day	Average income per bed
2010	1 363	6 503	22.91	1.73	1.67	6 640
2011	1 488	7 454	26.07	2.03	2.23	8 081
2012	1 737	8 308	29.47	2.13	2.15	8 712
2013	1 838	8 902	31.63	2.42	1.90	8 684
2014	2 039	9 741	35.29	2.57	1.81	9 481
2015	2 010	9 353	35.87	2.63	1.77	9 084
2016	2 117	10 084	37.49	2.56	1.76	9 776

Average cost per treated patient in the day hospitals in SPHs for 2010-2016

In BGN

Years	Total expenditures	Staff expenses	Food costs	Expenses for drugs	Operating expenses
2010	**1 363**	803	103	99	357
2011	**1 488**	814	116	127	431
2012	**1 737**	918	125	127	568
2013	**1 838**	1 034	141	110	553
2014	**2 039**	1 258	148	105	528
2015	**2 010**	1 270	147	99	493
2016	**2 117**	1 345	144	99	528

Average cost per bed-day in the day hospitals in SPHs for 2010-2016

In BGN

Years	Total expenditures	Staff expenses	Food costs	Drug costs	Operating expenses
2010	**23**	13	2	2	6
2011	**26**	14	2	2	8
2012	**29**	16	2	2	10
2013	**32**	18	2	2	10
2014	**35**	22	3	2	9
2015	**36**	23	3	2	9
2016	**37**	24	3	2	9

Income, expenditures, activities and economic indicators of the mental health centres (MHCs) for the period 2010-2016

Income by sources allocated for the Mental Health Centres for 2010-2016

In BGN

	2010	2011	2012	2013	2014	2015	2016
All income	**18 426 758**	**20 372 951**	**19 166 898**	**20 047 378**	**20 637 391**	**19 579 411**	**20 343 933**
Subsidies from the MoH	1 286 666	17 524 577	15 841 067	16 678 228	17 140 243	15 991 013	16 494 712
Financing from the Municipality	14 808 962	532 474	537 341	591 859	765 036	797 953	1 048 804
Funds from the NHIF	0	0	0	343 042	301 714	314 146	298 452
Funds from the VHICs	0	0	0	0	0	0	1 543
Income selling goods, services and others	1 926 895	1 850 751	2 400 434	1 640 464	2 059 734	2 040 989	2 056 459
Income from other sales	83 268	128 870	41 878	61 010	86 112	54 416	158 839
Other financial income	197 993	211 473	192 994	538 083	178 870	247 890	106 056
Fundraising donations	122 974	124 805	153 183	194 691	105 682	133 005	179 068

Expenditures by types in the MHCs for the period 2010-2016 (Including Day Hospital, Diagnostic-Consultancy Unit, etc.)

In BGN

Years	Total expenditures	Staff expenses	Food costs	Expenses for drugs	Operating expenses
2010	**17 984 987**	11 340 427	871 236	1 542 073	4 231 250
2011	**18 947 306**	11 587 737	889 288	1 329 464	5 140 817
2012	**19 489 889**	12 453 386	964 242	1 347 718	4 724 543
2013	**20 119 491**	13 861 163	1 018 428	1 129 101	4 110 799
2014	**20 565 571**	14 404 360	997 049	1 070 151	4 094 011
2015	**19 889 305**	14 075 186	1 089 526	1 012 690	3 711 903
2016	**20 360 312**	14 305 851	1 092 616	967 253	3 994 591

Capital expenditures to acquire long-term assets of the MHCs for 2010-2016

In BGN

Years	All capital expenditures for the group	Overhaul of long-term tangible assets	Acquisition of long-term tangible assets	Acquisition of intangible fixed assets
2010	**531 548**	433 955	97 593	0
2011	**1 091 431**	765 911	313 438	12 082
2012	**780 595**	584 371	183 763	12 461
2013	**480 757**	311 074	161 301	8 382
2014	**135 075**	87 038	41 529	6 509
2015	**46 616**	22 763	23 775	78
2016	**164 474**	9 608	154 866	0

Expenditure by types in the day hospitals of MHCs for 2010-2016

Years	Total expenditures	Staff expenses	Food costs	Expenses for drugs	Operating expenses
In BGN					
2010	**12 095 458**	7 159 887	855 370	1 220 912	2 859 290
2011	**12 942 347**	7 450 372	870 093	1 059 942	3 561 939
2012	**13 771 067**	8 242 046	960 135	1 076 074	3 492 813
2013	**14 269 995**	9 396 810	1 010 797	913 686	2 948 702
2014	**14 685 957**	9 924 663	990 130	845 279	2 925 885
2015	**13 883 869**	9 398 500	1 081 809	767 622	2 635 938
2016	**13 913 420**	9 423 219	1 064 415	694 687	2 731 099
In percentage					
2010	**100.0**	59.19	7.07	10.09	23.64
2011	**100.0**	57.57	6.72	8.19	27.52
2012	**100.0**	59.85	6.97	7.81	25.36
2013	**100.0**	65.85	7.08	6.40	20.66
2014	**100.0**	67.58	6.74	5.76	19.92
2015	**100.0**	67.69	7.79	5.53	18.99
2016	**100.0**	67.73	7.65	4.99	19.63

Activities of the Mental Health Centres for 2010-2016

Years	Average annual number of beds	Number of treated patients	Average length of stay per patient	Bed capacity usage
2010	1 364	18 480	21.2	287
2011	1 162	18 940	19.6	319
2012	1 184	18 350	19.7	306
2013	1 192	19 082	19.5	312
2014	1 227	19 943	18.8	305
2015	1 152	18 333	20.3	323
2016	1 030	16 826	20.3	331

Staff by category in the MHCs for 2010-2016

Years	Staff with high school medical education	Ratio: number of patients to staff with high school medical education	Healthcare professionals	Ratio: number of patients to healthcare professionals	Other staff
2010	83	223	246	75	195
2011	82	231	259	73	193
2012	82	224	270	68	197
2013	75	254	271	70	204
2014	76	264	254	78	190
2015	82	224	259	71	180
2016	81	208	256	66	182

Economic Indicators of the activity of MHCs for 2010-2016

In BGN

Years	Average costs per patient treated	Average costs per bed	Average daily costs per bed	*Average food costs per day*	Average drug costs per day	Average income per bed
2010	655	8 868	30.88	2.18	3.12	13 509
2011	683	11 138	34.92	2.35	2.86	17 533
2012	750	11 631	38.04	2.65	2.97	16 188
2013	748	11 971	38.36	2.72	2.46	16 818
2014	736	11 969	39.21	2.64	2.26	16 819
2015	757	12 052	37.30	2.91	2.06	16 996
2016	827	13 508	40.80	3.12	2.04	19 751

Average costs per patient treated in day hospitals of MHCs for 2010-2016

In BGN

Years	Total expenses	Staff expenses	Food costs	Expenses for drugs	Operating expenses
2010	**655**	387	46	66	155
2011	**683**	393	46	56	188
2012	**750**	449	52	59	190
2013	**748**	492	53	48	155
2014	**736**	498	50	42	147
2015	**757**	513	59	42	144
2016	**827**	560	63	41	162

Average daily costs per bed in the day hospitals of the MHCs for 2010-2016

In BGN

Years	Total expenses	Staff expenses	Food costs	Expenses for drugs	Operating expenses
2010	**31**	18	2	3	7
2011	**35**	20	2	3	10
2012	**38**	23	3	3	10
2013	**38**	25	3	2	8
2014	**39**	26	3	2	8
2015	**37**	25	3	2	7
2016	**41**	28	3	2	8

Income by sources allocated for the psychiatric ward

In BGN

Type of hospital	Years	**Total financial income**	Including income from:				
			MoH and Municipality	NHIF	VHICs	Sales of goods, services and others	Fundraising donations
University MHAT	2010	**6 571 773**	6 231 668	0	0	205 224	134 881
	2011	**6 630 331**	6 235 165	0	0	294 903	100 263
	2012	**6 050 855**	5 608 368	2 884	0	340 353	99 250
	2013	**6 160 657**	5 713 760	7 482	0	367 874	71 541
	2014	**7 609 807**	7 141 101	1 358	0	404 174	63 174
	2015	**5 879 810**	5 401 683	994	0	442 365	34 768
	2016	**4 438 440**	3 905 891	1 034	0	496 558	34 957
District MHAT	2010	**2 948 930**	2 815 127	0	0	120 689	13 114
	2011	**4 097 390**	3 966 689	0	0	100 929	29 772
	2012	**3 992 560**	3 826 959	0	0	106 113	59 488
	2013	**4 038 053**	3 901 768	8 246	0	95 349	32 690
	2014	**3 630 720**	3 540 017	8 260	0	65 095	17 348
	2015	**2 938 205**	2 842 747	11 214	0	82 503	1 741
	2016	**2 878 686**	2 768 384	11 354	0	85 931	13 017
Municipal MHAT	2010	**447 736**	440 000	0	0	6 850	886
	2011	**628 116**	545 800	0	0	13 808	68 508
	2012	**695 223**	673 500	0	0	11 558	10 165
	2013	**777 177**	747 896	0	0	28 511	770
	2014	**801 656**	783 952	0	0	17 704	0
	2015	**754 532**	731 612	0	0	20 528	2 392
	2016	**807 331**	741 668	0	0	25 866	39 797

Expenses of the psychiatric ward

In BGN

Type of hospital	***Years***	***Total expenses***	*Including costs for:*			
			Staff	*Food*	*Drugs*	*Operating needs*
University MHAT	2010	**6 674 283**	4 250 452	526 027	543 313	1 354 491
	2011	**6 587 149**	4 340 033	568 938	435 845	1 242 333
	2012	**6 334 185**	4 305 693	516 401	360 977	1 151 114
	2013	**7 127 044**	5 001 816	517 250	314 963	1 293 015
	2014	**7 929 293**	5 419 526	463 370	294 119	1 752 278
	2015	**7 708 204**	5 494 918	512 296	244 240	1 456 750
	2016	**6 746 867**	4 807 718	350 494	252 751	1 335 904
District MHAT	2010	**3 350 673**	2 107 906	183 108	326 340	733 319
	2011	**3 647 670**	2 367 263	164 944	318 469	796 994
	2012	**3 946 567**	2 610 937	170 816	338 651	826 163
	2013	**3 740 451**	2 570 784	189 098	273 523	707 046
	2014	**3 361 042**	2 351 161	180 636	217 095	612 150
	2015	**3 602 042**	2 619 571	156 352	190 447	635 672
	2016	**3 465 798**	2 502 779	157 603	194 453	610 963
Municipal MHAT	2010	**666 027**	466 798	20 501	53 721	125 007
	2011	**764 590**	494 036	25 042	102 247	143 265
	2012	**571 142**	450 124	25 170	33 631	62 217
	2013	**805 663**	615 006	27 934	32 856	129 867
	2014	**817 520**	625 488	23 801	32 398	135 833
	2015	**771 104**	587 728	28 666	33 276	121 434
	2016	**748 527**	573 851	30 658	31 617	112 401

Number of hospital beds in the psychiatric ward

Years	***University MHAT***	***District MHAT***	***Municipal MHAT***
2010	396	309	40
2011	403	266	42
2012	406	284	42
2013	408	286	43
2014	451	259	45
2015	461	260	55
2016	*295*	*274*	*47*

Number of treated patients in the psychiatric ward

Years	***University MHAT***	***District MHAT***	***Municipal MHAT***
2010	9 653	7 172	1 116
2011	8 897	6 880	1 192
2012	7 845	6 690	1 277
2013	7 713	6 583	1 451
2014	9 344	6 009	1 534
2015	8 334	5 453	1 582
2016	5 509	5 595	1 476

Average length of stay in the psychiatric ward

Years	***University MHAT***	***District MHAT***	***Municipal MHAT***
2010	13.4	13.6	12.3
2011	15.1	13.6	11.4
2012	15.5	13.9	11.2
2013	16.2	14.0	9.9
2014	14.8	14.0	9.8
2015	17.0	14.8	10.9
2016	17.8	15.1	12.7

Number of patients per a physician in the psychiatric ward

Years	***University MHAT***	***District MHAT***	***Municipal MHAT***
2010	163	206	237
2011	139	191	298
2012	111	203	255
2013	106	192	290
2014	130	211	383
2015	107	189	288
2016	85	178	328

Number of patients per a nurse in the psychiatric ward

Years	***University MHAT***	***District MHAT***	***Municipal MHAT***
2010	69	77	80
2011	66	74	74
2012	57	72	82
2013	58	70	102
2014	71	69	99
2015	61	65	100
2016	48	68	96

Average costs per bed in the psychiatric ward

Years	***University MHAT***	***District MHAT***	***Municipal MHAT***
2010	16 854	10 844	16 651
2011	16 345	13 713	18 205
2012	15 601	13 896	13 599
2013	17 468	13 079	18 736
2014	17 582	12 977	18 167
2015	16 721	13 854	14 020
2016	22 871	12 649	15 926

Average costs per patient in the psychiatric ward

Years	***University MHAT***	***District MHAT***	***Municipal MHAT***
2010	691	467	597
2011	740	530	642
2012	807	590	447
2013	924	568	555
2014	849	559	533
2015	925	661	488
2016	1 225	620	507

Average food costs per day in the psychiatric ward

Years	***University MHAT***	***District MHAT***	***Municipal MHAT***
2010	4.06	1.88	1.49
2011	4.58	1.79	1.72
2012	4.27	1.84	1.71
2013	4.18	2.16	1.85
2014	3.58	2.22	1.52
2015	3.69	1.99	1.54
2016	3.57	1.87	1.63

Average bed costs per day in the psychiatric ward

Years	**University MHAT**	**District MHAT**	**Municipal MHAT**
2010	52	34	48
2011	53	40	53
2012	52	42	39
2013	58	43	53
2014	61	41	52
2015	56	46	41
2016	69	41	40

Average drug costs per day in the psychiatric ward

Years	***University MHAT***	***District MHAT***	***Municipal MHAT***
2010	4	3	4
2011	4	3	7
2012	3	4	2
2013	3	3	2
2014	2	3	2
2015	2	2	2
2016	3	2	2