Depression scorecard: Bulgaria

This report is based on a user guide and template that were produced by The Health Policy Partnership as part of the Words to Actions initiative. The user guide and template were initiated and funded by Janssen Pharmaceutica NV. No experts involved in the original depression scorecard work, other than The Health Policy Partnership, were paid for their time. This report for Bulgaria was produced by PR Care Bulgaria with funding from Janssen Pharmaceutica NV.

About this scorecard

The depression scorecard is a tool that aims to support the assessment of national-level performance in key aspects of policy, delivery, and care for people with depression. The framework that underpins the scorecard was developed based on an international literature review and consultation with an expert advisory group.

The idea for the depression scorecard came from collaborative discussions between The Health Policy Partnership and Janssen Pharmaceutica NV as part of the Words to Actions initiative. For full details about the Words to Actions initiative, please see wordstoaction.eu/about.

The scorecard framework was developed and applied initially by The Health Policy Partnership, in collaboration with experts, to four countries: Belgium, France, Italy and Romania, with findings summarised in individual scorecard reports. National-level findings were developed based on in-depth literature review and interviews with leading national experts in depression.

The scorecard framework has now been made publicly available for advocates to use in their own countries, following the template and instructions provided in an accompanying user guide.

This scorecard report is based on that framework to assess depression care in Bulgaria.

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Janssen Pharmaceutica NV and The Health Policy Partnership have not been involved in the research and drafting of this depression scorecard report and are not responsible for its content.

Funding disclaimer

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No experts involved in the original depression scorecard work for Belgium, France, Italy and Romania, other than The Health Policy Partnership, were paid for their time. The same applies to experts involved in the work on the scorecard reports in Bulgaria, the Czech Republic, Hungary, Slovenia, Croatia, Serbia, Slovakia, Estonia, Latvia and Lithuania.

Contents

Depression: why it matters

Depression is a common disease that severely affects psychosocial functioning and impairs quality of life. In 2008, the WHO identified depression as the third leading cause of disability in the world, and predictions were then that it would reach number one by 2030. In practice, detecting, diagnosing and treating depression is often a challenge for clinicians due to its various manifestations, sometimes unpredictable course, difficult prognosis and variable response to treatment. However, the therapeutic possibilities are great and allow full recovery with appropriate treatment.

Depression is undoubtedly a common disease in the modern world and is sometimes extremely severe. It is a psychiatric illness that negatively affects the actions, thoughts and emotions of patients. It affects women twice as often as men.

The incidence of depression (12 months of illness) varies from country to country, but averages about 6%. The lifetime risk of developing depressive disorder is three times higher (15-18%), which means that every fifth person during his lifetime experiences a depressive episode.

The disease leads to problems of different nature - social, psychological, biological. This is the main disease leading to disability and the leading cause of death in the 18-44 age group.

The disease can appear both in mid-adolescence and in the mid-40s. Most often, the first episode of depression occurs before the age of 20 (in about 40% of cases), with a median of 25 years (18-43).

0.1%
of GDP expenditure on mental health in Bulgaria (direct)

6.2%
of people in Bulgaria [over the age of 15] living with depression[1]

9 per 100,000
per 100,000 inhabitants in Bulgaria, 800 per year, who died from suicide or self-harm. Estimates suggest that depression may have contributed to up to 60% of these deaths.[2]

2.5%
of health care expenditures in Bulgaria allocated for mental health in 2019.

X billion Euro
for mental health (direct and indirect costs) per year in Bulgaria

7.7
psychiatrists per 100,000 inhabitants in Bulgaria

*Data from 2019

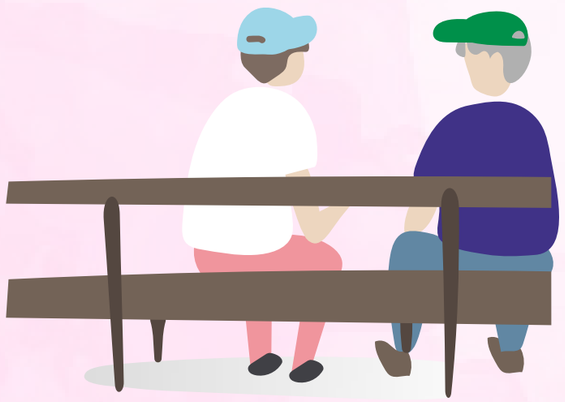
What is the situation in Bulgaria?

The health reform in Bulgaria in 2000 marked the beginning of new relationships in the system and introduced market elements in patient care, although largely mediated through the new health insurance institution. In psychiatry, the new conditions benefited mainly those working in outpatient care, where the processes of marketing services and decentralization took place as in most other medical specialties. However, psychiatry in its hospital part remained outside these processes and thus largely retained its institutional character. The lack of funding and managerial will to achieve the goals set out in a number of strategic documents has led to deep distortions and imbalances in the mental health services offered. As a result, the principles of continuity of care, complexity of care and maintenance therapy were violated.

The paradox in the development of the psychiatric system in our country is that during the totalitarian health care system some form of bio-psycho-social approach has found expression in the complexes of the hospital-dispensary and developed occupational therapy - the so-called occupational health farms (TLS), although strongly subject to the principles of isolationism and stigmatization of people with mental disorders. In the 1990s, these complexes were dismantled and largely looted (especially TLS) due to a lack of a clear concept of reform and resistance to change by various stakeholders. As a result of all this, mental health services are currently chaotic, of poor quality, inefficient and do not meet the requirements for modern psychiatric care. Isolated examples of good practice of individual structures with a developed rehabilitation and occupational therapy base do not guarantee sustainability, but are rather the result of individual efforts and favorable local conditions.

New technologies for the treatment of mental disorders go far beyond pure medical intervention, which in psychiatry is mainly limited to drug therapy and some non-drug methods - transcranial magnetic stimulation and electroconvulsive therapy. They involve coordinated actions of different groups of specialists in their competence and organization - doctors, nurses, psychologists, social workers, as well as the introduction of new positions and even professions such as, leading to the case, etc. The lack of a comprehensive concept for reform also leads to uncoordinated actions in sectors that, by definition, need to cooperate in one area. To achieve this, a change in the regulatory framework, funding and training is needed. So far, there is still no clear political will for change, despite a series of strategic documents, programs and action plans developed and adopted. The population of Bulgaria is about 6.5 million, and the number of psychiatrists is about 500, very unevenly distributed, concentrated mainly around the cities with medical universities (Sofia, Plovdiv, Varna, Pleven, Stara Zagora).

Psychiatrists are unevenly represented by gender. The number of psychiatrists who have contracted with the National Health Insurance Fund (NHIF) is about 400, and 25% of them are on the territory of Sofia[3]. At the same time, for the period 02. 2018 - 05. 2021 the number of contract psychiatrists has decreased by nearly 10%.[4]



About this report

This scorecard was developed to highlight to policymakers where change is most needed to improve the management of depression in Bulgaria. It is our hope that this document may galvanise policymakers to work in close partnership with all stakeholders to reverse the course of depression in Bulgaria, taking a comprehensive and preventive approach to address depression in all its complexity.

It focuses on four key areas, identified as priorities for improvement:

1

Joined-up and comprehensive depression services

Integrated care – that is, a patient-centred system that supports the person with depression throughout their lifetime and with continuity across the health system – is essential to delivering adequate support and treatment. Integrating mental health services into wider health and social care services is convenient and can increase treatment rates, improve comprehensiveness of care and reduce overall costs.[a]

2

Data to drive improvements in depression care

Collecting and analysing robust and up-to-date data on depression is essential for ensuring the right services are available for everyone who needs them. Monitoring patient outcomes helps to identify and inform good practice and may give hope to service users that their mental health can improve.[a] Data on services can support clinicians, policymakers and people with depression to better understand what treatment options are available and accessible. More transparent data will also facilitate shared learning across all domains of depression care. New digital tools may have the potential to facilitate documentation for transparency and research purposes while retaining the anonymity of the user.[a]

3

Engaging and empowering people with depression

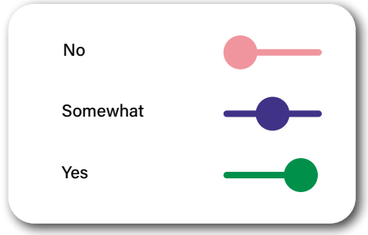
It is essential that people with depression – along with their families, friends and carers – are actively empowered to participate in depression care plans at all stages. Empowerment involves a person gaining information and control over their own life as well as their capacity to act on what they find important, which in turn will allow them to more optimally manage their depression.[b] Peer support, whereby a person who has previously experienced depression offers empathy and hope to others in the same position, can assist both people with depression and their peer supporter in their recovery.[c] Social systems, patient advocacy groups and other civil society organisations with access to underserved communities are critical in ensuring that mental health services reach everyone, including those who have 'slipped through the net.'[a]

4

Harnessing technology to improve access to care

Digital platforms such as those which facilitate remote therapy sessions and online prescription requests, as well as other depression-focused software, smartphone applications and virtual platforms, can allow greater choices of treatment for people with depression while supporting them to take more control of self-managing their condition. While virtual sessions cannot replace in-person therapy, they may be a flexible option to support people with depression between regularly scheduled visits. Health and social services may also use digital tools to facilitate data collection and monitor care.[d, e] In addition, people with depression may find it helpful to use digital tools to connect with others and reduce feelings of isolation.[f]

Summary scorecard for Bulgaria



Joined-up and comprehensive depression services

Is depression included in either the national health plan or a specific plan for mental health?

Is there a government lead on mental health, with cross-ministerial responsibility to support a 'mental health in all plans' approach?

Is collaboration between primary care and mental health services supported and incentivised/encouraged/facilitated?

Are there guidelines on depression care developed jointly by primary care and psychiatry?

Is a range of therapeutic options reimbursed and available to people with depression, such as psychotherapy, counselling and cognitive behavioural therapy?

Are depression services available and tailored for at-risk groups?

- Young people
- Older people
- People in the workplace
- Homeless people

Data to drive improvements in depression care

Are data on people with depression systematically collected by the health system?

Are data on mental health services being used for planning?

Are patient-reported outcomes being measured systematically?

Engaging and empowering people with depression

Do guidelines or care pathways for depression recognise the importance of patient empowerment?

Do guidelines on depression recognise the role of families and carers in making decisions on the planning and delivery of care?

Were patient and carer representatives involved in the most recent national plan or strategy covering depression?

Do carers have access to financial aid to help them support their loved ones with depression?

Is peer support recommended in depression care guidelines?

Are peer support roles reimbursed?

Are there national associations advocating for the rights of:

- People living with depression?
- Carers of people living with depression?

Harnessing technology to improve access to care

Can patients access depression support remotely (via telephone or the internet) in addition to services delivered face-to-face?

Do professional societies or guidelines recommend the use of remote services alongside face-to-face services?

Is remote support for depression reimbursed?

Are people with depression able to use telephone or online platforms that allow them to renew their prescriptions from home?

Joined-up and comprehensive depression services

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.[5]

A small number of psychiatrists are entirely in private practice /about 1% of all psychiatrists in Bulgaria/. Practically these are all psychiatrists who provide outpatient services /about 400 psychiatrists/. Almost all also work in inpatient psychiatric services. All psychological services are entirely private. Everyone who needs psychological help is forced to pay for it. The price of this service varies from 15 to 60 euros per visit. The minimum wage in Bulgaria is 305 euros. Unfortunately, the Ministry of Health and Social Welfare does not interact fully enough.

Professionals show low awareness of ongoing projects in the field of depression management. Innovative methods for the treatment of mental disorders go far beyond pure medical intervention, which in psychiatry is largely limited to drug therapy and some non-drug methods - transcranial magnetic stimulation and electroconvulsive therapy. They involve coordinated action by different groups of professionals - doctors, nurses, psychologists, social workers, as well as the introduction of new jobs and even professions, such as „mental health case manager“ and others. The lack of a comprehensive concept for reform also leads to uncoordinated action in sectors that by definition need to cooperate. To achieve this, there is a need for a change in the legal framework, for the provision of funding and training. So far, Bulgaria still lacks a clear political will for change, despite a number of strategic documents, programs and action plans. None of these documents focus on depression. They are all political and apply to all mental illnesses.[6]

An example of good practice is the RECOVER-E project.[7] Bulgaria is also participating in a project for the transfer of good practices and policies Joint Action Implemental.[8]

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 National Health Insurance Fund (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. A patient may be referred to a psychiatrist no more than four times a year. This is covered by the fund. The rules are very complicated, there is no specifics on how to interpret them.[9]

The European Psychiatric Association (EPA) was invited in 2018 to Bulgaria to send an official team to visit and review mental health services in Bulgaria and advise the Ministry of Health regarding their 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 has adopted a document that is key to the development of psychiatric care over the next ten years: the National strategy for mental health for citizens of Bulgaria.[10] A central priority and at the same time a mechanism for the implementation of the Strategy is the integration of cross-sectoral policies.[11]

Plans and measures of the National strategy for mental health:

- Assessment of the needs of the population for mental health services and their provision at the territorial level.
- Relocation of part of the state psychiatric hospital in accordance with the needs assessment.
- Respect for human rights and combat stigma and discrimination. Integration of psychiatric services into general health care (deinstitutionalisation).
- Establishment of a network of services for complex services for people with severe mental illness, close to the place of residence.
- Development of child and adolescent psychiatry, elderly psychiatry and addiction psychiatry. Opening a clinic for the treatment of eating disorders.
- Development of programs for prevention and early interventions for prodromes of psychosis, alcohol and drug use, case management and provision of psychosocial interventions in the community.
- Opening of psychiatric wards at the medical establishments for hospital care and of centers for mental health according to the assessment of the regional needs.
- Development of forensic psychiatry. Opening a specialized clinic for forensic psychiatry independent of the penitentiary system with sufficient capacity to provide assessment and treatment of forensic psychiatric cases.
- Improving the way of financing inpatient psychiatric care with opportunities for inclusion in the health insurance model.
- Development of human resources and increase of the capacity and motivation of the employees in the system.
- The existing network of state psychiatric hospitals should be optimized and gradually reduce its bed capacity to provide long-term specialized treatment of patients with severe mental illness. It should be aimed at stabilizing the condition of the sick and continuing care in the community, without this being related to the provision of residential care and institutionalization of the sick.[12]

A very complicated patient's pathway

One of the major problems of psychiatric care today is the fragmentary nature and lack of continuity in both care and therapy and patient information. After discharge from a psychiatric hospital, the patient cannot be routinely referred for follow-up, maintenance therapy and any psychosocial interventions to integrate him back into the community. These activities are undertaken chaotically depending on the condition, whether this patient is covered by a relevant outpatient service or has the initiative of relatives.

In order to use the services of the National Health Insurance Fund, the patient must visit a general practitioner, receive a referral to a specialist, visit a specialist, then certify the received protocol for medicines, and if it is for expensive drugs, go through a special commission and then return to the GP for a prescription and finally visit a pharmacy to receive the medication. Medications for schizophrenia and ADHD are fully reimbursed, but no more than 3 types of medications per patient. Antidepressants are partially reimbursed (a very small percentage of the price is paid, although their cost is low), but with an indication only for recurrent depressive disorder.

From contracts with the National Health Insurance Fund, the financing is mainly in the case of outpatient psychiatric care - separate offices or open offices to other medical structures. The revenues in some medical institutions for inpatient care are from the National Health Insurance Fund for dispensary activities.

There are no data on out-of-pocket payments to users of mental health services, but it can be assumed that they are significant, given two circumstances. Firstly, most people pass through these offices with the so-called common mental disorders, which account for about 19.5% of all illnesses, and secondly, the majority of people with severe mental disorders are insolvent and do not reach psychiatric offices without a contract with the NHIF.[13]

Data to drive improvements in depression care

According to the latest nationally representative epidemiological study (2017)[14], lifelong morbidity from common mental disorders in Bulgaria is 14.54%. These data show the relationship between stress levels and prevalence of this group of mental disorders in Bulgaria.

Lifelong illness is common mental disorder is as follows:

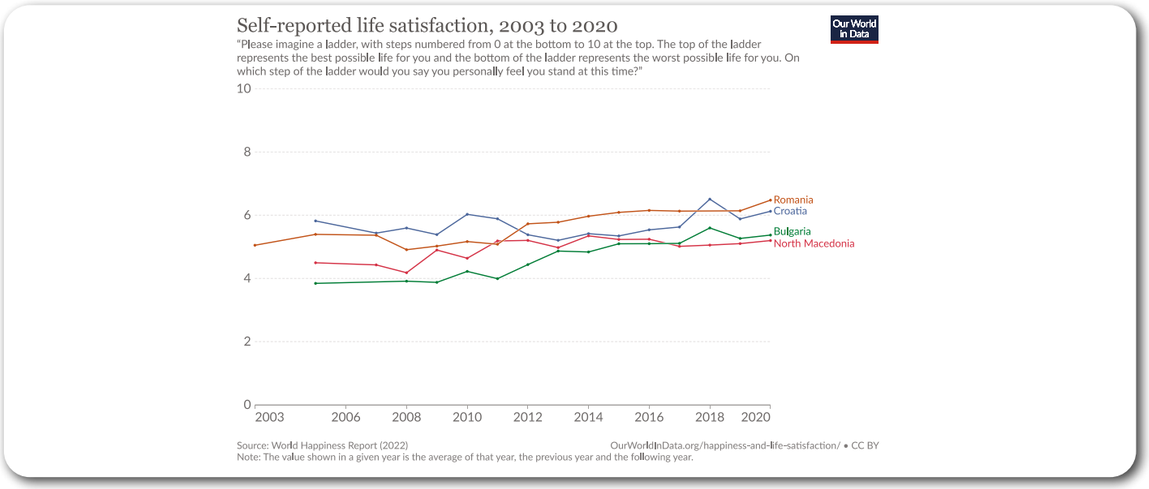
- Anxiety disorders - 8.4%
- Mood disorders - 4.5%
- Alcohol and drug abuse and dependence - 4.76% (as the share of alcohol abuse and dependence is 4.4%)[15]

Depression statistics in Bulgaria show worrying trends

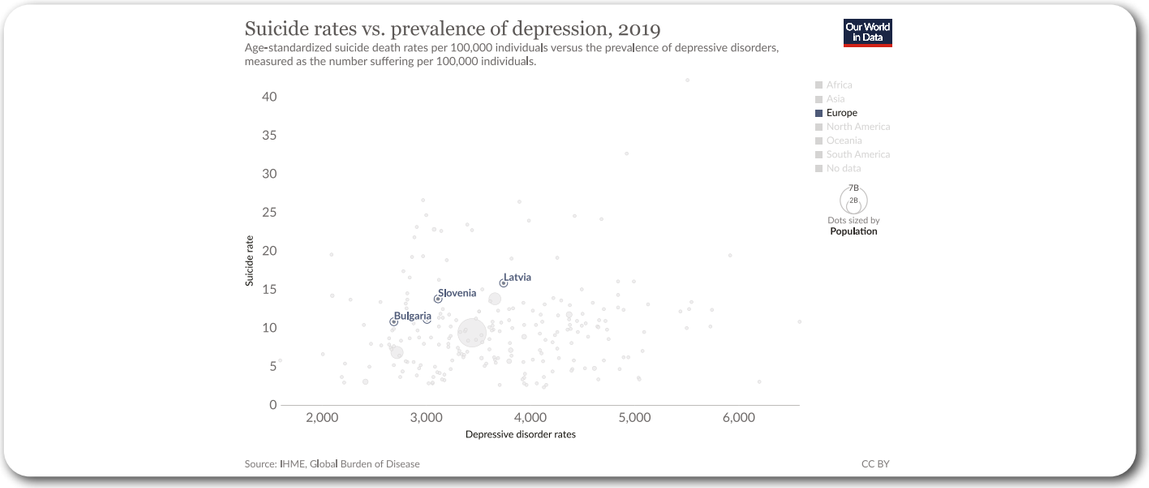
For Bulgaria, the lifetime incidence of affective disorders for both sexes is 6.2% and 12-month 2.8%. The disease leads to problems of different nature - social, psychological, biological. This is the main disease leading to permanent damage and the main cause of death in the age group 18-44 years.

The relative share of patients with depression in Bulgaria hospitalized in psychiatric institutions is about 15% of all hospitalized patients.[16] Deaths due to suicide reach 1.5%, while suicide is the 10th leading cause of death in the country.[17]

- Illness from depression and life satisfaction



- Suicide rate and morbidity from depression[18]



Psychiatric capacities are unevenly distributed

There are currently 12 state psychiatric hospitals with 2,225 beds and 128 day care facilities.[19] Although they are located throughout Bulgaria, the distribution is not always directly related to local needs and is influenced by historical factors.

There are 22 child psychiatrists in Bulgaria. There are two inpatient psychiatric wards for child psychiatry. In the Ruse and the "Prof. N. Shipkovenski "it is possible to consult children without bed rest.

The number of psychiatrists is about 500, very unevenly distributed, concentrated mainly around cities with medical universities, approximately 1 psychiatrist per 15,000 population. Nearly 80% of them work in psychiatric hospitals and 20% in outpatient services. The number of child psychiatrists with a recognized specialty in child psychiatry in the country is only 22 with extremely uneven territorial distribution. The number of contractors with the NHIF is about 400, and 25% of them are in Sofia (NHIF data, 2018). These indicators put Bulgaria last in Europe.

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

There is an uneven territorial distribution of the medical establishments for inpatient psychiatric care and of the hospital beds according to the levels of competence. The provision of inpatient psychiatric care in state psychiatric hospitals mainly includes hospital beds of the lowest first level of competence, which presupposes the diagnosis and treatment of patients under the conditions of a minimum requirement for the quality of medical services. For the administrative districts that do not have mental health centers, the Ministry of Health has not issued clear and precise instructions as to which medical institution should perform the legally assigned activities of a mental health center for establishing and maintaining a regional information system for persons with mental disorders, promotion, prevention and improvement of the mental health of the population, as well as for informing the public on the problems of mental health.

Investments in depression care are increasing

The amount of public funds planned for mental health is significant and increased from BGN 53,380 thousand in 2017 to BGN 65,932 thousand in 2019.[20]

By 2020, the cost per bed in state psychiatric hospitals is up to 5 times lower than the cost per bed in other hospitals.[21]

The financing of psychiatric hospitals is based on four lines: from the state budget, from contracts with the National Health Insurance Fund, from municipalities and from private payments. Funding from the state budget is carried out according to criteria and order determined by an ordinance of the Minister of Health (*Ordinance № 3 of April 5, 2019 on medical activities outside the scope of compulsory health insurance, for which the Ministry of Health subsidizes medical institutions, and the procedure for subsidizing medical institutions*), which includes inpatient treatment of patients with mental illness, treatment with substitution and maintenance programs with methadone and daily psychorehabilitation programs, creates opposition and tension between the different types of medical institutions and reflects on the quality of medical services.

Through Ordinance №3/2019, subsidies are provided to CPCs, clinics and wards at multidisciplinary hospitals with 1st, 2nd or 3rd level of competence in accordance with the medical standard "Psychiatry". From contracts with the National Health Insurance Fund, the financing is mainly for outpatient psychiatric care - separate offices or open to other medical structures. The revenues in some medical institutions for inpatient care are from the National Health Insurance Fund for dispensary activities. There are no data on out-of-pocket payments for users of mental health services, but it can be assumed that they are significant, given that most of these offices are people with so-called frequent mental disorders, whose prevalence is about 17.5% of all diseases.

In addition, the vast majority of people with severe mental disorders are insolvent and do not reach psychiatric offices that do not have a contract with the NHIF. In general, the costs of inpatient psychiatric care are estimated at about BGN 100 million or about 2.5% of the total health care budget in the country.

In Bulgaria, a lot of data is collected from various institutions - the National Statistical Institute, National Center of Public Health and Analyses, National Health Insurance Fund, Ministry of Health. This information is collected in different forms and with different questionnaires. There are also no specific targets for collecting this information. This creates preconditions for data discrepancies and disrupts planning opportunities.[22]

Engaging and empowering people with depression

Professionals are unanimous that caregivers, and especially patients themselves, are not sufficiently involved in decision-making. Patients and their carers need to be actively involved through various forms at both local and central level in order to be able to actively influence the policies, the work of mental health professionals, the reimbursement of medicines and services and, of course, the quality of care.

While acknowledging that this process is key, professionals believe it is used in a few places. One of the big problems in Bulgaria is the traditional medical model. Patients are not empowered and are not encouraged to participate actively in the treatment process[23]. Professionals are adamant that such support is lacking, as no rules and mechanisms have been developed for valuing and paying for such services.

Mental illnesses are traditionally linked with the failure of acceptance by the society, fear and stigma. Stigmatization of persons with mental health issues constitutes a serious problem, the consequences of which are numerous and they are manifested both in experiencing one's own illness and in the reduced motivation to request professional assistance. Stigma, due to mental illnesses is so strong that it creates a wall of silence in relation to this problem, worsens the underlying illness and makes it even more unbearable and difficult. Anti-stigma campaigns are isolated, sporadic and non-governmental. Suicide prevention and anti-depression campaigns by PR Care are good examples.[24]

Civil society organizations, established and registered under the Non-Profit Legal Entities Act, are involved in the problems of mentally ill people and protect the rights and interests of the groups they represent. Their goal is to provide the necessary support to people with mental health problems and their loved ones to cope better. Organizations protect the rights of these people by requiring the state to change systems adequately and ensure that their rights and interests are respected.

- Bulgarian Association for Persons with Intellectual Disabilities (BALIZ) is a national network of parents' organizations that works for the dignified and independent life of persons with intellectual disabilities and their families. The Association advocates for national and local policies that respect the rights of people with intellectual disabilities and help build the necessary supportive environment and full integration into society.
- Global Initiative in Psychiatry (GIP) is an organization that fights against stigma and discrimination against the mentally ill and works in support of mental health reform, the rights of the mentally ill; raising the standard of mental health care through the development of alternative services in the community; supporting partnerships between organizations and individuals working in the field of mental health. The organization maintains a complex of mental health services in the community, which includes a day center, sheltered housing and information center for people with severe mental disorders.
- Bulgarian Psychiatric Association (BPA) unites psychiatrists and other professionals in mental health and neuroscience, who practice medical, research, teaching and other professional activities in these fields. The purpose of the Association is to promote the free and dignified exercise of professions, as well as to help improve the mental health of the nation.

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.

Harnessing technology to improve access to care

The responses highlighted the low level of familiarity with digital technologies and the idea of how these technologies can be applied in the field of mental health.

Again, there is almost no knowledge of ongoing projects and initiatives in the field of digital technologies.

There is no idea of reimbursing this type of service in public policy. In Bulgaria, the electronic prescription was officially introduced in mid-2021. However, there is no clear regulation for its use. A proposal is made to improve the gaps and improve by creating regulations that would allow the valuation and payment of this type of services. In the first 10 months of 2021, psychiatric visits were about 23,000 more than in 2019. For the same period in 2020, about 15,000 fewer examinations were conducted than in the same nine months of 2019. For 2020 (during the pandemic to COVID-19), this can be explained by the restrictive measures introduced at the beginning of the pandemic, with the drastic reduction in the demand for psychiatric care due to people's fear and/or the postponement of "planned" visits. In addition, it is also possible that this is a result of the restriction of outpatient work by psychiatrists (Figure 12). For the increased number of sessions in 2021, the hypothesis is that the fear and anxiety of the pandemic is growing, and the demand for help from a psychiatrist is growing. From the beginning of 2021 until the end of October 2021, psychiatric consultations are almost as many as in the whole of 2019.[25]

Experts in Bulgaria report that digital platforms exist[26] , but they are a private initiative[27], not a government policy.[22] One example is chatbot via Viber platform – resolutionalry first in Bulgaria, containing comprehensive information for mental diseases, geolocation for determining psychologists and emergency centers, as well as interactive tests and questionnaires. Currently 25 000+ subscribers.

Conclusion and recommendations

The mental health strategy is key to the future of the psychiatric network in Bulgaria and to the development of care for people with depression. The main priorities of the strategy are:

- To 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 priorities and available resources.
- To Improve education and training in evidence-based psychotherapy and psychosocial interventions, including in human rights.
- To make an implementation plan and coordinate a realistic spectrum of services responsive to population needs.

There are many challenges to the strategy such as:

- A small number of clinical psychologists.
- Lack of a register of psychologists.
- Lack of a law on psychotherapy.
- The profession of psychologist is not clearly defined.

At this time psychotherapy can be practiced only in psychiatric institutions /This means that the practice of private service is semi-illegal/.

Priority recommendations

Joined-up and comprehensive depression services

- Implementation of the Mental Health Strategy.
- Continuing training for specialists in primary health care.
- Funding for alternative treatment methods - hardware and evidence-based psychotherapy.

Data to drive improvements in depression care

In Bulgaria, a lot of data is collected from various institutions - the National Statistical Institute. National Center of Public Health and Analyses, National Health Insurance Fund, Ministry of Health. This information is collected in different forms and with different questionnaires. There are also no specific targets for collecting this information. This creates preconditions for data discrepancies and disrupts planning opportunities.[24]

- Financing the collection of data on depression.
- Preparation of normative documents based on evidence.
- Creation of a unified information system.

Engaging and empowering people with depression

Patient organizations were established in Bulgaria as early as 1944-1989, but they were always “infiltrated” by professionals who “directed” patients in the “right” direction. After the changes in 1989, various patient organizations were established, but due to the lack of a state policy to ensure sustainability, they gradually ceased their activities.[23]

- Creating a sustainable organization of patients with mental disorders, funded and supported by the state.
- Engage “experienced experts” in the treatment of depression.
- Creating conditions to support relatives, caring for patients with depression.

Harnessing technology to improve access to care

Bulgaria has been working on information technology, e-prescription and diagnostically related groups since 2001. Unfortunately, the whole process of a unified, integrated information system, with a patient file, failed to materialize.[10]

- Administrative regulation of digital consulting.
- Reimbursement of digital services.
- Promotion of digital platforms.

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