Country Profile "Bulgaria"

Suicide and Suicide Prevention: Key Facts and National Priorities

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Introduction

The EU-Co-funded "Joint Action on Implementation of Best Practices in the area of Mental Health", short **JA ImpleMENTAL** has a duration of 3 years, lasting from October 2021 to September 2024. Detailed information can be found at the project's website JA ImpleMENTAL ja-implemental.eu. It aims to promote and improve mental health structures, services, capacity and outcomes in participating countries in 2 specific areas:

- mental health reform (promoting community health services) and
- suicide prevention.

Two national best practices - mental health reform in Belgium and the Austrian suicide prevention programme SUPRA - serve as best practice examples. Selected components of these should be prioritised and implemented over the course of the JA in 14 i.e. 17 participating EU-countries. JA ImpleMENTAL comprises 6 Work Packages (WPs), 4 horizontal WPS and one for each best practice. **WP6 on suicide prevention** aims to support improvement in knowledge and quality of suicide prevention services. Defined elements of SUPRA should be transferred and pilot implemented at national/regional level, suicide prevention strategies in participating countries developed i.e. revised.

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

1 Context

1.1 Country, Health and Social System

The Republic of Bulgaria is a country in Southeastern Europe. It is bordered to the north by Romania, to the west by Serbia and North Macedonia, to the south by Greece, to the southeast by Turkey and to the east by the Black Sea. The capital of the country is Sofia and the country is divided into 28 districts. Bulgaria has 6 838 937 inhabitants distributed over 110,879 km2 including small Turk /8.4%/ and Roma /4.4%/ populations, residents in cities /78%/ predominate over those in rural areas /22%/[1]. Bulgaria joined the European Union (EU) in 2007 and ranks 71nd in the world by per capita GDP. The Health Act was introduced in 2005 for the first time although some efforts in that direction have been done before[2]. The Health Act is a normative document that was adopted by the Bulgarian government before Bulgaria's accession to the European Union.

Table 1: Population structure: 2022, expressed as number of persons, by age and sex

	Sex		
Age group	male	female	**total**
<18	674 776	637 397	1 312 173
18 - 64	2 014 810	1 817 125	3 831 935
65+	621 725	1 073 104	1 694 829
Total	**3 311 311**	**3 527 626**	**6 838 937**

Healthy life expectancy at birth is 71.4, and 15.2 at age 65 (2021). A total of 31.7% of the population is at risk of poverty and social exclusion (2021). Income inequality, expressed as the Gini coefficient, is 39.7 (2021), and total healthcare expenditure relative to GDP is 7.1% (2021).

The Bulgarian healthcare system includes compulsory social health insurance. The Bulgarian healthcare system is based on a scheme for compulsory social health insurance, with voluntary health insurance playing a minor role. In the social health insurance system, the National Health Insurance Fund (NHIF), through its branches of 28 regional health insurance funds, is the sole purchaser of health services. State health policy is governed by the Council of Ministers and the Ministry of Health is responsible for the overall management of the health system. This includes drafting health legislation, coordinating and controlling the various subordinate bodies, as well as planning and regulating providers of health services. At district level, public health policy is organised by the regional health inspectorates (RHIs), which are the local bodies of the Ministry of Health (MoH).

1.2 Mental Health System

After an official evaluation and recommendations of the European Psychiatric Association in 2018, a National Strategy for Mental Health[3] was adopted by act of the Council of Ministers in 2021 . A National Council was established in 2022 to guide and steer the process of its implementation in 2022. The Strategy envisages a major paradigm shift towards community based care and seeks relevant funding for multidisciplinary case management in psychiatry.

The main aims of the Strategy are briefly summarized bellow :

- Reducing morbidity, morbidity and mortality from mental disorders.
- Integrating psychiatric services into general medical care (deinstitutionalisation).
- Creating a network of integrated services for people with severe mental illness, in close proximity to their place of residence, centres for the treatment of disorders in the community, eating disorders.
- Reducing alcohol and drug use and reducing manifestations of aggression and self-aggression.
- Developing child and adolescent psychiatry, old-age psychiatry and Forensic psychiatry.
- Special focus on child mental health in line with the Convention on Rights of the Child to ensure special protection of children's rights, including the right to health and access to health and medical care.
- Introducing a system to collect statistical information by region, type of mental illness among children, age and analysis of the data collected, including conducting targeted surveys on mental illness among children, disaggregated by age.
- Developing specific measures and incentives to attract and retain specialists in child and adolescent psychiatry, forensic psychiatry and psychiatry of advanced age.
- Restoring the balance between individual psychiatric professionals, social worker’s psychologists, nurses and orderlies with the development of appropriate Incentives to attract shortage of professionals.
- Respect human rights and combat stigma and discrimination.

Currently the National Strategy is under implementation and monitoring. The total budget of the strategy is approximately EUR 33 million, the money is provided under the Recovery and Sustainability Plan with 4% co-financing from the MoH.

Total governmental expenditure on mental health is 2.6% (as % of total public health expenditure).

The percentage for psychiatric services of the total percentage for health care is very low. A major part of the money is given for inpatient services.

Main forms of government social support available for persons with severe mental health conditions are several: Income support, housing support, employment support, education support, social care support.

The share of the people reporting unmet mental health care needs due to financial reasons are 2.7%[1]
The proportion of involuntary admissions of total admissions is 8.1% for psychiatric hospitals and 2.6% for wards in general hospital and university clinics.
The share of patients, who receive out-patient visits within one month after discharge is 25% or less.
Community-based mental health outpatient facilities are available but they are few.

Table 2: Facilities, number of beds and hospital admissions related to mental health 2020[4]

Indicator at national level[2]		number	rate per 100.000 adult/minor population
Mental health hospitals	Facilities	11	0.2
	Beds	2 074	37.67
	Admissions	7 243	131.53
Psychiatric wards/units in general hospitals	Wards/units	22	0.4
	Beds	891	16.18
	Admissions	11 764	213.63
Mental health inpatient facilities specifically for children and adolescents	Facilities	3	0.23
	Beds	41	3.11
	Admissions	208	15.75

[1] In the interview data, there is only an answer to the question about the presence of chronic depression. We indicate this data.
[2] All data are provided by the NCPHA and the Ministry of Health Bulgaria

2 Suicide and Suicide Prevention

2.1 Situation Analysis (SA)

Figure 1: Suicide rate per 100 000: in the year 2018, by age groups and sex

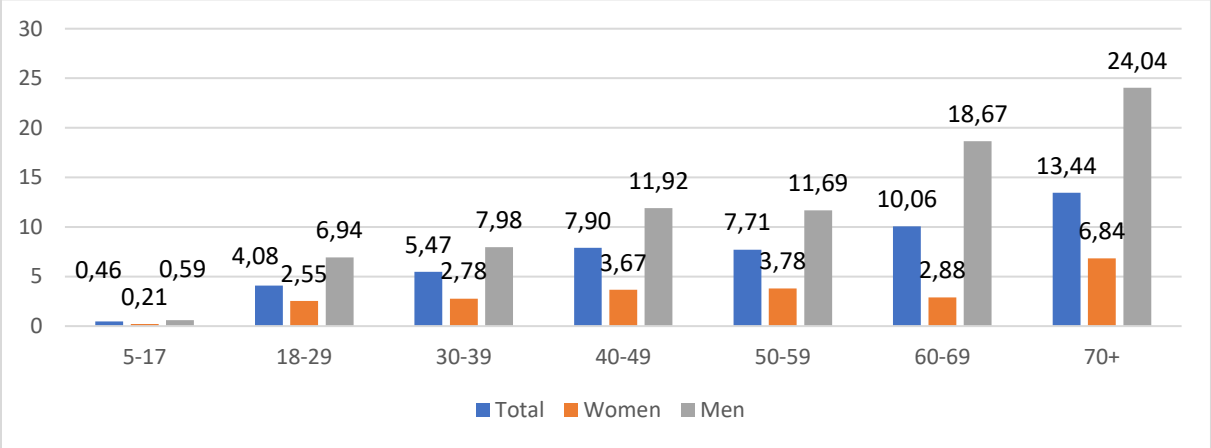
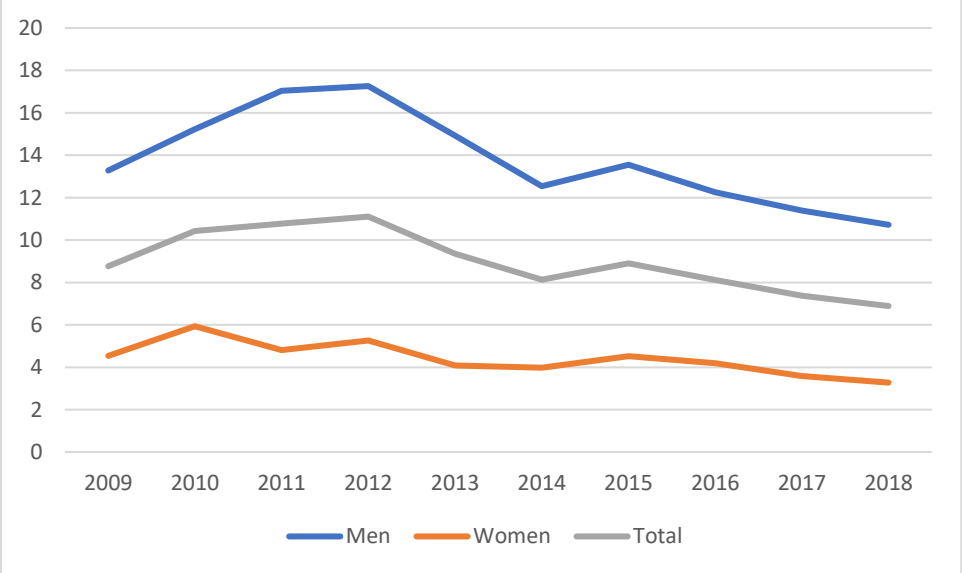


Figure 2. Suicide rates per 100 000 in Bulgaria, *2009-2018*, by sex



Both attempted and completed suicides showed differences between men and women. For women, the frequency of attempts during the period ranged from just over 2 times to 2.5 times that of men. There were no significant fluctuations in attempts for either males or females throughout the period 2009-2018. This was also true for the total number. In terms of the death rate, there has been a trend since 2012 for a steady decrease and reaching values below 10 per 100 000 people, or in other words Bulgaria enters the ranking of countries with low suicide rates. The ratio of deaths is the opposite of the attempts - men die 3 times more often than women. Overall, suicidal acts prevail by about 1.5 times in women. Despite fluctuations in the figures over the years, the median shows that the trend is downwards.

Table 3: Most common methods of suicide: 2018, by age group and sex

Sex/Age	0-19	20-39	40-59	60-79	80+
Women	1. Poisoning 2. Vein shearing 3. Other	1. Poisoning 2. Jumping 3. Vein shearing	1. Poisoning 2. Hanging 3. Jumping	1. Poisoning 2. Hanging 3. Jumping	1. Poisoning 2. Hanging 3. Jumping
Men	1. Poisoning 2. Vein shearing 3. Hanging	1. Poisoning 2. Hanging 3. Jumping	1. Hanging 2. Poisoning 3. Firearm	1. Hanging 2. Poisoning 3. Firearm	1. Hanging 2. Jumping 3. Poisoning

Box 1. Groups most vulnerable to suicide

Group 1 Unemployed /or recently unemployed

Group 2 Single adults

Group 3 People with mental illnesses

Group 4 People addicted to substances

Group 5 Divorced

Box 2. Most common barriers people face when seeking psychosocial help

Barrier 1 High levels of stigma
Barrier 2 Psychological support is not paid for by the health insurance fund
Barrier 3 Lack of resources to deal with psychosocial crises in the primary health care system
Barrier 4 Often, supplemental health insurance excludes mental health services
Barrier 5 Insufficient awareness of the problems related to mental health and low referral to services related to it

No data exist for hospitalization due to self-harm and for most common methods of self-harm with or without a suicidal intent.

In 1999, the World Health Organization (WHO) launched the SUPRE /Suicide Prevention/ programme, whose main goal is to reduce the number of suicides worldwide. Bulgaria participates in the initiative, and for this purpose a National Programme for Suicide Prevention and Suicide Prevention in the Republic of Bulgaria 2000 - 2006 was developed. Manuals on effective suicide prevention for different target groups have been produced (translated from English) and printed.

After 2006, although a new programme had been developed and proposed for a six-year period, practically no activities were funded by the MoH. These activities were carried out entirely on a voluntary basis. In August 2013, the Ministry of Health and Social Affairs launched a new programme

on the implementation of the programme. The Council of Ministers of the Republic of Bulgaria approved a suicide prevention programme in August 2014, but real activities only started in early 2015 with funding from the Norwegian Financial Mechanism. The programme was adopted as a matter of urgency following a series of self-immolations in Bulgaria in 2013.

There are only two suicide prevention helplines in Bulgaria, but they are regional. Measures are in place to store weapons and prevent incidents at national level.

2.2 Needs Assessment (NA)

The need assestmen analysis was done by the mental health team from NCPHA, based on previous prevention programs, international cooperation with Norway. Data on suicide attempts and completed suicides are collected centrally in this structure, allowing for processing and analysis.

Table 6.: SWOT Analysis

Factor	Contents				
Strengths	1. Since 2000, Bulgaria has a national program on SP with measures on both individual and population levels (i.e. multi-sectoral approach).	2. Bulgaria has a suicide registration system that records both attempted and completed suicides.	3.	4.	5.
Weaknesses	1. SP has traditionally focused on mental health services, mainly psychiatry. But many who die by suicide have not had contact with psychiatric care. The cross-sectoral nature of the area requires work by more stakeholders.	2. Despite the existence of a system, some cases are still not reported due to lack of sufficient funding.	3.	4.	5.
Opportunities	1. There is generally high interest in suicide preventive work. The number of people working in the field has increased in recent years, as has public funding to stimulate development.	2. Quick wins such as updated website, knowledge support, webinars and conferences help keep spotlight on SP during the process of working on the strategy.	3. JA ImpleMENTAL (networking with international experts in the field, training for Bulgarian stakeholders, advocacy)	4. Quick wins such as updated website, knowledge support, webinars and conferences help keep spotlight on SP during the process of working on the strategy.	5.
Threats	1. High expectations i.e. “the strategy will solve everything”. Risk for disappointment and critique. End product could also be perceived as too vague or watered down.	2. Further reductions in human resources availability within the social welfare system and health care services is a risk.	3. Negative developments or changes in society at large (e.g. climate change, global conflicts, economic recessions) can affect suicide rates and SP work; other issues can become more pressing and be prioritized. Such societal issues cannot be taken care of by a national strategy for SP.	4.	5.

3 Reflection on SANA results

Since the year 2013, the decline in the national suicide rate has stagnated, and in some groups, such as elderly people, there has been an increase in suicides in the last 10 years. Around 75% of all suicides are among men, and the highest suicide rate is among older males. Suicide attempts however, are more common among younger people, especially females. Among young girls (between 10 and 14 years), suicide attempts by poisoning are increasing.
Suicide and suicide attempts are still major public health concerns that require attention and action. Every suicide is a tragedy for the next of kin, who themselves risk deteriorating mental health and an increased risk of suicide. Many lives lost in this way also mean a great cost to society in years lost.
Several challenges remain such as the need to broaden both professionals' and the public's view of suicide prevention, as something that is not limited to mental health care.
With the current pressed situation in the social welfare and healthcare sectors, especially in regards to lack of human resources, it is imperative that the work is done more effectively, with better coordination and with a stronger focus on mental health promotion and prevention, using an integrated approach. There should be more focus on building secure environments and fostering a more inclusive and forgiving society, where people get help and support when needed.

Box 3.

Prioritized measures for implementation

Measure 1 Cooperation with the media

Measure 2 Reducing access to means

Measure 3 Training of all groups involved in suicide prevention

QUICK WINS

Quick win 1 Improving information quality

Quick win 2 Highlighting the issue of suicide to the public.

! **Quick wins** - easy to implement actions; not expensive, within the control of the team, have visible effects and an impact on high risk groups

4 Next steps

Step 1: Dialogue meetings with stakeholders for input and anchoring of the proposal.

Step 2: Meeting with all 28 director generals for the authorities that have been commissioned to prepare the proposal.

Step 3: Preparation of a communication plan that will include naming the strategy and deciding on its main messages, and which target groups and channels the proposal should be communicated.

Step 4: Finalizing the report to the government that will contain the proposed strategy.

Step 5: Continue work on quick wins, i.e. planning the national conference in the fall, where we can launch the strategy to a wider audience.

Step 6: Initiate first steps of building a structure for implementation and a system for monitoring and evaluation of the national strategy.

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2023 National Statistical Institut Bulgaria
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6 Corresponding authors

The National Center of Public Health and Analyses (NCPHA) as a health institution is engaged in conducting state policy in the field of health care. As a structure of the national health care system on public health issues, the NCPHA carries out a large volume of activities specified in the current legislation - the Health Act and the Regulations on the structure and activity of the NCPHA.

The role of NCPHA is to provide the Bulgarian Ministry of Health with expertise, consultation and analysis in the field of public health: promotional activities, expertise in variety of aspects that influence the public health such as environment, work place, foods and nutrition, physical and chemical factors, etc.

The mission of the National Center of Public Health and Analyses is to combine these diverse activities that contribute to better population's health. All efforts of the Center's persons holding academic ranks, experts and technical staff are aimed at applying modern technologies in the field of public health and taking a leading position in the National healthcare system.

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[4] Mental Health Atlas