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Bulgaria

Failings in the provision of care

The fate of the men of Dragash Voyvoda



Batoshevo, June 2004 © Amnesty International

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Bulgaria Failings in the provision of care The fate of the men of Dragash Voyvoda

Since January 2002 Amnesty International has followed the fate of residents of the now closed Social Care Home for Adults with Mental Disorders in Dragash Voyvoda, in northern Bulgaria. Living conditions and lack of adequate care for the residents in Dragash Voyvoda amounted to inhuman and degrading treatment, in violation of international law¹. During 2001, approximately every fifth man in this social care home, which held around 140 men, died apparently as a result of inadequate medical treatment and care. In August 2002 the Ministry of Labour and Social Policy (MLSP), responsible for the social care home, announced the closure of the institution and the transfer of its residents to other institutions. In November 2002, the Office of the Chief Prosecutor informed Amnesty International that the Pleven County Prosecutor had opened a preliminary inquiry into the deaths of 27 residents of Dragash Voyvoda. No further information regarding this inquiry was received and Amnesty International believes that no criminal investigations were initiated into any of the reported deaths. The transfer of residents to other institutions began in September 2002 and was completed in October 2003 when the last remaining residents of Dragash Voyvoda were transferred to Govezhda.

In April 2003, following a visit to four of the five institutions where about 70 men of Dragash Voyvoda had been transferred, Amnesty International expressed concern to the Bulgarian authorities that the living conditions in these institutions could be described as only marginally better². In a number of documented cases the authorities had placed people with different needs in the same institution, neglecting to ensure each person's physical safety and mental well-being and that they should be provided with adequate care and services. In September 2004 Amnesty International wrote to Christina Christova, Minister of Labour and Social Policy, about the organization's findings and concerns following visits in June 2004 to 12 social care homes. These visits took place as part of Amnesty International's programme to monitor the respect for basic human rights of people with mental disabilities who have been placed for care and treatment in institutions in Bulgaria³. The institutions visited included four which had received, by order of the MLSP, men with mental disabilities from Dragash Voyvoda, upon the decision of its closure. This report focuses on those four institutions, which are located in Govezhda, Batoshevo, Kudelin and Tvarditsa.

¹ See Bulgaria: Residents of Dragash Voyvoda are dying as a result of gross neglect (AI Index: EUR 15/004/2002) published on 15 April 2002 and Bulgaria: Far from the eyes of society – Systematic discrimination against people with mental disabilities (AI Index: EUR 15/005/2002) pages 34, 41, 43, 46, 57-59.

² See Bulgaria: Where are the men of Dragash Voyvoda? (AI Index: EUR 15/003/2003).

³ These visits were conducted jointly with the Bulgarian Helsinki Committee, a human rights non-governmental organization based in Sofia that has worked over the years with Amnesty International in monitoring the discrimination of people with mental disabilities in Bulgaria.

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Govezhda

Following the closure of Dragash Voyvoda in October 2003, the last 64 men were transferred to a refurbished facility in Govezhda, a mountain village 25 kilometres west of Montana. At the time of his visit in June 2004, Amnesty International's delegate observed that the new facility provided improved living quarters in small bungalows, each accommodating six men in two rooms, sharing a bathroom. However, there were no rooms for any day-time activities other than the dining room which was equipped with a television set, providing the only leisure activity. Lack of organized activities was not considered to be as acute in warmer months when a number of residents were engaged in gardening and farming. Although improved, medical care still appeared to be inadequate. For instance, only one of 45 men who are over the age of 50 was diagnosed as suffering from hypertension and no one in this group had a diagnosis of a coronary condition, which is highly unusual given the incidence of cardiovascular conditions in men of that age group in the general population and the fact that most residents are heavy smokers.



Govezhda, June 2004 © Amnesty International

The problem of staffing, particularly on night shifts in this as well as in all other institutions for adults, remained acute and posed great risk to the lives of residents. On 24 February 2004, in the early morning hours, Yoncho Filipov Lazarov died after he was reportedly pushed by an agitated resident who had previously spent two hours in the medical ward and was then returned to his dormitory. It appears

that the staff on duty had not taken appropriate action by making a risk assessment of returning the resident to the dormitory or supervising him following his return. According to the director there was no internal inquiry to establish what failures in the provision of the services may have contributed to this incident.

In April 2003, before the residents of Dragash Voyvoda were moved to Govezhda, Amnesty International's delegate expressed concern about the location of the new facility to Nikolay Angelov, Director of the National Agency for Social Support. As with most other social care homes for people with mental disabilities, Govezhda is remote and it is difficult to recruit staff that has appropriate training. None of the orderlies⁴ employed in the new facility

⁴ Non-medical staff involved in simple care tasks, maintenance of the facility and occasionally entrusted with ensuring security related matters.

have any experience or on-the-job training for work with people with mental health problems. The remote location of the facility also provides few opportunities for reintegration of residents – including possibilities to work in a protective environment. Even the opportunities to visit the community are severely limited. Amnesty International's delegate was told that the residents were not allowed to leave the institution without permission. Visits to the village are allowed only if a resident is accompanied by a staff member. The director stated that such visits were rare as "most residents prefer to stay in the home".

In September 2004 Amnesty International requested from MLSP information about any inquiry into the death of Yoncho Filipov Lazarov and, if available, to receive a copy of its report and recommendations. No reply from MLSP had been received at the time of publication of this report.

Batoshevo

This social care home, which is designated for care of men with intellectual disabilities and currently accommodates around 100 residents, has 27 residents whose only diagnosis is schizophrenia. The inappropriate placement of residents with different needs in the same institution is one of the factors which contributed to the killing of Vasil Malinov in March 2003. Vasil Malinov, a 32-year-old man with intellectual disabilities, shared a room with four other men, some reportedly suffering serious mental illness. On 18 March staff found Vasil Malinov bruised and battered. After medical treatment he was returned to the same room, where three days later he was found dead, having apparently been assaulted once again.⁵

Another factor which appears to have influenced this tragic incident was lack of adequate supervision of residents by the staff. Although the number of staff has been slightly increased, and five orderlies have been engaged by the municipal authorities on temporary work contracts (the MLSP did not provide any additional budgetary resources for this purpose), lack of adequate supervision continued to result in frequent complaints of abuse, including sexual abuse, and violence committed by residents against other residents. Lack of adequate supervision may also have influence an incident which occurred on 11 June 2004 when a resident, who had apparently drowned, was found in a lake close to the social care home. Staff believed that he may have jumped from a bridge over a mountain stream just outside the home's main entrance. However, the results of a criminal investigation were not known at the time of the visit to the institution.

Following the death of Vasil Malinov, when only an orderly was on duty, two staff members are assigned to night shifts: an orderly and a nurse. However, this is still far from adequate, particularly as residents are accommodated in two separate buildings which are structurally difficult to supervise (both of the buildings are multi-storied and far apart and one of the buildings is subdivided with two separate entrances). The staffing situation is only marginally better on day-time shifts. There are four orderlies on duty in the morning and three in the afternoon. Orderlies who were contracted by the municipality have no relevant training.

⁵ See Bulgaria: Where are the men of Dragash Voyvoda? (AI Index: EUR 15/003/2003).

The inadequate number of staff not only fails to effectively protect residents from abuse but is unable to organize any activities for the vast majority of residents. A few residents are engaged in gardening or help the staff to do their work.

In the course of the visit, Amnesty International's delegate obtained information concerning the MSLP Inspectorate's inquiry into the death of Vasil Malinov. The inquiry report, completed on 15 April 2003 established that: the shifts schedule was not properly maintained as some shifts appeared to last 10 to 11 hours; the sign-in sheet was not maintained accurately (two orderlies changed shifts without appropriately recording it); the daily report book was not kept accurately and thoroughly (in the entry for 18 March 2003 there were two incident reports but no mention of the one involving Vasil Malinov, and for 19 March 2003 an attachment to the daily report should have been filed, noting any treatment that he may have received for the injuries he had suffered); and medical documentation was also not accurately maintained (Vasil Malinov's injuries and treatment prescribed on 19 March and 20 March had not been correctly recorded in 'Annex 4'⁶).

The inquiry recommended that appropriate documentation should be accurately maintained and that the director should comply with regulations concerning staff working hours. The director of the institution has appealed to the MSLP about the findings of the inquiry report. There have apparently been no follow-up visits to check on the implementation of these recommendations.

The provision of medical care for Batoshevo residents was another matter of concern. The general practitioner is based in the village and visits the social care home, in principle, twice a month, but sick residents can be taken to his practice when needed. However, the general practitioner is reportedly reluctant to refer residents for specialist examinations and the institution, therefore, had to pay for these services from a very limited budget. One indication that many of the Batoshevo residents may require more medical attention than people of similar age in the general population is that about 40 per cent of residents had suffered tuberculosis in the past, apparently as a result of poor living conditions, nourishment and inadequate medical care. Poor living conditions and nourishment still prevail and several new cases (the exact number was not given) of this condition had been treated in 2003 and 2004.

A number of residents have problems with mobility. Several wheel-chairs, although available, were not in use as the staff feared that other residents would push wheel-chair bound residents down the flights of stairs, in the dormitory buildings or in the grounds. One resident was observed during the visit crawling while another spent all his time in a wheelchair in the dormitory or on the adjoining balcony.

Nikolay Borisov had been transferred to Batoshevo in September 2002, together with nine other men, from Dragash Voyvoda. His brother, who reportedly had also been a resident of Dragash Voyvoda, was transferred to Kudelin. Apparently there has been no response to Nikolay Borisov's request to be reunited with his brother which was communicated to the MLSP by the Batoshevo staff. Nikolay Borisov, who had reportedly twice left Batoshevo

⁶ Reference to a section of the medical file.

without permission and returned to Dragash Voyvoda, was interviewed by Amnesty International's delegate in a three-room section of a dormitory block which he shared with seven other men. This section appeared to be under constant guard during the time of the visit. Some residents stated that it was otherwise locked and that the movement of its residents was strictly controlled.

Tvarditsa

There were plans to divide this large institution for men with mental disabilities, with a capacity for 220 residents, into two institutions: one for men with mental health disorders and another for men with intellectual disabilities. The director of the institution and the responsible municipal and regional authorities believe that this arrangement (both establishments would continue to share existing facilities) will improve staffing levels and funding over the current arrangement⁷. In 2003, 13 new residents had been admitted, including four who had been transferred from social care homes for children. In 2004 two new residents were transferred from social care homes for children.

This practice of continued placement of people with mental disabilities in institutions appeared to be in stark contrast with the government's self-proclaimed policy of reintegration and inclusion. At the same time, the municipality reportedly has plans to refurbish a house in a nearby village, previously used as an orphanage, and to make it a protected home for those residents who have slight disabilities and could begin a programme of reintegration into the community. The establishment of a protected home for residents of Tvarditsa is also mentioned as an example of concrete measures to be taken on the basis of the results of "National monitoring of homes for adults with mental disabilities"⁸. Amnesty International welcomed this initiative and asked the MLSP for information about any support the ministry would provide for its realization.

As during a visit to the institution in April 2003, Amnesty International's delegate found that the living conditions for about 50 men with more complex intellectual disabilities were extremely poor. The dormitories were overcrowded; many beds had dilapidated mattresses and worn bedding, while some beds did not have any sheets. A dining room, also used in winter months as a day room, was empty of furniture (in warmer months of the year the simple wooden benches and tables from this room are kept outside). A bathroom with two showers was in the process of being built at the time of the visit. In the past winters, it was very difficult for residents of this block to take showers or bathe as the bath-house is a considerable distance from the dormitories. There appeared to be no organized activity of any kind and the care for residents in this block seemed to be grossly inadequate.

⁷ This is nominally an institution for men with intellectual disabilities although half of the residents have been diagnosed with a mental health disorder. These institutions receive smaller budgets per resident than institutions which care for men with mental health disorders.

⁸ http://www.mlsp.government.bg/bg/news/news.asp?newsid=6750&catid=1



At the time of the visit of Amnesty

International's delegate in June 2004, as on the previous occasion in April 2003, only one orderly was on duty in this block. About 50 residents were sitting silently on benches. the outside the building. The

Residents of Tvarditsa, June 2004 ©Amnesty International

nurse on duty later told Amnesty International's delegate that residents with intellectual disabilities were treated with antipsychotic drugs. Such practices had been noted in many other social care homes in the past and were evidently intended to control the residents rather than to treat any psychiatric condition.

Amnesty International was also concerned that the conditions in the two sick-rooms in the *statsionar* (surgery), a small building with a doctor's and a dentist's surgery, were not adequate to serve their purpose. These rooms provided only very simple accommodation and patients had to use an outside toilet as there were no sanitary facilities for them in this small building. Amnesty International was also concerned about the quality of medical care provided to residents of this facility. Zh.N.⁹, a 69-year-old resident, who was in the sick-room at the time of the visit, had broken his left femur on 6 March 2004. Subsequently his entire leg was put into a plaster cast in a local hospital. When the cast was taken off it was established that the patient had a wound on his heel. Subsequently, this wound became gangrenous and Zh.N. was taken to a hospital in Sliven on 18 May 2004 where his leg was amputated above the knee. Zh.N. was brought back to the social care home on 15 June 2004. No rehabilitation or physiotherapy had been prescribed nor had this elderly resident, who at the time of the visit appeared deeply depressed, distressed and was uncommunicative, been provided with prosthetic aids or a wheel-chair.

The sick-rooms also appeared to be used to seclude residents whose behaviour was perceived by staff as difficult. P.D., a resident with an intellectual disability, was found lying on a bed even though he was not suffering from any acute condition and was not receiving any treatment. The nurse explained that he was there to be under constant guard as he was prone to leave the institution without permission. Several healthy residents assisted the nurse in keeping this man and possibly other 'patients' effectively guarded.

The conditions in the block for 50 residents with more complex needs and in the two sick-rooms were in stark contrast to those in the new dormitory block, for about 50 men, built

⁹ The identity of some of residents mentioned in this report has been withheld for reasons of confidentiality.

with the funds provided by a foreign charitable organization. This building, however, was only used at night. Each room has new furniture; including wardrobes which were empty (most residents were dressed in old army uniforms and appeared to have no personal belongings). The atmosphere in the dormitories was spartan as residents were evidently not permitted to decorate them in a way that would be more appropriate for them. The bathrooms contained few signs, such as a soap bar or a towel, that they were in use. The entire block was impeccably clean and kept locked and guarded by three residents during the day.

In the large TV room of an older dormitory block, about 50 men were watching a programme. They were supervised by two orderlies, of imposing height and developed musculature, who with threatening looks and gestures prevented anyone from getting up from the benches. A single-story pavilion, between the central dining room/kitchen and the dormitory block with the TV hall, was also in a poor state of repair. The dormitories were very overcrowded and the beds and bedding old.

Kudelin

The current capacity of this institution for men with intellectual disabilities is 200 residents. Between 11 and 13 residents have been diagnosed with schizophrenia and their placement in this home for men with intellectual disabilities was not appropriate. Forty-two men from Dragash Voyvoda were transferred to Kudelin in September 2002. During the recent visit, one of them stated: "A distinction is made here between us [former residents of Dragash Voyvoda] and the old residents. We are not treated equally. And if you are not one of them then life is harder." He was referring to discriminatory treatment of residents. Although in the course of the visit it was not possible to observe any discriminatory treatment of former Dragash Voyvoda residents by staff, it was evident that the conditions in the dormitories they occupied



Dormitory at Kudelin, occupied by former residents of Dragash Voyvoda, June 2004 © Amnesty International

were considerably inferior to those occupied by other residents. Following their transfer from Dragash Vovvoda the men were accommodated on the top floor of a three-storied block, which apparently had not previously been used as sleeping quarters. There was considerably greater degree of overcrowding on this floor, particularly in a large room which contained about 20 beds. The beds and bedding were much shabbier than in dormitories on the lower floors; in some cases

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the state of dilapidation was such that it was difficult to imagine the beds serving any function. The former residents of Dragash Voyvoda have spent the past two winters in these quarters without the benefit of central heating which is available on the two lower floors. Another disadvantage of the top floor accommodation concerns the ease of access to toilets, as the only functional toilets are outside the dormitory block.

Some decorating work on this dormitory block was in progress at the time of the visit. Amnesty International's delegate was told that plans had been prepared to renovate the toilets on each of the three floors. The outside toilets were very crude and dirty and afforded no privacy.

Amnesty International's delegate was informed that in spring 2004 a seven-person MLSP inspection team spent four days visiting this social care home. In September 2004 Amnesty International requested from the MLSP a copy of a report containing any observations and recommendations made following their visit.

General conclusions and recommendations

Safeguards against abuse

Amnesty International is concerned that inquiries conducted by the MLSP Inspectorate into reported cases of abuse, such as the inquiry into the death of Vasil Malinov (see above under *Batoshevo*), appear to have been carried out in a superficial manner and that the recommendations fail to address crucial issues regarding the provision of service which contribute to the occurrence of abuse of residents. Amnesty International is concerned that such inquiries are not effectively focused on establishing the main failings in the provision of care services which should have adequately and effectively protected residents of social care homes and users of community based services from abuse. These inquiries should issue recommendations that would address all the identified failings in the provision of care service in order to minimize the possibility of any similar abuse occurring in the future. Furthermore, the recommendations should be distributed to, and if appropriate, enforced in all similar institutions or service providers.

In April 2003 an Amnesty International delegate discussed the case of Vasil Malinov with Nikolay Angelov, Head of the National Agency for Social Support. Concerned that the procedure followed in the transfer of Dragash Vovyoda residents in September 2002 was inadequate and has resulted *inter alia* in inappropriate placement of Vasil Malinov in an environment with very high risks to his physical and mental integrity, the delegate asked whether anyone from the agency had visited the five institutions before 70 men of Dragash Voyvoda had been transferred there. Such visits would have been necessary to ascertain whether conditions in these homes were suitable for their accommodation and care. Amnesty International believes that this would have been an important measure which would have protected former residents of Dragash Voyvoda from further neglect and other abuse. Nikolay Angelov replied that he had personally visited these institutions. However, directors of the social care homes in question, who had been interviewed on this point by Amnesty

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International's delegate¹⁰, stated that neither Nikolay Angelov nor any of his colleagues from Sofia had visited the institutions prior to the transfer of the men from Dragash Voyvoda. On the same occasion Amnesty International's delegate presented Nikolay Angelov with extensive literature on how independent inquiries into abuse of people with disabilities are conducted in the United Kingdom, as a model of good practice which could assist Bulgarian authorities in improving their own system.

The failure to conduct thorough and impartial inquiries into the deaths of Vasil Malinov, Yoncho Filipov Lazarov (see above under Govezhda) and other residents who died in similar circumstances¹¹ appears to indicate lack of political will in the MSLP to effectively and adequately perform its statutory function to supervise the services for which it is responsible. The authorities have also failed to put in place legal safeguards to protect residents and other service users from abuse and to establish independent mechanisms for investigations into incidents of abuse.

Amnesty International reiterates its appeal to the Bulgarian authorities to implement international standards which stress the need for independent monitoring which, among other things, provides safeguards against abuse for service users, in this case residents of social care homes. The United Nations (UN) Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care¹² require in Principle 22 that: "States shall ensure that appropriate mechanisms are in force to promote compliance with the present principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient."

The UN Committee on Economic, Social and Cultural Rights, in its General Comment on persons with disabilities¹³ also states that "the methods to be used by States Parties in seeking to implement their obligations under the Covenant towards persons with disabilities... include the need to ascertain through regular monitoring, the nature and scope of the problems existing within the state...".

Regrettably, at the time of publication of this report Amnesty International had not received a reply to the September 2004 letter and the requested information on this and other concerns from the MLSP. In the meantime the organization noted that on 29 October 2004 the MLSP posted on its website that the ministry has completed a survey: "National monitoring

¹⁰ The director of Batak, who in April 2003 declined to meet with Amnesty International's delegate or to allow him access to the institution, is the only exception. According to an interview in 24 Chasa published on 2 November 2004, Deputy Minister of MLSP, Ivanka Christova, stated that she is among four directors of social care homes to be removed from their posts.
¹¹ Other death cases include a 41-year-old resident in Social Care Home in Podgumer who was reportedly

¹¹ Other death cases include a 41-year-old resident in Social Care Home in Podgumer who was reportedly strangled by another resident in April 2003 and 59-year-old Boris Ivanov who died in Social Care Home in Pastra in November 2004, reportedly from head injuries caused by another resident.

¹² Adopted by the General Assembly Resolution number 46/119 of 18 February 1992.

¹³ UN Committee on Economic, Social and Cultural Rights, General Comment No. 5, Eleventh Session (1994); "Persons with Disabilities" cited in HRI/GEN/1/REV.5.

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of homes for adults with mental disabilities"¹⁴. The information available indicated that conditions and care in all 40 specialized institutions for people with mental disabilities in Bulgaria had been examined. On the basis of this survey a seminar was reportedly to be organized for directors of social care homes and municipal officials responsible for social services at the end of November 2004 to inform them about the general conclusions, as well as individual assessments of each of the social care homes and possible funding through an investment fund established under the MLSP.

Amnesty International would be grateful to receive the full report of the survey as well as the individual assessment of each home and suggested measures for improvement of conditions and care.

Living conditions and care

Amnesty International is aware that in October 2003 the Ministerial Council increased the funding for social care homes. However, according to the staff of all institutions visited, these resources are still only sufficient to cover the cost of food, medication and essential maintenance of their establishments. Although progress was observed in several institutions visited, by-and-large Amnesty International's concerns regarding the placement and care for children and adults with mental disabilities in social care homes in Bulgaria, presented to the Bulgarian authorities in a series of documents and letters in the past three years, are outstanding. These issues include:

- living conditions and/or lack of appropriate care and treatment in some of the institutions visited, which, depending on the situation, affect all or only some of the residents, are so inadequate that they amount to inhuman and degrading treatment, prohibited by international law, and need to be addressed with utmost urgency;
- there were no effective efforts to set up arrangements which would provide those currently in institutions with opportunities for reintegration into the community; when an institution was closed down due to unacceptable conditions, care and treatment, its residents were simply transferred to another existing or a refurbished institution, most of which were not in a position to provide significant improvements in living conditions or care;
- social care homes continue to receive new residents; the development of communitybased services is still in rudimentary stages and families are not provided with appropriate social support to care for a person with a mental disability at home; some recently admitted residents appeared to have only sight disabilities and would be able to live in the community if they had the relatively little support that they required;
- the staffing in institutions is, to varying degrees, inadequate in number and training, particularly on night shifts, when lack of appropriate supervision and care resulted in situations endangering residents' physical integrity;

¹⁴ http://www.mlsp.government.bg/bg/news/news.asp?newsid=6750&catid=1

- little improvement has been observed in the provision of medical, including psychiatric care, and other therapies and activities;
- some observations made during the visits indicate that the order of the MLSP prohibiting seclusion of residents is not being strictly enforced in all institutions; there appeared to be no guidelines regulating the use of restraint and seclusion methods which would be in line with international human rights standards and best professional practices.

In its report *Bulgaria: Far from the eyes of society – Systematic discrimination against people with mental disabilities* (AI Index: EUR 15/005/2002), published in October 2002 Amnesty International addressed extensive recommendations to the Bulgarian authorities. At the time, Minister Christova gave assurances to Irene Khan, Amnesty International's Secretary General, that the Bulgarian authorities were fully committed to comprehensively reforming the care system and wished to engage on these matters in a constructive dialogue with the organization. However, Amnesty International regrets that the reform efforts observed so far have been inadequate and ineffective and that the authorities have failed to provide the organization with the requested information about the implementation of its recommendations.

Amnesty International's concerns and recommendations with regard to the situation in social care homes, addressed to the Bulgarian authorities in the past three years, have been shared by a number of other international and regional organizations. Most recently, international and regional organizations with a mandate to monitor the implementation of Bulgaria's compliance with international human rights law have expressed concerns which confirmed our findings, and issued similar recommendations. In May 2004 the UN Committee against Torture (CAT), having considered Bulgaria's third periodic report under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment expressed concern about poor conditions in homes for persons with mental disabilities and the insufficient measures taken by the authorities to address the situation, "including the failure to amend the legislation relating to involuntary placement in such institutions... and the lack of judicial appeal and review procedures"¹⁵. The CAT also recommended that the authorities take all necessary measures to ensure "that living conditions, therapy and rehabilitation provided are not in violation of the requirements of the Convention", as well as to ensure that the placement of children in institutions is regularly reviewed. Similar concerns were expressed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) in two reports published in June 2004. These reports concern the CPT visits to Bulgaria in April 2002 and December

¹⁵ See Conclusions and Recommendations of the Committee Against Torture: Bulgaria CAT/C/CR/32/6, published in May 2004.

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2003¹⁶. Both CPT reports contained extensive observations and recommendations with regard to the psychiatric hospital in Karlukovo, and the social care homes in Razdol and Pastra.

Amnesty International, once again calls on the Bulgarian authorities to fully implement its recommendations regarding the treatment of people with mental disabilities, and to ensure that people with mental disabilities are adequately and effectively protected from all forms of discrimination and abuse.

An example of good practice

Mindful of the limited resources provided by Bulgarian authorities for the care of people with mental disabilities, Amnesty International would like to highlight the social care home for adults with intellectual disabilities in Plovdiv, as an example of good practice. It illustrates the feasibility of an acceptable care service provided that the number of residents is limited to a reasonable size, staff has appropriate professional background and training, the facility is effectively and competently managed and effective programmes of integration into the community are implemented for each resident as appropriate.



Plovdiv, June 2004 © Amnesty International

Amnesty International believes that only an institution based in a major urban centre like Plovdiv is likely to be able to recruit such staff and management, indispensable provision for the of appropriate care and therapy. International's Amnesty delegate observed that the residents in this institution, many of whom have very complex needs. were provided with care and activities that appeared to be in line with international human rights standards and best professional practice. The residents also benefited

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¹⁶ See Report to the Bulgarian Government on the visit to Bulgaria carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

from 17 to 26 April 2002 [CPT/Inf (2004) 21] and Report to the Bulgarian Government on the visit to Bulgaria carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 16 to 22 December 2003 [CPT/Inf (2004) 23], both published in Strasbourg in June 2004.

from a pleasant living environment even though the dormitories were far from ideal in view of restricted space available for each individual. However, the residents were encouraged to decorate their area to suit their preferences and were provided with many personal items, ranging from clothes to small household appliances such as coffee-makers. Residents were also assisted in developing skills for independent life and self-autonomy and benefit from social and cultural activities in the city, as well as excursions in the countryside. A number of residents independently visit the city.

However, even if the services and conditions provided in Plovdiv should be the norm for other institutions in the system, for the majority of people with mental disabilities placement in an institution is not the most appropriate way to ensure that they are provided with equal opportunities to exercise their basic rights, including economic, social and cultural rights. The way to achieve this is through integration into the community, which promotes attitudes of inclusiveness and provides appropriate community-based support. According to the staff of the social care home in Plovdiv, about 10 residents could be reintegrated into the community with relatively modest resources and effort, provided that they are appropriately supported by community-based services which have yet to be developed. In September 2004 Amnesty International urged the Bulgarian authorities to support the reintegration of these residents into the community by providing them with the alternative services that they require, such as sheltered housing, protected workplaces and social care support.

Amnesty International believes that human rights apply to all human beings and that the deprivation of rights to one part of the community is a loss to the whole community. People with mental disabilities, who have been placed into institutions have been and remain subject to human rights violations. Amnesty International supports stronger protection for the rights of those with disabilities and campaigns for the full reintegration into society of people with mental disabilities in line with international human rights standards and best professional practices.