NORTHERN IRELAND HUMAN RIGHTS COMMISSION

DHSSPS Strategy and Action Plan to Promote Equality, Good Relations and Human Rights in Health and Social Services: Response of the Northern Ireland Human Rights Commission

1. The Northern Ireland Human Rights Commission (the Commission) is a statutory body created by the Northern Ireland Act 1998. It has a range of functions including reviewing the adequacy and effectiveness of Northern Ireland law and practice relating to the protection of human rights,[1] advising on legislative and other measures which ought to be taken to protect human rights,[2] advising on whether a Bill is compatible with human rights[3] and promoting understanding and awareness of the importance of human rights in Northern Ireland.[4] In all of that work the Commission bases its positions on the full range of internationally accepted human rights standards, including the European Convention on Human Rights (ECHR), other treaty obligations in the Council of Europe and United Nations systems, and the non-binding 'soft law' standards developed by the human rights bodies.

2. The Commission welcomes this opportunity to comment on the consultation on a Strategy and Action Plan to Promote Equality, Good Relations and Human Rights in Health and Social Services (the Strategy). The Commission would like to express its appreciation for the time that was taken out by staff from the Department of Health, Social Services and Public Safety (DHSSPS) to meet with staff of this Commission in December to discuss the human rights aspects of the Strategy.

3. Much of what follows was have been expressed at that meeting, and this written response is provided to assist the

[1] Northern Ireland Act 1998, s.69(1).
[2] *Ibid.*, s.69(3).
[3] *Ibid.,* s.69(4).
[4] *Ibid.,* s.69(6).

DHSSPS and to enable the Commission to make its views available via its website.

4. The Strategy as it stands is an extremely broad one that draws on, and refers extensively to existing strategies, action plans and policy initiatives across Government. The Commission welcomes such cross-referencing; in the past several public-sector strategies have been developed in ways that show little or no awareness of how existing Governmental initiatives may impact on them.

5. The Commission understands the need for a balanced document that, on the one hand, is broad enough to be open to innovative and new approaches and, on the other, is sufficiently detailed to be worthwhile at a practical level. In many ways this Strategy differs significantly from others because it deals with matters so universal and relevant to people's life experiences. The simple fact is that almost everyone in Northern Ireland will at some point be personally engaged with the agencies within the remit of the Strategy as they try to access health and social care for themselves or friends, family or dependants. The Commission appreciates the complexity of the task that faces the DHSPSS both in devising the Strategy in the first place and then in ensuring that it is implemented.

6. However, at present, it would seem that the human rights aspect of the Strategy requires considerable development. As it stands it is difficult for both users and service providers to grasp exactly what human rights mean for them in terms of health and social services. From the user perspective, what difference from the health care profession can we expect once human rights have been mainstreamed into the DHSSPS? How will their experiences be different and what can they reasonably expect from front-line staff, from Practice Manager at their GP surgery up to consultant level? For service providers, the Strategy should offer guidance on how the way in which they carry out their duties ought to be changing in line with human rights protections.

7. It would be useful if the Strategy document could begin with a list of those human rights enshrined in international and domestic law that the Strategy engages and aims to protect and fulfil. This would help readers gain a better understanding of exactly what human rights they can rely on in accessing appropriate health and social care.

Health care-related human rights

8. The notion of access to health and health care as a human right is articulated in a number of international instruments that are binding on the United Kingdom only in terms of international law, without being justiciable in the domestic courts. For example, under the International Covenant on Economic, Social and Cultural Rights everyone has "the right to enjoyment of the highest attainable standard of physical and mental health".

9. The European Convention on Human Rights, which has been incorporated into domestic law through the Human Rights Act 1998, does not contain an explicit formulation of health-related rights but has several provisions that can be relevant both in terms of providing individual remedies, and in terms of policy making. For example, Article 2 of the ECHR, under which "Everyone's right to life shall be protected by law", needs to be borne in mind when making resource decisions that could increase the risks for particular groups. Individuals may also rely on Article 2 to challenge decisions around potentially life saving treatment, or in relation to health ands safety concerns, in the context of investigation of death resulting from medical accidents, or in other ways.

10. Likewise Article 3 of the ECHR, prohibiting "inhuman or degrading treatment", could be engaged in such contexts as seriously deficient facilities in care settings, or denial of a treatment where that could result in extreme suffering.

11. Access to, or lack of, health care, and the way in which individuals and members of their families are treated by health care providers also engage Article 8 of the ECHR. This provides that: "Everyone has the right to respect for his private and family life, his home and his correspondence. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others".

12. Article 5 of the ECHR also enshrines the right to "liberty and security of person". The principal exceptions concern lawful arrest and detention in the criminal justice context, and here it is worth underlining the point that anyone so detained has

the right to an equivalent standard of health care to that available in the wider community. The transfer of responsibility for health care from the Prison Service to local Trusts provides an opportunity to reexamine whether that equivalence of care is ensured.

13. Beyond that context, Article 5 also provides that "No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:… the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, drug addicts or vagrants". The evolution of human rights law has narrowed the scope of that exceptions clause but it remains particularly relevant for persons compulsorily admitted for assessment or detained for treatment of mental health problems. Article 5 is also of potential relevance for anyone in a health care or social care setting who, even if not formally detained, has their freedom of movement restricted by act or omission; for example, where someone is inappropriately held in a locked ward, or where provision is not properly made to enable someone to enjoy their freedom. Article 5 considerations will need to inform the reshaping of mental health legislation following on from the Bamford Review.

14. In addition, Article 14 of the ECHR prohibits states from discriminating on a number of grounds in guaranteeing the rights in that treaty.

The Strategy's human rights content

15. Reference to these human rights then need to be further elaborated in the Strategy. For example, as noted above, Article 2 of the European Convention is not only engaged when individuals are denied treatment that could be life-saving but also requires effective investigations in the event of a death occurring in hospital. It is difficult, even for this Commission, to see how all relevant information on the human rights standards, relevant caselaw and possible real-life scenarios could be factored into one accessible document that aims to cover human rights, equality and good relations, particularly if it is to be completed, even in draft, relatively soon.

16. The Commission would suggest that perhaps it would be more feasible to formulate a separate strategy for human rights. There are a number of reasons for making this suggestion.

The human rights obligations on the DHSSPS obviously arise directly from the Human Rights Act 1998, and less immediately from a number of international human rights treaties to which the UK is a party. However, the duties to promote equality and good relations arise from a separate piece of legislation, the Northern Ireland Act 1998. Thus two separate strategies dealing with different bodies of legal obligations may be one way forward.

17. It is the Commission's understanding, through interaction with government departments at various levels, that there are varied levels of knowledge of the requirements of equality and human rights obligations across the Northern Ireland Administration. While all policies and legislative proposals must be accompanied by an Equality Impact Assessment, there is no corresponding mechanism for human rights that might act as an aid for policy makers. This would suggest the need for a strategy that aims to build on current work to develop such mechanisms for human rights. That would in turn make the strategy for human rights much more of a living document than perhaps the equality and good relations strategy which is in effect able to point to much more concrete examples of good and bad practice.

18. At present there is a significant amount of work being undertaken to develop a human rights framework for the provision of health care. For example, in the context of Great Britain, the British Institute of Human Rights and the Department of Health are working on a joint project to bring together and test existing and developing best practice in order to create a practical human rights framework that can be used by organisations across the NHS to help them use human rights in the delivery of health services.

19. The United Nations, in May 2006, published a "Report on Indicators for Monitoring Compliance with International Human Rights Instruments" which includes a list of indicators on the right to enjoyment of the highest attainable standard of physical and mental health.[5] There are also a number of academics working on developing human rights indicators and also looking specifically at the social determinants of health.[6]

20. In addition the work of the Regulation and Quality

[5] UN *Report on Indicators for Monitoring Compliance With International Human Rights Instruments*, HRI/MC/2006/7

[6] See for example, M.l Marmot and R. Wilkinson (eds) *Social Determinants of Health*, Oxford University Press, 2005

Improvement Authority will also have implications for the work of the DHSSPS. The guidelines provided by the National Institute for Health and Clinical Excellence (NICE) are also likely to touch upon the remit of any Strategy being developed by the DHSSPS.

21. The DHSSPS may also wish to look at the experiences of other public bodies that have been through the process of developing a human rights framework to its work.

22. The Commission would also suggest that perhaps the DHSSPS could consider convening some further meetings to develop the human rights aspects of the Strategy, (or as suggested above, a separate human rights strategy) with relevant stakeholders and experts in the field. This would aid the DHSSPS in developing the human rights aspects of the Strategy in a number of ways. It would, for example, alert it to work being taken forward in this area in other jurisdictions and by other organisations in this jurisdiction, which could be adapted appropriately for the Strategy in Northern Ireland. It would also, by engaging with non-governmental organisations and community groups, alert the DHSSPS of the types of issues users of health and social services experience at grass roots level. Such an approach would also help keep the Strategy a living document because the DHSPPS would be kept aware of the changing environment in this field.

23. The Commission itself is keen to take forward its own work in relation to the protection of economic, social and cultural rights and plans to prioritise health as one aspect of this over the next business year. It would therefore be willing to advise the DHSSPS on the Strategy's development insofar as the many demands on its limited resources allow.

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