Right to Health: Putting principles into practice

Introduction

The purpose of this aspect of the Charter Toolkit is to explain what is meant by the right to health for people affected by substance use and give examples of how a rights-based approach to health can be applied in practice.

It will do this by:

1. Explaining what is meant by the right to health as a right in international law.
2. Explaining the **PANEL** principles (**P**articipation, **A**ccountability, **N**on-discrimination and equality, **E**mpowerment and capacity-building, and **L**egality) which provide the foundation for taking a human rights-based approach in practice.
3. Providing a **checklist** to support assessment of the right to health in practice.
4. Identifying **examples** of how the AAAQ framework and the PANEL principles can be applied in practice. Guidance on how the FAIR model can support the application of a human rights-based approach in different contexts can be found here: https://www.alliance-scotland.org.uk/blog/resources/charter-toolkit-fair-documents/

What do we mean by the "right to health"?

Everyone has the **right to the highest attainable standard of physical and mental health**. This is set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). This is a right in international human rights law which means that the UK – and Scotland – is required to put it into practice although it is not enforceable through the courts. At the time of publication of the Charter, the Scottish Government is developing proposals for a new Scottish Human Rights Bill which intends to bring this right into domestic law within the limits of devolved competence.

The Committee on Economic, Social and Cultural Rights adopted General Comment No. 14 in 2000 which provides an authoritative interpretation of the right to health. This sets out that every person is entitled to, among other things, access to timely and appropriate support for physical and mental health and that services need to be

available, accessible, acceptable and of quality, without discrimination. [1] This has become known as the **"tripleAAAQ"** framework.

"Health" is broadly understood as relating to healthcare (including drug and/or alcohol treatment services) AND positive determinants of good health. These are non-medical factors that influence health outcomes by affecting the conditions in which we are born, grow, live, learn, work and age. They include things like income, education, employment, food, community and housing.

Therefore, the right to health is closely related to and dependent on other human rights. Some of these are already in our legal framework (e.g. right to life, freedom from torture and inhuman or degrading treatment).

Along with the right to health, the proposals for a new Human Rights Bill intend to incorporate other human rights into our domestic law, within the limits of devolved competence (e.g. the right to an adequate standard of living.)

What is expected of "duty bearers" in implementing the Right to Health?

States have an obligation to **respect, protect and fulfil** human rights. In the context of people affected by substance use this requires action from across different levels of law, policy and practice by a range of "duty bearers."

Some aspects of obligations under the right to health may be "**progressively realised"** due to resource constraints. To progress these aspects, services and Governments need to have considered the human rights of individuals when making decisions and show that they have a plan for how to improve things that is informed by communities.

There are other "core" parts of the right to health which should be implemented immediately, including:

- ensuring that the right to health is realised without **discrimination.** For example, the level of health and care services available to people in prisons must be equal to what is available in communities. People must not be turned away from health-care services because they are using drugs or have used drugs in the past.[2]

[1] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 11 and 12. See also Committee on Economic, Social and Cultural Rights, general comment No. 20 (2009), paras. 7 and 8 (a) and (b).
[2] A/65/255, para. 23.

- Ensuring **access to essential medicines** including those used for drug treatment.

These aspects of the right to health are referred to as **Minimum Core Obligations** which set out the thresholds that, if not met, may point to a failure to implement the right to health.

At time of publication of the Charter, the Scottish Government is developing proposals for a new Human Rights Bill which intends to create a process to develop and agree these thresholds.

The **checklist** below aims to help "duty bearers" develop plans for the realisation of the right to health for people affected by drugs and/or alcohol.

PANEL: underlying human rights principles

The PANEL Principles, developed by the UN as the common understanding of a human rights-based approach, provide the foundation of the Implementation of the Charter of Rights. They are interrelated and need to be understood and applied as a whole.

Participation:

People should be able to be involved in and have the chance to meaningfully influence the outcomes of decisions that affect them.

- This applies to decisions about treatment and related support services. For example, an individual should be involved in their care plan. This respects their autonomy and allows them to choose the types of care and support they receive.
- Participation also applies to involving people in decisions about laws, policies and practices which affect them and is therefore linked to Empowerment (see below).

Accountability:

Those who are responsible for delivering services and support should be held to account in relation to fulfilling their obligations.

- It should be clear who is accountable and for what.
- Accountability requires effective monitoring, through data collection and collation of qualitative evidence.

- People have the right to an effective remedy when their rights are not fulfilled or are breached. This means that there must be a way to raise issues and complaints and get things resolved. These processes must be accessible, affordable, timely and effective.

Non-discrimination and Equality:

All forms of discrimination must be prohibited, including structural, indirect discrimination and intersectional discrimination.

- People affected by substance use are marginalised, compared to the general population, and face barriers in accessing health and social care and other support.
- This means that people responsible for delivering services must take steps to consider how their services respect, protect and fulfil the rights of all people affected by substance use. For example, any policies that prevent people accessing support based on their substance use should be reviewed considering the need to avoid discrimination.
- People at risk of discrimination for other reasons should be prioritised within planning of drug and alcohol services. For example, services should take steps to address the specific needs of different people including women, people with underlying health/mental health conditions or disabilities and people experiencing homelessness.

Empowerment and Capacity-Building:

Everyone should know and understand their rights and the rights of people they support

- People should be supported to claim their rights and participate in the development of laws, policies and practices affecting the fulfilment of those rights.
- People working in services should be supported to improve their ability through training, sharing of best practice and provision of adequate resources.
- In the context of substance use, empowerment is interrelated with non-discrimination and the taking of effective measures to address stigma and self-stigmatisation. People affected by substance use will not be empowered to claim their rights or participate meaningfully in decisions affecting them while they are

self-stigmatising or considering themselves to be less deserving of rights than other people.

Legality:

The above Principles should be grounded in the legal rights that are set out in national and international frameworks.

- It is this Principle of Legality which shifts the power and supports a shift of culture from stigma and self-stigma to one of "rights-holders" and "duty-bearers".

A PANEL Principles Checklist on the Right to Health

The aim of this checklist is to provide a framework to assess whether a policy or service has been developed or delivered using a human rights-based approach (i.e. using the PANEL principles and the AAAQ framework)

It could be used in several ways, including:

- self-assessment by public authorities, including the Scottish Government and Alcohol and Drug Partnerships, of their implementation of the right to health.
- As part of future reporting and monitoring requirements
- As a tool for scrutiny bodies such as the Care Inspectorate and Healthcare Improvement Scotland to use in their inspections.
- by rights-holders in community groups to hold their local systems to account.

For each of the PANEL principles, depending on the context, "duty bearers" need to identify indicators. These should (as far as possible) be SMART i.e. specific, measurable, achievable/appropriate/attributable, relevant, and time bound.

Legality: is the approach grounded in the legal rights that are set out in national and international frameworks?

What is needed	Questions to Consider	Actions
Right to Health: Availability, accessibility, acceptability, and quality of health and care and substance use and related	• **Available:** Do services provide sufficient choice and person-centred support? • **Accessible:** Are services inclusive? Are people excluded	Identify actions to be taken to improve AAAQ of health and care services.

support services to be provided to enable the achievement of the right to the highest attainable standard of physical and mental health.	due to geographical or financial barriers? • **Acceptable:** Can services respond and adapt to people's different needs? Consider the different needs of families, women, people in the criminal justice system, people of different ethnicities, LGBTI people and people with disabilities, people experiencing language barriers, people with other health issues such as mental health. • **Quality:** Are services of sufficient standard? Are they aware of the impacts of stigma, evidence-based and trauma informed? Do they meaningfully involve individuals and families in decision-making?	**Outcomes Indicators** Evaluate the outcomes in improving the AAAQ of health and care services – including learning from the life experience of people affected by substance use.

What is needed	Questions to Consider	Actions
Right to Health (Social determinants and links to other rights): Targeted efforts to determine minimum thresholds and progressive realisation of the social determinants of health for people affected by substance use. This includes adequate housing, food and social security are available, accessible, acceptable and of sufficient quality.	• Do substance use support services provide information to help people access other services including those relating to housing, food, and social security? • Are concrete and targeted steps taken to help people affected by substance use to access social determinants of health e.g., adequate housing and food?	Identify actions to be taken to improve AAAQ of social determinants. **Outcomes Indicators** Evaluate the outcomes in improving the AAAQ of services providing the

		social determinants of health, e.g. adequate housing and food – including learning from the life experience of people affected by substance use.

Participation: are people affected by substance use able to participate in decision-making in a way that influences outcomes?

What is needed	Questions to Consider	Actions
Availability, accessibility, acceptability, and quality of participatory processes which enable individuals – as well as families and communities - to influence the outcomes of decisions which affect the healthcare treatment and support services provided to people affected by substance use.	• **Available:** Are there recognised ways for individuals - as well as families and communities - to participate in and influence decisions made about healthcare treatment and support services? • **Accessible:** Are these forms of participation inclusive? Are people excluded for any reason? • **Acceptable:** Is the approach taken responsive to people's different needs? Consider the different needs of people who are currently using drugs and/or engaging in services, women, families, people in the criminal justice system, people of different ethnicities, people with disabilities and LGBTI people, people who have language barriers and people with other health issues such as mental health.	Identify actions to be taken to improve AAAQ of meaningful participation. **Outcomes** **Indicators** Evaluate the outcomes in improving the AAAQ of meaningful participatory processes – including learning from the life experience of people affected by substance use.

	• **Quality:** Is participation done in a non-stigmatising, trauma-informed way? Are people able to influence the outcomes of decisions?	

Accountability: Are responsibilities clear? Are there ways for decisions to be challenged and resolved?

What is needed	Questions to Consider	Actions
Availability, accessibility, acceptability, and quality of accountability processes by which people affected by substance use can hold to account those making decisions about their health and care.	• **Available:** Are there different ways for people to address things that they are not happy with? Consider complaints procedures but also other less formal ways lessons can be learned. • **Accessible:** Are these ways of addressing issues inclusive? • **Acceptable:** Are people with different experiences able to address issues? Consider the different needs of women, families, people in the criminal justice system, people of different ethnicities, people with disabilities and LGBTI people, people experiencing language barriers and people with other health issues such as mental health. • **Quality:** Are the accountability mechanisms effective for individuals and communities? Are people able to get things resolved? Does poor practice change? Are there ways to follow up if nothing changes?	Identify actions to improve the AAAQ of accountability processes. **Outcomes** **Indicators** Evaluate the outcomes in improving the AAAQ of accountability processes – including learning from the life experience of people affected by substance use.

Non-discrimination and equality: does the approach recognise those most at risk and ensure that there is equal access to all rights for everyone affected by substance use?

What is needed	Questions to Consider	Actions
Targeted steps to identify and address all forms of stigma and discrimination which lead to the denial of the right to health, particularly for those most at risk.	• What is being done to identify stigma and discrimination against people who use drugs in different settings, including health and social care? • Are people at most risk prioritised? Consider, for example: ○ women who may also be mothers who are afraid of having their children removed, ○ family carers concerned about any consequences for the family, ○ people from ethnic communities who might experience racial discrimination, ○ people who use different types of substances or who are not abstinent, ○ People currently in the criminal justice system, or with experience of the criminal justice system.	Identify actions to be taken to address all forms of stigma and discrimination. **Outcomes** **Indicators** Evaluate the outcomes of actions taken towards addressing all forms of stigma and discrimination – including learning from the life experience of people affected by substance use.

Empowerment and capacity-development: does the approach enable people to know and claim their rights and improve the ability of duty bearers to implement these rights?

What is needed	Questions to Consider	Actions
People affected by substance use are provided with the knowledge needed to claim their rights and the ability of duty bearers to provide human rights-based services is improved.	• **Available:** Is information about services and support available to people? Are people made aware of their rights? • **Accessible:** Is information provided in a way that people understand and use? Is it accessible to everyone including people who may not be engaged in services? • **Acceptable:** Is information provided in a way that is relevant for different groups? Consider the different needs of women, families, people in the criminal justice system, people of different ethnicities, people with disabilities and LGBTI people, people experiencing language barriers and people with other health issues such as mental health. **Quality:** Is information adequate and useful for people? Are service providers adequately trained in relation to taking a trauma-informed, rights-based approach?	Identify actions to provide knowledge which empowers people affected by substance use and actions to improve the ability of duty bearers to provide human rights-based services. **Outcomes** **Indicators** Evaluate the outcomes of actions taken to empower people affected by substance use and actions taken to improve the ability of duty-bearers to provide human rights-based services.

Examples of the PANEL principles in practice

Our analysis of the evidence provided by community conversations identified examples of good practice which help to show how the PANEL principles can be applied in practice.

The Charter offers a way of making examples of "good practice" more systemic. We have tried to break down what makes services effective from the perspective of communities and through the lens of the right to health. To bring it to life we have named some examples of services which were identified during community conversations. These are not exhaustive but aim to build up a picture of what human rights-based services look like in practice.

1. **Services which are developed and delivered with people who use drugs and/or alcohol**

- *"…people with lived and living experiences are "divorced" from mainstream service planning. If services are to be fit for purpose, this needs to be reversed with people with experience included in decision-making processes and planning across other non-addiction services and within addiction services."*
- *"We currently are getting it wrong in trying to "fit" the individuals to the existing services"*

Services are more effective when they have been designed and delivered by people affected by drugs and alcohol. This often involves good partnership working between statutory services and community-based organisations who bring experience of working alongside people.

Whilst we heard about consultation fatigue and examples of tokenistic approaches, there were also examples of approaches which adopted the principle of "nothing about us without us". These involved effective use of reference or steering groups with lived/living experience involvement, and good feedback loops (e.g. 'you said/*together* we did'). There were also examples of services where people affected by drugs and/or alcohol had had a role in shaping the service model and the commissioning process.

Involvement in service design:

- Simon Community Connect Hub
- Martha's Mammies (Glasgow)
- The Beacons (Blantyre, Lanark, Cambuslang, East Kilbride)

2. Low threshold services- community hubs and assertive outreach

- *"People don't want to have to tell their story multiple times or visit multiple places"*
- *"They show you flexibility and kindness whereas statutory services are bound by risk and procedure"*
- *"When people are living in difficult situations appointments don't work- we need flexible drop ins and choice for people"*

Many people highlighted that typical service opening hours of Monday-Friday, 9-5pm, can be a significant barrier and that more out-of-hour services are required, e.g. 24-hour/weekend services. The importance of low threshold services and multidisciplinary outreach services - for example mobile harm reduction services were recognised to be able to "meet someone where they are."

Often the examples of good practice identified by participants were community-based hub models which delivered holistic support. These hubs tend to be welcoming spaces for people to go to get support, advice and connection.

Recovery Cafes (a style of community hub) offer a vital source of social connection and linking to other services. They are low threshold, free and offer incentives like food and friendship. Because multiple services are co-located within a hub model, people don't experience as much stigma, and they don't have to navigate the normal siloed approach.

Community hub models:

- The Beacons (Blantyre, Lanark, Cambuslang, East Kilbride)
- Simon Community Access Hubs (Glasgow, Edinburgh)
- Shetland Recovery Hub & Community Network (Shetland)

- Circle Recovery Hub (Renfrewshire)
- Lochee Community Hub (Dundee)
- Recovery Communities/ Cafes – such as Borders In Recovery cafes (Galashiels, Duns, Peebles & Hawick) Forth Valley Recovery Community cafes (Grangemouth, Stenhousemuir, Denny, Alloa, Stirling, Falkirk) Horizons Recovery Café (Midlothian), Kinross Recovery Café (Perth & Kinross)

Mobile Harm Reduction/ Assertive Outreach:

- Turning Point Scotland Mobile Harm Reduction Service (Glasgow)
- Harm Reduction Response Team (HaRRT) (Renfrewshire) operate a mobile support unit
- Drug Harm Reduction Mobile Unit (West Dunbartonshire)
- Transform Forth Valley Assertive Outreach Plus Service (Forth Valley)
- ARIES Aberdeenshire Responsive Intervention Engagement Service (Aberdeenshire)

3. Women-only services and groups

- *"Women feel scared to come forward for support and help over fear of children being removed from their care"*
- *"middle class families get CAMHS, working class get social work. There is a real class disparity in how we support poor families"*

During community conversations and at the launch of the Draft Charter, people emphasised the need for women only spaces and services which are tailored towards the specific needs of women during pregnancy, mothers (including mothers who have had their children removed), sex workers and victims of domestic violence.

Examples of good practice:

- Simon Community Women's Group and Connect Hub (Glasgow)
- Dundee developing a women's hub
- Harper House - Specialist Family Service (national)

- Aberlour Mother and Child Recovery House (Dundee)
- Martha's Mammies (Glasgow)

4. Family involvement and support

- *"There's a lot of mistrust between services and families"*
- *"In Fife family support teams sit alongside treatment services and link in with the treatment recovery workers and psychologists"*
- *"In crisis families are left isolated and responsible for care but not with tools to cope"*

Families affected by a loved one's substance use are often unsupported, excluded, isolated and judged by others. Many do not feel able to talk to anyone about what is going on, due to the secrecy, shame and stigma of alcohol and drug harm in families. People highlighted the need for families to be supported in their own right and included in their loved one's treatment and care.

Family Groups offer a vital source of support for family members.

Examples of good practice:

- My Support Day (South Lanarkshire)
- SFAD Family Support Groups and Whatsapp Group (national)
- Circle Scotland (Edinburgh, West & East Lothian)
- Family Addiction Support Service (FASS) (Glasgow)

5. Advocacy and accessible information about services

- *"Services happen to people unless you're able to speak for yourself"*
- *"People (including professionals) don't know what's out there"*
- *"More promotion of services that are available would make a huge difference, such as posters in pharmacies"*
- *"Staff aren't trained on resolving issues, so won't publicise pathways to raise complaints"*

People told us that *how* information is communicated is crucial: people wouldn't pick up a resource in a GP waiting room and there are low literacy rates and digital exclusion. Informal communication, word of mouth and relationships are important for connecting people to support. Partnership working with the 3rd sector is essential to this. Advocacy - particularly peer advocacy - was widely recognised by individuals and families as key to navigating the complex systems and processes and helping to uphold people's rights.

Making complaints was considered a challenging process, people highlighted a lack of information on how to complain and the fact that people feared consequences. For example, complaints processes in some prisons involve having to ask prison officers for the complaint form, which is a barrier.

Examples of good practice:

- Loch Lomond and Argyll Advocacy Service (LAAS)
- Advocard (Edinburgh)
- REACH Training offers an SQA Qualification for Human Rights Based Advocacy (national)
- West Dunbartonshire QR Code with service directory
- The Advocacy Project (Glasgow & East Renfrewshire)
- Partners In Advocacy (Highland, Lothians & Greater Glasgow)
- Mental Health Advocacy Project (West Lothian)

Conclusion

The key elements of human rights-based services have been distilled from what people in community conversations told us. The aim of this document was to show how these examples already incorporate the PANEL principles which underpin the Right to Health.

We hope this can provide guidance for people who are either reforming or developing services and support for people affected by drugs and/or alcohol to implement the Charter of Rights.

The elements of human rights-based services may change over time in response to new threats and shifts in the service delivery landscape. Changes in drug trends (e.g. who is experiencing harm and the nature of those harms) as well as opportunities brought by new digital technology may lead to innovation in how services are delivered. Human rights standards and principles are designed to be used as a way of progressively improving people's experiences of services. As shown by how they apply to the key elements of human rights-based services, the PANEL principles are broad enough to apply in a dynamic way. The Charter should therefore be interpreted considering any future changes by people seeking to take a human rights-based approach to service design and delivery.