



**The *Care Cameos* series is designed to present short but challenging sketches of various issues and to provide a forum to encourage and foster debate on a whole range of issues important for the delivering of care and support for older individuals across Scotland.**

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## **HUMAN RIGHTS AND SOCIAL CARE**

**A CARE CAMEO BY:  
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## Preface

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Welcome to the fourth of Scottish Care's *Care Cameos*.

The *Care Cameos* series is designed to present short but we hope challenging sketches of various issues and to provide a forum to encourage and foster debate on a whole range of issues important for the delivering of care and support for older individuals across Scotland.

I am delighted that this *Cameo* contains the text of the address given at the Scottish Care's Inaugural Care Lecture. This Lecture was delivered in Autumn 2017 by the Chair of the Scottish Human Rights Commission, Ms. Judith Robertson. We were very grateful that the event was supported by the Clydesdale and Yorkshire Bank in whose Banking House in Glasgow, the Lecture was held.

An appreciative audience in Glasgow heard Ms. Robertson explore the subject 'Social care and human rights' with both intellect and vigour. I hope you find the text of such a thoughtful evening to be equally stimulating. Ms. Robertson issued a range of challenges which are of real urgency to all who are concerned about social care and its future direction in Scotland.

Throughout 2017 Scottish Care has sought to argue the importance of moving beyond the rhetoric of rights to the reality of their delivery. This *Care Cameo* issued on UN Human Rights Day summarises that challenge with real articulacy and urgency. Its arguments should be the focus of all our efforts in 2018 and beyond.

A prominent international politician once said:

*"The gap between what we seem to promise, and what we actually deliver, has grown. The answer is not to draw back from an ambitious human rights agenda, but to make the improvements that will enable our machinery to live up to the world's expectations."*

It is time to bridge the human rights gap in social care in Scotland.

Dr Donald Macaskill  
CEO Scottish Care

*'A society that does not value older people denies its roots and endangers its future. Let us strive to enhance their capacity to support themselves for as long as possible and when they cannot do so any more, care for them.'*  
Nelson Mandela - 1998

Clearly social care impacts on many more people than those who are elderly but I think Nelson Mandela's point captures some of the key human rights issues as they, in fact, affect all of us, but for this discussion, those who use and need social care – the valuing of all people, the need to support and maintain independence and the need to recognise that when that ability and capacity is reduced, care is key.

## Care is a great word.

Care for me is at the heart of human rights and it is what is lost when human rights are violated – when we no longer care enough - to take the time, to allocate the resources, listen to what is being said, to subsume our own needs. The notion of social care – that people need care to maintain their place in society, that social dimensions of life are as valuable as any other and are worthy of real time and attention, training and professionalism .

And care for me is what will transform our relationship to social care, define its future and determine how we care for people in our society when they need it.

Care is also what drove the establishment of the human rights framework after the Second World War – but more of that shortly.

## Why human rights – why are they important in this dialogue?

The international consensus that generated the Universal Declaration of Human Rights (UDHR) was borne out of the horror of the aftermath of the Second World War when more than 60 million people died at the hands of state actors. The international recognition that states can exceed the limits of their power and act against the interests of their citizens led to over 150 countries signing the Universal Declaration of Human Rights (UDHR)– on December 10th 1948 - 70 years ago next year.

The UDHR outlines the fundamental universal and indivisible rights that

are inherent in being human and that apply to us all. In places, it made special mention of those made vulnerable by age, infirmity, difference or discrimination and drew out the responsibilities of states to act to secure their rights. It also highlighted that citizens need to be empowered to hold states to account for their actions and that effective and fair processes need to be in place to enable them to do that when things go wrong. And the final recourse is to the courts – a crucial factor in effective accountability and in achieving both justice and change.

The UDHR was then reinforced by two more detailed treaties that focus on different aspects – firstly the International Covenant on Civil and Political Rights and its two protocols (ICCPR) and then the International Covenant on Economic, Social and Cultural Rights (ICESCR).

These three instruments comprise the International Bill of Human Rights and are the principle sources of human rights law that states sign up to. They have been further developed over the years by a series of more focused treaties and protocols, dealing with specific rights as they relate to key groups or issues: the Convention on the Elimination of Discrimination Against Women (CEDAW), the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of Racial Discrimination (CERD), the Convention Against Torture (CAT), and the Convention on the Rights of the Child (CRC). Over many years, the UK has played a key role in building the framework and its developments. More recently, one could say that role has diminished but still the state is signatory to seven major international human rights treaties and, through the Scotland Act, so too is the Scottish Parliament and Government.

**This is all very well and good, you may say, but what does this have to do with social care?**

Good question –

Both ICCPR and ICESCR, and then the CRPD, contain many aspects which relate to social care, as in fact do many of the other treaties, but these have the most developed understanding of what the treaties mean in reality and what standards and norms should be achieved when making people's rights a reality in these spheres.

ICESCR's focus on economic, social and cultural rights brings in rights

like the right to an adequate standard of living, incorporating the right to adequate housing, the right to work and receive fair remuneration for that work, and the right to the highest attainable standard of physical and mental health.

The indivisibility of the rights framework is also relevant here because the right to life and the right to private and family life, both highly relevant in relation to social care, are included in ICCPR. But where I am going to focus my comments today is on the Convention on the Rights of Persons with Disabilities (CRPD) and specifically on the deliberations of the CRPD committee on the right to live independently and be included in the community.

But possibly the most relevant factor in why human rights are important in this discussion is that local authorities in Scotland spend £3.4 billion a year on non-residential social care, supporting more than 200,000 adults and 18,000 children and their families. Assistance ranges from everyday tasks such as dressing and preparing meals, to helping individuals live more fulfilling lives at home, at work and in their communities.

Getting that care right for those people is not just a good investment in terms of money but, in the words of the *Shared Ambition for the Future of Social Care Support in Scotland*, this has the potential to be an investment in *“social care support that will be an instrument of transformative social change. It will protect, promote and ensure human rights and tackle inequalities for disabled people and carers”*. The Shared Ambition was developed in 2016 by a coalition of 16 Scottish organisations, representing disabled people and older people, women, care providers, paid and unpaid carers and the voluntary sector<sup>1</sup>. They believe *“that this infrastructure will also play a critical role in building and sustaining Scotland’s economic and social prosperity.”*

So the role for social care is huge, as is the money spent on it. As I will advocate throughout this lecture – taking a human-rights based approach to that process can deliver better outcomes, more effective provision, more empowered staff and, ultimately, a population supported and cared for to live life with dignity, independent and included, maintaining positive well-being, with strong social and family relationships.

I said I was going to focus on CRPD – there is a reason for that which is,

although this is the Convention on the Rights of Persons with Disabilities, and we know that not everyone who uses or needs social care is necessarily disabled, the Convention looks at disability through a social model i.e. barriers in society that are disabling, not just whether or not you have an impairment. So it does bring together a lot of people who receive social care who may not ordinarily think of themselves as disabled. The fact they receive social care suggests they need it to overcome what might otherwise be a barrier. The Convention recognises that people face many of the same issues, whether that be issues around who makes decisions, what provision is available and accessible, the actual standards of care. This convention brings these issues together from across the human rights framework and does that analysis from a human rights perspective.

It does this through a number of different processes:

Each human rights convention or treaty has its own committee – generally made up of global experts in the field. On a roughly four or five-year basis, they review the performance of each state against the terms of the treaty – you may have seen in the media last week reports of the UN CRPD Committee describing the UK's record. Here is an excerpt of what the Committee said:

*“The Committee was deeply concerned that the United Kingdom still considered itself a leader despite its inconsistent disability policy, and urged it to take appropriate measures to address the recommendations contained in the Committee’s inquiry report [on welfare reform measures]. The delegation had provided extensive information on the legal framework, however, the Committee was convinced that the existing legislation was not being adequately implemented and it failed to secure the rights of persons with disabilities throughout the State party’s territory<sup>2</sup>.”*

Over time, Treaty Bodies have also developed detailed comments on specific issues which are intended to inform states of the meanings of the articles of the Convention. These are called General Comments and, while they are not specific legal commitments, they are intended to inform interpretations of law and give states guidance as to how they should meet the human rights standards.

The CRPD Committee has developed a number of relevant and specific



General Comments that relate to social care. One such example, General Comment no.5 focuses its attention on Article 19 of CRPD – the right to live independently and be included in the community. It has a great deal to say about what that right means and how states might achieve the standards they set. Reading it is highly instructive, not least as a measure of how far we have to travel.

Let me share some of it with you....

Article 19 entails civil and political as well as social and cultural rights and is an example of the interrelation, interdependence and indivisibility of all human rights. The right to independent living and being included in the community can only be realised if all civil, social and cultural rights enshrined in this norm are fulfilled.

The General Comment recognises that in order to be realised, all human rights require resources and structural changes which have to be taken step by step, no matter whether civil and political or social, economic and cultural rights are at stake.

*“Article 19 reflects the diversity of cultural approaches to human living and ensures that the right covered under the article is not biased towards certain cultural norms and values. Living independently and being included in the community are concepts of human living across the globe, applied to the context of disability. They mean exercising freedom of choice and control over decisions affecting one’s life with the same level of self-determination and interdependence within society as everybody else. The realisation of the right therefore must be effective in different economic, social, cultural and political contexts. The Committee also finds it important to reaffirm that the right to live independently and be included in the community refers to all persons with disabilities, irrespective of support required, age, impairment, sex, race, ethnicity, migration status, income or any other relevant category.*

*"The right to live independently and be included in the community is deeply rooted within the normative framework of international human rights. The Universal Declaration of Human Rights stresses in article 29 (1) the interdependence of an individual’s personal development and the social aspect of being a part of the community: “Everyone has duties to the community in which alone the free and full development of his personality*

*is possible”.*

*“The Committee on the Rights of Persons with Disabilities has noted significant advancements in the past decade concerning the implementation of article 19. However, the Committee continues to observe a clear gap between the goals and spirit of article 19 and the scope of its implementation. Some of the remaining barriers are the following:*

- 1. Denial of legal capacity, either through formal laws and practices or de facto by substitute decision-making concerning decisions about the living arrangements of persons with disabilities (interrelation with article 12);*
- 2. Inadequacy of social support and protection schemes for ensuring independent and community living (interrelation with article 28);*
- 3. Inadequacy of legal frameworks and budget allocations aimed at providing personal assistance and individualized support;*
- 4. Physical and regulatory institutionalisation, including of children and forced treatment in all its forms (interrelation with article 14);*
- 5. Lack of deinstitutionalisation strategies and plans;*
- 6. Negative attitudes, stigma and stereotypes that prevent persons with disabilities from being included in the community and accessing available support;*
- 7. Misconceptions about independent living and culture;*
- 8. Lack of available, acceptable, affordable, adaptable and accessible services and facilities within the community, such as transport, health care, schools, public parks/spaces, housing, theatres, cinemas, shops and public buildings;*
- 9. Lack of adequate monitoring mechanisms for ensuring the appropriate implementation of article 19, including the participation of representative organisations of persons with disabilities;*
- 10. Insufficient mainstreaming of disability in general budget allocations; and*
- 11. Decentralisation, resulting in disparities between local authorities and unequal chances of independent and community living in a State party (inappropriate implementation of article 4 (5))”*

## **Any of this have a familiar ring – recognise any of it?**

It is important to stress that this is an analysis of the global context and

situation which, in my view, is reassuring on one hand, in that it's good to know that Scotland's problems are shared ones – we don't have a monopoly on not doing so well in this area – but, on the other hand, we are one of the richest countries in the world and this analysis is drawn from studies that include the poorest countries (Malawi, Haiti, Sudan).

We can and should be doing better than this – we have much more resource at our disposal and we have considerable state capacity to deliver. So there is a problem. We know there is problem and we have known for some time. We also know it is getting worse as a result of austerity, public sector cutbacks and the demographic inevitability of an ageing population.

### **But what then do human rights bring to the discussion?**

The explicit principles that underpin and run through the whole human rights framework are reflected in a set of principles that the Commission uses to help guide law, policy and practice as it develops. These principles don't just apply to social care – they apply across any policy or legislative or practice development that impacts on people's human rights.

We describe them under the term PANEL – some of you may have heard of this construct before; others of you when you hear what they are will say – what's new?

PANEL stands for Participation, Accountability, Non-discrimination and equality, Empowerment and Legality – none of them new concepts. What makes PANEL different is that within the context of human rights they have specific meanings:

- Participation is the right of people to be fully engaged as decisions are being made that affect their lives – in short, *"anything for us is with us. Anything for us without us is against us"*.
- Accountability is that process I outlined earlier – it is based on a recognition that public authorities and governments sometimes fail to act in the best interests of their citizens and through any process that impacts on people's rights there need to be clear and explicit lines of accountability. How do we access redress when things go wrong and how do public authorities make sure they know whether or not they are delivering people's rights?

- Non-discrimination is possibly the easiest process to understand and arguably the hardest to deliver – it's simply that of ensuring we don't discriminate against people who are most at risk but, more than that, that we put in place steps to ensure society takes responsibility to overcome barriers which create discrimination and doesn't leave it to the individual to be solely responsible for that process.
- Empowerment in this context is about ensuring people know their rights and are enabled and supported to have them fulfilled – that might mean putting in place effective information systems, independent advocacy or other supported decision-making processes. It doesn't mean deciding on someone's behalf what we think is best for them.
- And finally – Legality. Again, in human rights terms, this means that the work we are undertaking – development of law, policy or practice - is undertaken within the framework of human rights law, is designed to respect, protect and fulfil those laws, and has in place effective systems to monitor delivery.

So not difficult concepts but often difficult to deliver.

I was interested and delighted in fact to see the report by In Control Scotland, Scottish Care and Alzheimer Scotland, called '*Self-directed Support – your choice, your right*'<sup>3</sup>, use the PANEL principles to make their assessment of whether or not current delivery of Self Directed Support in Scotland was meeting our human rights obligations – I hope the joint authors won't mind me quoting some of their excellent work.

These are some of their findings:

## **Participation**

There are significant examples across Scotland where individuals have not been enabled to be involved in decisions that affect their rights under the SDS Act. They have not been able to be fully engaged in assessment, support-planning and determining their access to all the four options. In addition, it appears that duty-bearers at local authority level have actively discouraged participation, either through poor understanding or lack of training in SDS or an unwillingness to accept a power shift to the individual. SDS means that the individual being supported should have much more control of the support relationship; not just at the point of initial choice but in its delivery.

For this to be achieved, assessment processes must be as person-centred as possible. This applies to the whole relationship between a professional or provider and the supported person. It seeks to place person-centred support based on an individual being able to exercise their human rights at the heart of all social care support and delivery. It is of particular importance when making decisions around risk enablement and personal safety. In order for the person receiving care or support to exercise choice and control, the worker providing that service must also have the knowledge, training and autonomy to assist in the interpretation and delivery of that service.

### **Accountability**

The issues raised by the problematic implementation of SDS can only be addressed by adequate and robust monitoring and evaluation. Whilst bodies such as Audit Scotland have a role in this, ultimate responsibility lies with central government. Central government also has primary responsibility for ensuring that implementation of new legislation is robust, that barriers are removed, that public awareness is raised and that action is taken where legislation is not followed. In current circumstances it is questionable if this sense of accountability at national level can be evidenced.

The lack of a rigorous central accountability in favour of local implementation and autonomy has served to create an SDS postcode lottery across Scotland. Apart from through civic society, there seems little monitoring of how people's rights are being affected, nor have there been active remedies when things have gone wrong.

### **Non-Discrimination**

Some social work practitioners are openly using language such as *'we are putting that person through the SDS route'*, *'not everyone wants to take the SDS option'* or *'SDS isn't going to work for everyone.'* These statements, particularly the latter one, imply that some individuals should not have access to SDS. This attitude – that SDS will not work for certain individuals or situations – has disproportionately affected key groups such as people with mental health conditions, people living with homelessness, people with a criminal record, people over 65, people with dementia and people in residential care. Many individuals fall into all of those last three groups and, as such, are currently being prevented from accessing all four

SDS options; indeed some cannot access any options.

Ostensibly this is because there are two pilot test sites exploring residential care and SDS, but in reality this has acted as a convenient excuse to prevent individual authorities from tackling enabled choice within a National Care Home Contract framework.

The stated human rights assumption that nobody should be treated unfairly because of their age, gender, ethnicity, disability, religion or belief, sexual orientation or gender identity has not been achieved. There has been a clear failure to embed the stated human rights principle that the people who face the biggest barriers to realising their rights should be prioritised when it comes to taking action.

In addition, the implementation of SDS has occurred against a backcloth of austerity and financial restriction. This has created a negative association between personalised models of assessment and support with the need to make savings and increase cost efficiencies. We need to address this as a matter of priority. While implementation happens at a local level, the influencing of attitudes around SDS in a time of austerity occur at a national level; it is here that the issue of affordability becomes most acute and where decisions based on affordability need to be directed by a human rights perspective. It is here that debates over equitable funding and political expediency must be at their sharpest and most articulate.

## **Empowerment**

The current situation requires a context where everyone – people requiring support themselves, family members seeking support on behalf of someone else and social care workers providing support – should understand their rights, and be fully supported to take part in developing policy and practices which affect their lives.

In the SDS Act, the local authority has a duty to give independent information to those seeking the provision of support. The authority must provide the supported person with any assistance that is reasonably required in order a) that the person can express their views about the options available and b) make an informed choice about those options. The authority also has a responsibility to explain the implications of those options to the individual. However, it is clear in current SDS implementation that there is no consistency in either the content or delivery

of this information and that, in some cases, it is being communicated in a non-independent manner.

The authority should use terms appropriate and relevant to the supported person that can be easily understood, and it should make the options clear. However, it is also evident that many local authorities and social work practitioners are not communicating this information in a way that recognises the needs of the individual involved or using other appropriate methods of communication where this could aid in participation in SDS.

Public understanding of SDS and its potential is woefully inadequate, reflecting the inadequacy of information available, where it is even present at all. The lack of any consistent and clear media and public awareness campaign, either at national or local level, is indicative of the lukewarm approach to implementation from central and local government.

Historically, whenever someone presented themselves to social care services, the assessment process concentrated on individual needs and whether those could be met within the eligibility criteria the professional was working to. The problem with this type of ‘needs as deficiencies’ based assessment is that it results in supports provided around task and time, rather than addressing what is ultimately important to the supported individual (‘needs as common human needs’) It emphasises the deficits of an individual – ‘what is not working’ – rather than highlighting (and looking to support) the attributes, strengths and abilities that allow people to have their common human needs met – ‘what is working’. There is also a potential for individuals, whether the supported person or the practitioner, to overemphasise the deficits because that has traditionally been the most effective route through which support and services have been achieved.

While an individual must be fed, warm and safe, people also have other fundamental needs which must be recognised and met. To keep in touch with friends, to continue to be engaged in a pursuit or activity, to continue to be involved in your community and its organisations, are as essential to any of us as food, drink, shelter or safety.

SDS Guidance and the Act itself encourage social work practitioners and other duty bearers to embed a more holistic approach to assessment. This should be driven by a person-centred conversation with the individual (and those seeking support on that individual’s behalf, where appropriate). It

emphasises the importance of helping an individual discover solutions to their challenges that might not come through traditional services but from natural, community and social networks.

Sections 1 and 2 of the Act specify the general principles that guide practice:

1. Involvement – this requires that the supported person must have as much involvement as they wish in both the assessment and in the provision of any support agreed on completion of their assessment.
2. Collaboration – practitioners and providers must collaborate with the supported person in the provision of any support identified and agreed on completion of their assessment in order for them to be supported to achieve the outcomes they have identified.
3. Informed Choice – the supported person must be provided with any assistance that is reasonable to assist them to express their own view about the support that is being provided or to make any changes to that support including the specific involvement of individual staff in their lives. Clearly, as has been stated, the lack of real information, robust communication, resourcing of delivery amongst neglected groups – all have countered against a sense of empowerment, which was such a clear driver in this legislation. In addition, the systemic disempowerment of social care support workers, constrained within an outmoded, time-allocated approach to service delivery that stubbornly refuses to shift, is creating a volatile job market marked by low morale, poor pay and condition, and high turnover.
4. Legality - to date there has been little legal challenge to the current practice of SDS. It is the contention of this paper that there is no shortage of potential challenge for the failure to ground the legal rights set out in domestic law in the implementation of SDS.

It is therefore our conclusion that, against any human-rights based assessment, the current implementation of SDS is failing. Fixing this situation, we have argued, can only be achieved by the greater articulation and embedding of a human-rights based approach to the future delivery of Self-Directed Support in Scotland.

So here we have the use of PANEL as an assessment tool, a way of describing the situation against human rights standards and creating an analysis which is rooted in human rights law and the law of Scotland. Most crucially, it looks at all of law, policy and practice and makes its initial, and



final, considerations on the basis of the actual lived experience of people on the ground

It is worth noting that the General Comment on independent living essentially describes SDS as a human rights requirement:

*“Personal assistance is a tool for independent living. The funding is to be controlled by and allocated to the person with disability with the purpose of paying for any assistance required. It is based on an individual needs assessment and a person/user’s life circumstances. The service is led by the person with disability, meaning he or she can either contract the service from a variety of providers or act as an employer. (para 15 (d))”.*

One of the things really missing between SDS policy and practice is accountability and there is more that can be done to push for that.

The Commission is currently working with MECOPP<sup>4</sup> (who provide a range of support services to informal carers and those in receipt of social care in Scotland) to support their work on a Legal Rights Project, with a view to helping people realise their right to Self-directed Support and building capacity within their network around human rights. For MECOPP, that means providing advice and information to people about their rights and doing casework on their behalf. We’re helping them train people to understand the links between SDS and human rights and how they can use human rights in their work.

## Commission’s work in this area

Given the importance of social care in providing both immediate access to care and routes into many other rights, the Commission has, over the years, prioritised work in this area.

In order to better understand some of the issues in relation to social care and to provide an evidence base for what became *Scotland’s National Action Plan for human rights*<sup>5</sup>, we undertook research which formed *Getting it Right?*<sup>6</sup> – an analysis of human rights in Scotland. It was published just five years ago.

The headline findings in relation to care were:

### **1. Quality of care**

A wide range of rights affected by issues of funding and the extent of "free" personal care the procurement of care services and delayed discharges. Care aimed at children and young people, older people, and people with disabilities was of particular concern.

## **2. Independent living**

The "co-production" approach to independent living and de-institutionalisation were identified as positive steps, however, issues arose regarding the ability to move from one part of country to another and maintain care packages and access to services by disabled people. Self-Directed Support and move towards personalisation highlighted as opportunities at that time.

## **3. Self-determination**

Issues were found regarding legal capacity, the use of guardianships and end of life decisions.

## **4. Carers' rights**

The research noted an increasingly recognition of the connection between the impact of unpaid caring responsibilities and human rights, including the right to an adequate standard of living, the right to work and the right to respect for private and family life.

## **5. Health inequalities and health promotion**

We found that lifestyle choices remain a significant health challenge in Scotland including in relation to smoking, diet and alcohol consumption. Research also indicates that health outcomes are also related to more "fundamental" factors such as deprivation and poverty, an ageing population and a complex geography with large and sometimes sparsely populated rural areas. The impact of increased pressure on public funds in a time of recession was also identified in some sources.

## **6. Non-discrimination within health care**

The right to health includes an obligation to ensure that health facilities, goods and services are accessible to all without discrimination. We found continuing issues faced by groups - minority ethnic and religious communities, people with disabilities and LGBT people, and particular challenges in accessing health services faced by those living in rural areas.

## **7. Access to and quality of mental health care and treatment**

We found issues regarding access to mental health care, quality of mental health care of treatment (including restraint, seclusion and reports of individuals being forced to take certain medications) and specific concerns for those patients receiving dementia care.

## **8. Mental health stigma**

Our research found people who experience mental health problems still

experience stigma and discrimination.

Prior to *Getting it Right?*, in the *Care about Rights*<sup>7</sup> project, done in partnership with Scottish Care, Age Scotland and the then Care Commission (now Care Inspectorate), around 1,000 care sector managers and workers were trained in taking a human rights based approach to their work, alongside a smaller number of older people and their advocates and Care Inspectorate staff - supported by a resource pack of films, case studies and information.

It was found that human rights assisted in balancing issues of risk, for example, the use of restraints, door locking, allowing people to leave the care home setting, the use of medication or restricted diets, against the rights of the individual to choice, control and autonomy.

Central to resolving these issues was the understanding that you might interfere with an individual's rights where it is properly justified and proportionate, that is the minimum necessary interference taking account of the individual's views and decision making. This approach counter-balanced what was sometimes seen as a risk averse approach of services, intent on safeguarding the individuals.

It was also found to assist in delivering care in a person centred way as it ensured the rights of the individual were the starting point for decision making, as opposed to consideration of the policy or service requirements coming foremost.

Human rights provided a framework for communication between professionals, individuals using services and family members, helping to resolve tensions in the way in which care was delivered.

It was also understood to be a foundation for other duties under, for example the Adult Support and Protection Act, Adults with Incapacity Act etc, where the legislation itself is rights based and reflects concepts such as proportionality and minimum interference, which are central to the human rights framework.

Human rights were then seen, not as something new, nor as something which pose a risk in a legal or regulatory sense, but rather as a tool for improving practice and outcomes.

And, most recently, we have been working with the Care Inspectorate as they worked with Scottish Government on reviewing the National Care Standards to integrate a human rights-based approach into the standards, thereby helping to ensure human rights are mainstreamed into care delivery. The recently published *Health and Social Care Standards*<sup>8</sup>, while perhaps not perfect, incorporate key human rights principles and demonstrate a real shift towards placing people in greater control of their lives and ensuring they have support when they need it. But of course the real test comes when this moves beyond the paper and into services. It is crucial that those providing care are also supported to make this shift – to change culture and be supported by a system that allows them to realise people's rights.

## A Scottish Commission on Social Care

As a National Human Rights Institution, one of the functions of the Scottish Human Rights Commission is to report on the state – in our case, Scotland – in relation their international legal commitments to respect, protect and fulfil human rights. Recently the Universal Periodic Review of the UK was being done by the UN Human Rights Council and the Commission submitted our report to the council.

One of our clear areas of recommendations was on social care, where we highlighted a number of concerns – specifically on delivery of SDS, where we expressed our concern that the legislation may, in practice, have the unintended consequence of restricting choice and control, and on social care charging, where we supported the call from *The Shared Ambition on the Future of Social Care Support in Scotland* for the urgent establishment of a national independent Commission of inquiry to explore the development of new approaches to funding as demand rises.

The *Shared Ambition for the Future of Social Care in Scotland* outlines in some detail what they consider to be priorities for the conversation that needs to happen around social care in Scotland. In line with the Commission's own view, the Shared Ambition focuses on 4 things:

1. A new national narrative which sees social care support as an infrastructure investment in the social and economic wellbeing and development of society as a whole; not the spiralling cost of an ageing

society; nor merely the provision of ‘healthcare in the community

2. An honest conversation about where we should invest and disinvest to make this vision a reality
3. Consideration of all the available resources at our disposal and the implications of using each of them to fund social care support, including exploration and development of new models for funding social care support in Scotland
4. Commitment from politicians and the public to make the changes that are needed to create a social care support system in Scotland that lives up to our social justice and human rights rhetoric.

This needs to be the starting point of a Scottish Commission on Social Care. The Scottish Commission needs to fully engage those with lived experience of social care, both in setting its terms of reference and developing its recommendations in line with taking a human right based approach as previously outlined. It needs to incorporate PANEL in its deliberations and processes – human rights law and its implications, effective and accessible accountability mechanisms, full participation and empowerment of people with lived experience and be clearly non-discriminatory in its processes and recommendations.

It is clear that in Scotland people’s rights have been and are being eroded due to under-funding, poor training, lack of empowerment and limited political will. Based on this evening’s event and many other initiatives in relation to social care and human rights there is a real appetite in Scotland to get this right for people – to raise standards, empower people and build a system fit for the future that is compassionate, sustainable and effective – a system that cares.



## References

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- <sup>1</sup> <http://www.socialcareambition.co.uk/>
- <sup>2</sup> <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21993&LangID=E>
- <sup>3</sup> <http://in-controlsotland.org/wp-content/uploads/2017/07/SDS-Your-Choice-Your-Right.pdf>
- <sup>4</sup> <http://www.mecopp.org.uk/>
- <sup>5</sup> <http://www.snaprights.info/>
- <sup>6</sup> <http://www.snaprights.info/how-snap-was-developed/getting-it-right>
- <sup>7</sup> <http://careaboutrights.scottishhumanrights.com/>
- <sup>8</sup> <http://www.newcarestandards.scot/>

## About the Author

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Judith Robertson is full time Chair of the Scottish Human Rights Commission.

Previously Programme Director of *See Me*, Judith has had long-standing involvement in social justice campaigning and advocating for the rights of many disadvantaged groups.

Prior to this post she had a 17 year career with Oxfam as both Programme Manager for Oxfam's Poverty Programme in Scotland (8 years) and as Head of Oxfam Scotland (9 years).

The Scottish Human Rights Commission is an independent public body, accountable to the people of Scotland through the Scottish Parliament.

The Commission has a general duty to promote awareness, understanding and respect for all human rights – economic, social, cultural, civil and political – to everyone, everywhere in Scotland, and to encourage best practice in relation to human rights.



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