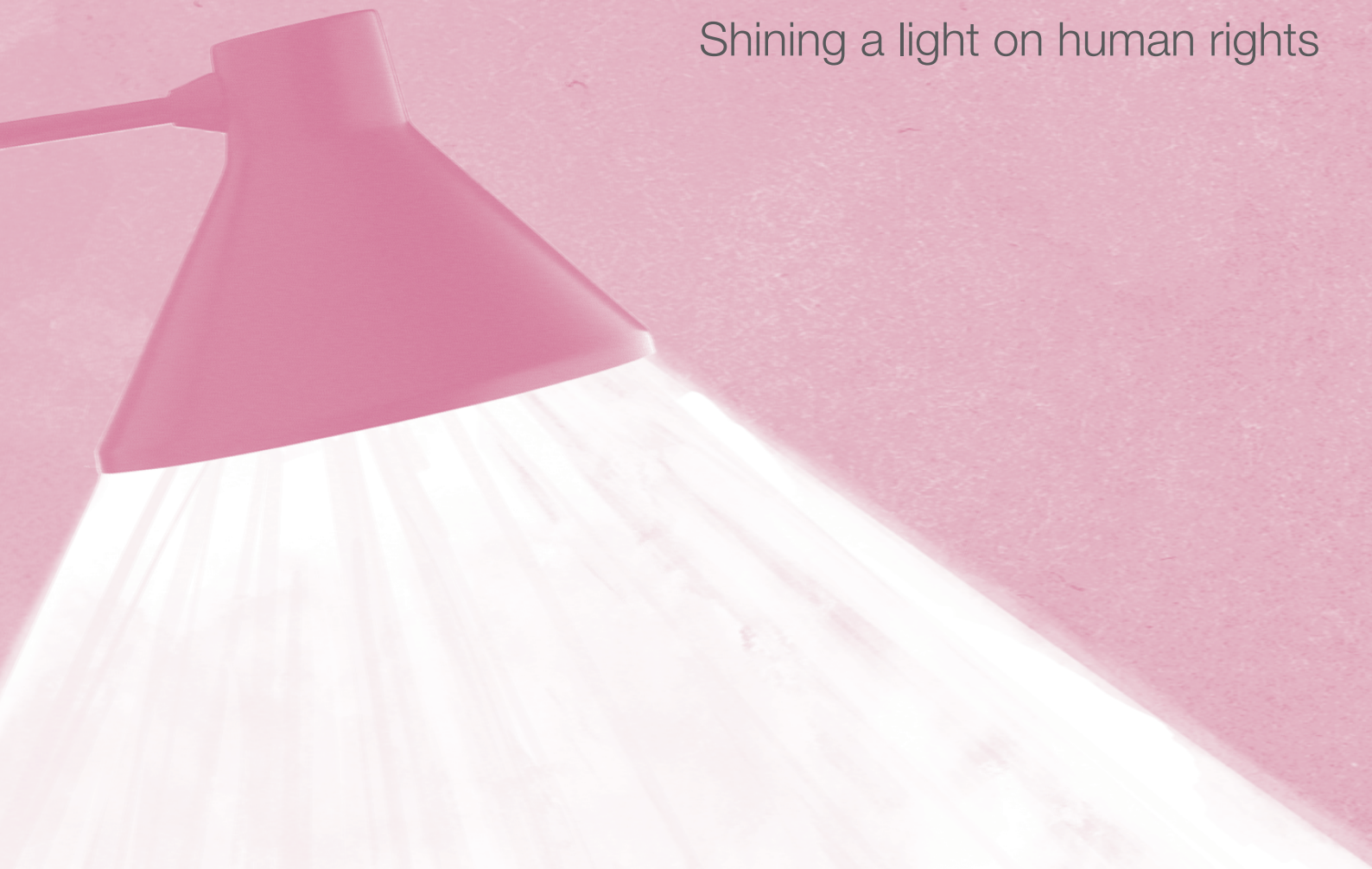
Shining a light on human rights



Mental Health Early Intervention and Human Rights:

A practitioner's guide

The British Institute of Human Rights
bihr.org.uk

About this booklet

This booklet is about human rights in mental health early intervention services. It is aimed at professionals working in those settings, in hospital or in the community. We use the term 'practitioner' throughout to include anyone working in early intervention (e.g. qualified and unqualified workers). Lots of information in the booklet may also be useful for people using mental health early intervention services, their family, carers or advocates (BIHR has also produced a range of resources aimed at people using mental health services, see www.bihr.org.uk).

This booklet was written by the British Institute of Human Rights (BIHR), in partnership with **North and South Tees Early Intervention Service (part of the Tees, Esk and Wear Valleys NHS Foundation Trust)**. The service is working with BIHR on our project called **Delivering Compassionate Care: Connecting Human Rights to the Frontline**. The project aims to place human rights at the heart of mental health services, helping to ensure frontline staff have the knowledge and skills to fulfil the vital role they can play in upholding the dignity and human rights of people using their service. The project is funded by the Department of Health, therefore the information in this booklet focuses on English law and bodies.

BIHR would like to thank the practitioners at North and South Tees Early Intervention Service for their help in producing this booklet, particularly the Human Rights Leads for their ideas, advice and guidance.

This booklet should be read in conjunction with our other resource **'Mental Health, Mental Capacity and Human Rights: A Practitioner's guide'**. That resource contains more information about how UK law protects human rights, key rights for mental health/capacity services and where to find more information/support.

Early intervention and human rights

As services helping people at the early stages of psychosis, the aims of early intervention align with human rights values. This includes:

- reducing the stigma associated with psychosis and improving awareness of symptoms
- promoting recovery
- providing a wide range of psycho-social interventions and support
- supporting people to take control over their own lives, care and treatment
- support for family and carers

This booklet aims to give practitioners the knowledge and confidence to use human rights in practice to design and deliver rights-respecting early intervention services. It's arranged around three key issues for early intervention services, identified by our partner.

Finding your way around

1 **This booklet is for information purposes only. It is not intended, and should not be used, as legal advice or guidance.**

one

Medication and consent

Consent to medication in early intervention services may raise human rights issues. An aim of early intervention services is to offer a range of psycho-social interventions and support. Whilst medication may be an option for some people, it is important to work with the person to discuss all other options and identify what is right for them.

Consent to medication is a key principle in healthcare (and now embedded in the NHS Constitution) as well as in human rights law. Protecting people's autonomy – to make their own choices, participate in decisions about their care and give consent to treatment – is protected by the right to respect for private life (protected by Article 8 in the Human Rights Act 1998).

Potential human rights issues for practice

- failing to act when a person taking antipsychotic medication is experiencing side effects which severely affect their physical or emotional well-being
- someone in your care becoming isolated as a result of taking antipsychotic medication (for example, if the side effects result in a breakdown of relationships with their family/friends, they are no longer able to work or socialise)
- a person deciding they want to stop taking their medication where you have serious concerns about their safety or the safety of others
- failing to respect the decision of a person with capacity to stop taking their medication where the potential risk of harm to themselves or others does not justify intervention under the Mental Health Act 1983 (MHA)

A human rights approach to medication and consent

This could include:

- ✔ taking into account the person's particular needs, including their current mental health, and discussing with them all the care and treatment options available
- ✔ empowering the person about their rights, including their right to autonomy and to making their own decisions (with support if necessary), and your duty to protect their well-being (protecting them/others from serious harm) and family life
- ✔ supporting the person to make an informed choice about the medication and to agree a care plan
- ✔ where you have serious concerns about the person's capacity to make a decision about their care/treatment, arranging an assessment under the Mental Capacity Act 2005 (MCA), and, if necessary making a best interests decision after consulting the person and their family/carer (if appropriate) about their wishes. Support the person to be involved in the process as much as possible and keep the situation under review as capacity can fluctuate
- ✔ regularly reviewing the medication (and the level prescribed) with the person to make sure that it is still necessary and appropriate for them
- ✔ where the person raises concerns about the medication, conducting a review with them to assess whether other treatment options, or a reduction in medication levels, is more appropriate for them

Key rights for medication and consent

Right to respect for private and family life

(protected by Article 8 in the Human Rights Act)

The right to private life protects people's **well-being**, and places a positive duty on practitioners to act where they know someone might be at risk. This includes where:

- a person is at risk of harm as a result of taking the medication, for example through the side-effects
- a person is a risk to themselves or other people if they stop taking their medication

If the harm is very serious, this might engage their right not to be treated in an inhuman/degrading way.

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A Practitioner's guide' page 12**

The right to private life also protects people's **autonomy**, including:

- having control over their own care and treatment
- participating in decisions about their care or treatment, including informed consent to medication
- where a person is assessed as not having capacity to make a decision, supporting them to be as involved as possible in decision-making

The right to private life to also covers people being able to **participate in the life of their community**, and places a positive duty on practitioners to support a person to do so, including where:

- a person is at risk of isolation or unable to engage in everyday life due to the medication (such as relationships with family/friends, work, socialising etc.)

The right to **family life** protects:

- people's relationships with family members and others, including maintaining those relationships
- people being able to develop new relationships with others

Relevant practitioners' duties:

- to respect this right: not interfering where possible, except where this is lawful, for a legitimate reason and proportionate
- to protect this right: taking action to protect where necessary

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 17** for more information, including your other duties.

one

"Human rights have provided us a different focus, which helps support our service users live independently with dignity, respect and pride"

Practitioner on BIHR's Delivering Compassionate Care project

Worked example: : medication and consent

Terri is a 27 year old woman who was recently detained under the MHA following a serious episode of psychosis. Terri is now living at home and receives support from mental health services. She has regular psychiatric reviews and monthly home visits from Dan, her care coordinator. Terri continues to experience some psychotic symptoms at certain times, but has managed to maintain her mental health in the community.

During Dan's visit, Terri tells him that she feels she has reached the point where her antipsychotic medication is getting in the way of her recovery. Terri's side effects include a slowness of thought and speech, preventing her from socialising. She says she wants to stop taking the medication and see if she can maintain her mental health using the psychosocial strategies she has learnt.

Dan is aware that almost all of Terri's previous relapses have happened shortly after she stopped taking her antipsychotic medication. Terri's prescription is already at what her psychiatrist believes to be the minimum dose necessary to control her symptoms. Dan tells Terri that he is concerned about her well-being if she comes off the medication too early, but that she has a right to autonomy and to make informed decisions about her medication.

Dan arranges a review with Terri's psychiatrist at her request and they have a meeting afterwards to consider all the options. It is agreed that Terri will stop taking the medication for a trial period of three weeks but that Dan will use a risk relapse plan and increase his visits to weekly during that time. If Terri is coping well they will then revert to monthly visits for as long as Terri feels she needs them.

one: Decision-making flowchart

Early intervention and medication

This flowchart is for practitioners supporting someone who wants to stop taking their early intervention psychosis medication, to help you think about using a human rights approach.

Which of my Human Rights Act duties are triggered?

- Duty to protect person's private life
- Duty to protect person's family life
- Duty to respect person's right to private life: autonomy

Duty to **protect** person's private life

Step 1: Is the person's well-being at risk?

- **YES** → If the person is at risk of harm as a result of taking the medication, or could be a risk to themselves if they stop taking their medication, you must take reasonable steps to protect the person from harm. **Move to step 2**
- **NO** → **Move to step 2**

Step 2: Is the person's right to participate in their community at risk?

- **YES** → If the person is unable to participate in their community as a result of taking the medication, you must take reasonable steps to protect this right. **Move to step 3**
- **NO** → **Move to step 3**

Duty to **protect** person's family life

Step 3. Is the person's family life at risk?

- **YES** → If the person's family relationships are at risk as a result of taking the medication (or stopping taking the medication), you must take reasonable steps to protect this right. **Move to step 4**
- **NO** → **Move to step 4**

Duty to **respect** person's right to private life: autonomy

Step 4. Are you considering trying to keep the person on medication?

- **NO** → **Exit the flowchart**
- **YES** → This will engage the person's right to private life as it protects autonomy: having a say and making their own decisions. **Move to step 5**

Step 5. Do you have concerns about the person's capacity to make the decision about staying on their medication?

- **YES** → Arrange a mental capacity assessment. If assessed as not having capacity, make a best interests decision. **Exit flowchart.**
- **NO** →

Step 6. You have a duty to respect the person's autonomy but this is not an absolute right; you must follow the three stage test to see if your interference would be permissible:

1. Lawful: there isn't a law which permits you to insist a person takes medication against their will in this situation (unless you need to use the MHA or MCA). If you do need to use the MHA or MCA, you would still need to show…
2. Legitimate reason: these are written into the right, e.g. the safety of the person or others?
3. Proportionate: you would need to show that insisting the person takes medication is the least restrictive way to achieve that aim. Have all other options been explored, including other treatment options?

Support the person to make an informed decision about their care

Explaining the steps in the flowchart

Step 1. Is the person's well-being at risk?

If the person is at risk of harm you have a positive duty to take reasonable steps to protect them. An example of this would be if the medication is affecting their health (through side-effects) and/or they are at risk of self-harm. If the risk of harm is serious, remember that this could engage your duty to protect the person from inhuman or degrading treatment (under Article 3, see our other booklet 'Mental Health, Mental Capacity and Human Rights: A Practitioner's guide' page 12).

If you decide the harm is serious enough to reach the high threshold for inhuman and degrading treatment (which covers very serious abuse and neglect), you will need to take immediate action.

If the risk of harm is less serious, it will engage your duty under the right to private life (Article 8) to take reasonable steps to protect the person's well-being. Reasonable steps could include arranging a mental health assessment, and/or supporting them to make an informed decision about whether to stop taking their medication.

Step 2. Is the person's right to participate in their community at risk?

A person's right to participate in their community (protected by the right to private life, Article 8) may be engaged if, as a result of taking the medication, they are isolated, feel unable to leave their home, are unable to work or socialise etc.

You have a duty to take reasonable steps to protect this right, which could include discussing different options with the person and/or supporting them to make an informed decision about the medication.

Step 3. Is the person's family life at risk?

If the person's medication and/or mental health issue is putting their right to family life at risk (for example, by interfering with family relationships, causing relationships to breakdown etc.) you have a duty to take reasonable steps to protect this right.

This could include discussing this with the person, considering different options and/or supporting the person to make an informed choice about the medication.

Step 4. Are you considering trying to keep the person on medication?

The right to private life protects people's autonomy. This includes people having control over their own lives, care and treatment, having a say and participating in decisions and consent to treatment.

If you have concerns about a person wanting to stop taking their medication, you would need to justify any interference with their right to autonomy by following the three stage test in step 6 below.

Step 5. Do you have concerns about the person's capacity to make the decision about staying on their medication?

If you have concerns about the person's capacity to make the decision about their medication you must arrange a mental capacity assessment under the MCA. Remember that capacity should be assumed, and an assessment should only be carried out where there is a genuine concern. If the person is assessed as not having capacity to make this particular decision, a best interests decision can be made about whether they should continue taking their medication.

This should take into account the person's wishes and feelings and the person should still be supported to participate in the decision as far as possible.

For serious interventions or where there is a disagreement about what is in a person's best interests (including among practitioners, family members, carers or their advocate) a court order may be necessary (see chapter 6 of the MCA Code of Practice).

Step 6. You have a duty to respect the person's autonomy but this is not an absolute right; you must follow the three stage test to see if your interference would be permissible:

Any interference with the person's autonomy will need to be justified by following the three stage test:

Lawful: there must be a law which allows the interference. In this situation, where a person has capacity and is not detained under the MHA, there is not a law which permits you to insist a person takes medication against their will. Therefore, the interference would fail at the first stage of the test and would not be lawful. (If a person is receiving treatment under the MHA, medication may be administered without their consent provided it is a 'medical necessity'. If a person has been assessed as lacking capacity to make this decision under the MCA, a best interests decision may include treatment options, see step 5.)

There would be no need to follow the other two stages of the test (legitimate reason and proportionate) because all 3 stages of the test must be met (we have included all 3 steps in the flowchart for completeness, in case you are considering using the MHA or MCA). You should therefore support the person to make an informed choice about their care and treatment and discuss all the options with them, such as reducing the medication, trying a different medication, more contact/support for the person, or alternative forms of treatment for their mental health issue.

Assertive outreach

Assertive outreach practice has the potential to raise human rights issues. Working with people who experience severe and enduring mental health issues, and who have a history of non-engagement with services, raises issues about how 'assertive' to be in trying to engage them in treatment.

Using a human rights approach can help assertive outreach practitioners make the sometimes difficult decisions about how to protect rights and manage risk, particularly when other people's rights might be involved.

Potential human rights issues for practice

- a person repeatedly states that they do not want to be contacted by mental health services but the early intervention team persist due to concerns about risk
- a person is discharged by the early intervention team when available information indicates that they are at serious risk of harming themselves or others as a result of mental health relapse
- the early intervention team contact the person's friends or family members to try to assess the risk following a period of no contact with a person
- the early intervention team agree a care plan to regularly visit a person to try to avert a metal health crisis against the person's wishes

A human rights approach to assertive outreach

This could include:

- ✔ ensuring that the person is aware of their rights including their right to autonomy; to consent to and participate in decisions about their care/treatment
- ✔ talking through all the care/treatment options open to the person and their mental health issue, including any impact this might have on their well-being, so that they are able to choose what (if any) treatment options are best for them and give informed consent
- ✔ if you have serious concerns about a risk to themselves or others, discussing this and explaining your duty to take action to protect their/other people's rights may arise in the future. This could mean taking measures such as arranging an assessment under the MHA, or in very serious situations detaining someone under the MHA. Be clear that these are not threats
- ✔ discussing what issues the person has had in the past which made interactions with services difficult to see if there is anything that can be adapted/changed, or support groups they might join
- ✔ if a care plan is agreed, ensuring the person understands what steps they can take if they become unhappy with how it operates in practice
- ✔ regularly reviewing the care plan to ensure that it remains appropriate and proportionate to the person's needs

Key rights for assertive outreach

Right to respect for private life
(protected by Article 8 in the Human Rights Act)

The right to private life protects people's **autonomy** and **privacy**, including:

- people having control over their own life, care and treatment, including people with capacity making choices about whether to consent to/ take part in mental health treatment, even if those choices might appear unwise
- maintaining the confidentiality of information about a person's care and treatment and not passing this onto third parties, including family members, without the person's consent (except where lawful, for a legitimate reason and proportionate, such as when there is a safeguarding concern)

Relevant practitioners' duties:

- to respect this right: not interfering where possible unless it is lawful, for a legitimate reason and proportionate
- to protect this right: taking action to protect where necessary

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 17** for more information, including your other duties.

Right to life
(protected by Article 2 in the Human Rights Act)

This right may be relevant in cases of severe risk where:

- a person has suicidal thoughts
- a person poses a risk to other people's lives

Relevant practitioners' duties:

- to protect this right: taking reasonable steps to protect where there is a known and immediate risk to a person's life

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 10** for more information, including your other duties.

Right to be free from inhuman or degrading treatment
(protected by Article 3 in the Human Rights Act)

This right may be relevant in cases of severe risk, such as where:

- a person is at risk of serious self-harm
- a person poses a risk of seriously harming others

Relevant practitioners' duties:

- to protect this right: taking action to protect someone from a known and immediate risk of serious harm, often called **safeguarding**

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 12** for more information, including your other duties.

Worked example: assertive outreach

Jamie is a 29 year old man living with his boyfriend, Trevor. He is unemployed, has been diagnosed with severe bipolar disorder and regularly takes psychoactive substances, cannabis and other drugs. This is causing a significant strain on the relationship. Jamie's relationship with his family has also broken down and his parents no longer have any contact with him. If Jamie's relationship with Trevor ends there is a risk he will end up homeless.

After a serious incident of self-harm which resulted in an admission to Accident and Emergency, Jamie is referred to the Assertive Outreach Team. Angela, a Community Psychiatric Nurse writes to Jamie and offers him an appointment to meet. Jamie is annoyed by this contact and worried that if Trevor sees the letter this would further strain their relationship.

Jamie calls Angela and is obviously distressed, telling her to leave him alone and not to contact him again. Angela apologises for any distress the letter might have caused. She explains that Jamie has a right to privacy and for his admission to A&E and referral to her to be kept confidential. She agrees not to write to him at his home address. She also explains that the referral was triggered by his A&E admission and that he also has a right to well-being.

Jamie is still distressed and tells Angela that it is 'none of her business' and that he can do what he wants. Angela explains that he does have a right to autonomy and to make his own choices, but that she would like to talk him through what support they can offer him if he'd like. After assuring Jamie that their talk will be completely confidential, Jamie agrees that Angela can call him back at a pre-arranged time.

After a few phone conversations to build trust, Jamie agrees to meet Angela in a local park. They talk through Jamie's history and the problems he's had with substance abuse as well as possible treatment options for his bipolar. Jamie agrees to meet with Angela again so that they can agree a plan to support him. The plan includes a slow phased approach to withdrawing from the substances Jamie has become dependent on, with special support, to avoid the serious physical and mental side effects of a rapid withdrawal.

As part of a dual diagnosis programme, Jamie starts to take medication for his bipolar disorder on a trial basis to monitor any side effects. Angela makes sure that Jamie knows how the plan can be reviewed and how to raise any concerns. After a few months Jamie's mental health begins to improve and his use of substances has reduced significantly. Jamie is more confident and agrees with Angela that their meetings will be reduced to once every two months unless he wants more regular contact.

"A social worker challenged a plan for a man discharged from hospital after detention under the Mental Health Act to have four home visits a day to support and monitor his mental health on the basis that it was a disproportionate interference with his right to private and family life. The number of visits was re-adjusted to reflect this concern and reach the right balance"

Practitioner on BIHR's Delivering Compassionate Care project

Community Treatment Orders

Community Treatment Orders (CTO) may raise human rights issues. The purpose of a CTO is to allow a person to be discharged from hospital and be treated in the community. However, it will be necessary to take into account the person's human rights when deciding if a CTO is appropriate and any conditions attached to it.

Compared to continued detention in hospital, CTOs may offer a less restrictive option which may be more respectful of patients' rights to liberty and to family life. On the other hand, CTOs may interfere with a person's human rights long after they are discharged from hospital through the conditions attached to the order and the power to recall the person back to hospital.

Potential human rights issues for practice

- inappropriate use of CTO for a person still at high risk of seriously harming themselves or others
- placing a person on a CTO with a power to recall to hospital without sufficient evidence of risk of non-compliance with medication or of relapse which would have a significant impact on their well-being
- imposing a CTO with a power to recall to hospital without procedural safeguards to protect a person's right to liberty
- failing to take into account other options which are less restrictive of rights
- placing conditions on a CTO which lead to a disproportionate interference with a person's private and family life e.g. through home visits and compulsory contact with mental health services
- use of conditions which deprive the person of their liberty
- failing to keep conditions to a minimum number and consistent (proportionate) with achieving their purpose
- a person discharged on a CTO not being offered the support they would need to comply with the conditions or care plan

Worked example

Craig is a 19 year old man who has been diagnosed with paranoid schizophrenia. After a period of being in and out of hospital, he is placed on a CTO. However, the conditions are very restrictive. Craig is not allowed to leave the area without notifying someone, must obey a strict curfew, and is not allowed to drink any alcohol.

He is unhappy with the conditions and struggling to comply with them, particularly as he lives alone and does not want to be isolated. Craig is also finding it hard to maintain his relationship with his girlfriend and friends, because the CTO conditions make it difficult for him to visit them and socialise. He talks to his early intervention team as he is worried that he will end up being recalled to hospital.

The early intervention team recognise that the conditions are disproportionately interfering with Craig's family life and agree that they can be modified so that they are easier to comply with and his relationships maintained.

Key rights for CTOs

Right to be free from inhuman or degrading treatment
(protected by Article 3 in the Human Rights Act)

This right may be relevant when determining if a CTO is appropriate where:

- a person is at risk of serious self-harm
- a person poses a risk of seriously harming others

Relevant practitioners' duties:

- to protect this right: taking reasonable steps to protect someone from a known and immediate risk of serious harm, often called **safeguarding** (this could include arranging re-assessment under the MHA or considering other options besides CTO)

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 12** for more information, including your other duties.

Right to liberty
(protected by Article 5 in the Human Rights Act)

This right prevents extreme restrictions being placed on people's movement, except in specific circumstances (such as detention under the MHA or a Deprivation of Liberty authorisation). Even if a restriction on liberty is for a lawful reason, there are still human rights safeguards which must be in place. For CTOs you will need to consider:

- whether a CTO may help to respect the person's right to liberty by offering a less restrictive alternative to continued treatment in hospital
- however a CTO giving the responsible clinician the power to recall the person back to hospital under certain circumstances could be a continued threat to the person's right to liberty
- the right to liberty comes with procedural safeguards, such as ensuring the person knows why the restrictions are in place and ensuring restrictions on liberty are subject to independent and speedy review
- any restrictions on the person's liberty as a result of a CTO should be the minimum necessary to meet the aim of treating the person safely in the community (see MHA Code of Practice chapter 29.31)

Relevant practitioners' duties:

- to respect this right: not interfering where possible
- to protect this right: applying the procedural safeguards written into the right

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 15** for more information.

"A better understanding of people's rights means decision-making is better"

Practitioner on BIHR's Delivering Compassionate Care project

Right to respect for private and family life
(protected by Article 8 in the Human Rights Act)

The right to private life protects people's **autonomy** (choice, control and independence), this could be relevant to CTOs where:

- conditions attached to a CTO impose compulsory contact with mental health services, rather than the person and having control over their own life, care and treatment

The right to **family life** could be relevant where:

- discharging a person from hospital means they can return home to their family life
- conditions attached to the CTO, such as home visits, interfere with people's family life

Relevant practitioners' duties:

- to respect this right: not interfering where possible unless it is lawful, for a legitimate reason and proportionate
- to protect this right: taking action to protect where necessary

See our other booklet **'Mental Health, Mental Capacity and Human Rights: A practitioner's guide' page 17** for more information, including your other duties.

A human rights approach to CTOs

This could include:

- ✔ discussing with the person, as part of their care plan, whether a CTO is an option they would like to consider
- ✔ considering whether there is sufficient evidence of risk of non-compliance with medication or of relapse which would have a significant impact on the person's well-being
- ✔ where a CTO appears to be the best option, respecting the person's right to liberty and family life, and only restricting these as permitted by human rights law, after talking this through with the person
- ✔ a good practice approach to people's right to participate in decisions about their care or treatment would include obtaining their consent to CTO
- ✔ consulting people about a CTO will help you to determine whether the risks involved in making a CTO are really proportionate to the risks of not making one – you will need to consider the likely impact of the proposed CTO conditions on the person and their family/carer if appropriate
- ✔ discussing other options less restrictive of rights, so that you can determine with the person whether a CTO is the least restrictive, most proportionate route for them - other options could include informal admission to hospital, reassessment under the MHA, discharge with a care package and support to meet assessed needs, Guardianship (see section 7 of the MHA), a leave of absence from hospital etc.
- ✔ when considering a CTO with a power to recall to hospital, ensuring procedural safeguards to protect the person's right to liberty are in place and known to the person - this could include formal assessment by a psychiatrist and an approved mental health practitioner to determine the suitability of the CTO and access to a mental health advocate
- ✔ keeping the CTO under close review to check that the person is happy with how it works in practice or whether other options might be more appropriate for them
- ✔ agreeing a time limit for the conditions and a care plan with the person which includes a time limit for the CTO

The rights protected by our Human Rights Act:

Right to life
(Article 2)

Right not to be tortured or treated in an inhuman or degrading way
(Article 3)

Right to be free from slavery or forced labour
(Article 4)

Right to liberty
(Article 5)

Right to a fair trial
(Article 6)

Right not to be punished for something which wasn't against the law
(Article 7)

Right to respect for private and family life, home and correspondence
(Article 8)

Right to freedom of thought, conscience and religion
(Article 9)

Right to freedom of expression
(Article 10)

Right to freedom of assembly and association
(Article 11)

Right to marry and found a family
(Article 12)

Right not be discriminated against in relation to any of the rights contained in the Human Rights Act
(Article 14)

Right to peaceful enjoyment of possessions
(Article 1, Protocol 1)

Right to education
(Article 2, Protocol 1)

Right to free elections
(Article 3, Protocol 1)

Abolition of the death penalty
(Article 1, Protocol 13)

This booklet has been produced for staff delivering health and care services. If it has helped you to deliver rights-respecting care BIHR would love to hear your examples. You can email your real life examples of positive changes to your practice on info@bihr.org.uk.

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