Joint submission on Norway
by We Shall Overcome (WSO), the World Network of Users and Survivors of Psychiatry (WNUSP), the European Network of (Ex-)Users and Survivors of psychiatry (ENUSP) and the International Disability Alliance (IDA)
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Norwegian organisation of users and survivors of psychiatry, We Shall Overcome (WSO), the World Network of Users and Survivors of Psychiatry (WNUSP), the European Network of users and survivors of psychiatry (ENUSP) and the International Disability Alliance (IDA) have prepared the following information in response to the list of issues, and recommendations for Concluding Observations (p 12) with respect to the review of Norway's 7th periodic report to the Committee against Torture.

Please find attached:

- Annex I "Recognising forced psychiatric interventions as torture" (page 13);
- Annex II which compiles CRPD Committee Concluding Observations on informed consent, legal capacity, involuntary treatment and detention, medical experimentation and the right to live in the community (page 14); and
- Annex III which includes information on the organisations making this submission (page 18).

NORWAY

Norway signed the Convention on the Rights of Persons with Disabilities (CRPD) but has not yet ratified it nor its Optional Protocol.

List of issues

24. Please provide information on steps taken by the State party to ensure that prisoners suffering from a mental illness are given access to appropriate health care and transferred to a specialized hospital when their condition so requires. In this respect, please describe steps taken to establish an independent commission with the authority to decide on the admission of mentally ill prison inmates to psychiatric hospitals.[1]

[1] **State Reply to the issues raised in paragraph 24 of the list of issues, CAT/C/NOR/6-7**
206. Reference is made to Norway"s sixth report under the International Covenant on Civil and Political Rights (CCPR/C/NOR/6), paragraphs 168–171.
207. A proposal to establish an independent commission was made and considered by the Government. In 2008, the proposal was discussed with the Ministry of Health and Care Services, which is responsible for mental health care in Norway, but it was decided that at present there is no need to create a new system for dealing with such matters. The Government considers that the existing bodies, such as the Supervisory Commission and the Parliamentary Ombudsman for the Public Administration, are adequate//that instead more use should be made of existing bodies such as the Supervisory Commission and the Parliamentary Ombudsman for the Public

25. Please indicate if measures, including legislation, have been taken to regulate and minimize the use of police and restraints, such as handcuffs and ankle cuffs, for the transportation of patients to psychiatric establishments and to ensure that adequately trained health personnel are used for this purpose.[2]

26. Please provide information on measures taken to minimize the use of force in psychiatric institutions. In this respect, please provide statistical data on the use of coercive means in psychiatric institutions, including the use of restraints, seclusion and electroconvulsive treatment (ECT).[3]

Mental Health Act

Norwegian mental health legislation authorises administrative deprivation of liberty based on psychosocial disabilities ("serious mental disorder") combined with the additional alternative requirements "need for care and treatment" or "danger to self or others".[4] According to Norwegian law, "Compulsory mental health care", including psychiatric incarceration, can be carried out when:

"*The patient is suffering from a serious mental disorder and application of compulsory mental health care is necessary to prevent the person concerned from either*

Administration. The prison and the health authorities cooperate on improving the situation of mentally ill prisoners. A nationwide survey of the mental health of prison inmates is about to be conducted.
208. In November 2008 the Ministry of Justice and the Police appointed a multi-disciplinary team to consider the need for resource sections – smaller units in various prisons for detainees with mental illnesses and major behavioural disorders. The purpose of these units is to provide better adapted serving conditions for prisoners who show various types of dysfunctional behaviour during deprivation of liberty. In November 2009, the team submitted their report, which concluded that there is a need for such resource sections.
209. The report has been subject to public consultation, and the response was in general positive to the proposed measures.
210. The proposals in the report are now being processed at the Ministry of Justice and the Police.

[2] **State Reply to the issues raised in paragraph 25 of the list of issues, CAT/C/NOR/6-7**
211. The Norwegian Government has focussed strongly on the use of detention and restraints. There is no new legislation concerning the use of police and restraints for the transportation of patients to psychiatric institutions, but the Government has appointed a committee to review the Mental Health Act provisions on detention and restraint with a view to reducing the use of force and ensuring that it is only used when necessary. This includes the use of force for the transportation of patients. The committee"s report is to be delivered in May 2011. According to existing guidelines, qualified health personnel must always participate in involuntary admissions, including cases where police authority is needed. Cooperation agreements have been established between the health authorities and the police authorities.

[3] **State Reply to the issues raised in paragraph 26 of the list of issues, CAT/C/NOR/6-7**
212. The Ministry of Health and Care Services has ordered the regional health authorities to draw up regional and local plans in 2010–11 for reducing and ensuring the correct use of force and detention in the mental health services. The reason is that in previous years the health authorities had not succeeded in reducing the use of force in the mental health services despite clear signals to the regional health authorities. The Directorate of Health has also been requested to identify measures at the national level to assist the regional health authorities to reach the goal of reduced use of force. The national, regional and local plans are part of the New National Strategy on Reduced and Correct Use of Force. The quality of national reporting is also not satisfactory and the strategy contains measures to improve data quality and reporting procedures.
213. Some important steps have already been taken. During the last five years approximately 150 outreach teams have been established in order to reach those needing help at an early stage and to ensure closer follow-up when necessary. Although there is little available outcome research, there are local reports that the incidence of involuntary admissions and involuntary treatment has declined as a consequence of the outreach activity. The concept of patient-governed admission to local psychiatric institutions seems to reduce the use of detention among seriously ill persons. Patient-governed admission is based on the principle that patients should be able to decide for themselves when they need institutional support, and will be admitted when this is the case.
214. All cases of restraints/force/detention are required to be registered in patients' records. However, the quality of the statistical data is unsatisfactory. The available data seem to indicate that there have been very small changes in the use of force. There are no national statistics for the use of electroconvulsive treatment.

[4] Mental Health Act 1999 § 3-3 first section no. 3

a. having the prospects of his or her health being restored or significantly improved considerably reduced, or it is highly probable that the condition of the person concerned will significantly deteriorate in the very near future, or
b. constituting an obvious and serious risk to his or her own life or health or those of others on account of his or her mental disorder."[5]

The Norwegian Mental Health Act also authorises non-consensual psychiatric treatment,[6] including forced drugging, and out-patient compulsory treatment.

Despite numerous attempts for more than a decade, the Norwegian authorities have not succeeded to reduce the use of force in psychiatry. The action taken to reduce force has not been proven effective, and does not address the severe consequences and trauma to which the individual subjected to coercion experiences.

The New National Strategy on Reduced and Correct Use of Force (see State replies, para 212) takes steps to register and collect data of incidents, but fails to properly address registration and investigation of infringements related to the use of forced psychiatric interventions, nor does it put in place effective action towards the elimination of the use of force.

The proposed revision of the Mental Health Act (see State replies, para 211, footnote no 2) does not address the issue of discrimination based on disability, and proposes restrictions with respect to the exercise of legal capacity and deprivation of liberty based on disability, which constitutes disability-based discrimination and a violation of the rights of persons with disabilities under international law.

Upon the release of the state budget on 8 October 2012, the government provided information stating that there is no intention to move forward with the revision of the mental health legislation aiming at reduction of the use of force, the report delivered in June 2011[7].

Despite expressed intentions to reduce the use of force in psychiatry, the implemented or proposed legislative amendments are actually expanding recourse to coercive means.
In fact, an amendment of the Mental Health Act was passed and entered into force on 1 July 2012.[8] This amendment expands recourse to coercive means in regional security units and establishes a new hospital-unit with especially high security level. With a short deadline for public response, this legislative amendment was rushed through with little public debate, apparently because of the situation that could occur if the perpetrator of the terror-attack of 22 July 2011 was to be deemed of unsound mind and sentenced to confinement under the Mental Health Act.

The amendment means extended access to highly restrictive security measures in the Regional Security Units that includes examination of room and individual without founded suspicions, body cavity searches of patients, body search of visitors, communications restrictions / control of mail and visit limitation.
The majority of the people deprived of liberty in the high security wards are not convicted of any crime, but subject to preventive detention on discriminatory grounds (perceived mental illness and perceived dangerousness).[9]

[5] These are the central criteria for deprivation of liberty through the Norwegian Mental Health Act, see additional conditions in the unofficial translation of the Norwegian Mental Health Act; http://www.ub.uio.no/ujur/ulovdata/lov-19990702-062-eng.pdf
[6] Treatment can on specific terms be carried out without free and informed consent when a person is under involuntary confinement, see chapter 4 of the Mental Health Act.
[7] Referred to in State Reply 211, see footnote no 2 above.
[8] Legislative enactment 73 (2011–2012)
[9] Changes in the Mental Health Act (regional security wards and unit with especially high security level). Proposition to Parliament. Prop.108 L (2011-2012)

Following this amendment, severe criticism arose from civil society. The Norwegian branch of the International Commission of Jurists wrote in their consultation response;
"There are already significant provisions in the current mental health legislation that allow for searches, shielding and the use of coercive measures. To implement stricter regulation in mental health care than those practiced in the correctional services is in violation of people's right to liberty and dignity."

Another amendment in the Mental Health Act has recently been proposed by the government concerning new rules that will allow locking patients into their rooms during the night in the regional security units and the new unit with especially high security level.[10]

Deprivation of liberty and the use of force against persons with psychosocial disabilities constitute disability-based discrimination

Deprivation of liberty and forced treatment based on criteria linked to the existence of a disability ("serious mental illness") is discriminatory and runs counter to the provisions of the CRPD,[11] which Norway has signed but not yet ratified. Though not yet being legally bound by the CRPD, Norway is nevertheless obliged under other binding human rights treaties to which it is a party, including the Convention against Torture (CAT), not to discriminate based on disability and to ensure that the law prohibits such discrimination.

In particular, forced psychiatry is in breach of Article 1 of CAT, i.e. it constitutes torture, defined as "act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person ... for any reason based on discrimination of any kind.. by or with the consent or acquiescence of a public officer or person acting in an official capacity"
It may also breach Article 16 of CAT, i.e. as "other acts of cruel, inhuman or degrading treatment or punishment". The former Special Rapporteur on Torture, Manfred Nowak, applied the anti-torture framework to persons with disabilities:

The definition of torture in the Convention against Torture expressly proscribes acts of physical and mental suffering committed against persons for reasons of discrimination of any kind. In the case of persons with disabilities, the Special Rapporteur recalls article 2 of CRPD which provides that discrimination on the basis of disability means "any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including lack of reasonable accommodation.

Furthermore, the requirement of intent in article 1 of the Convention against Torture can be effectively implied where a person has been discriminated against on the basis of disability. This is particularly relevant in the context of medical treatment of persons with disabilities, where serious violations and discrimination against persons with disabilities may be masked as "good intentions" on the part of health professionals.[12]

In addition, the Special Rapporteur on Torture has recognised the CRPD as the latest international human rights standards on the rights of persons with disabilities;

[10] Changes to the Mental Health Act - Notification to victims and their kin to changes in the execution and termination of the judgment on transfer to compulsory mental health care, access to night locking patient rooms etc.., http://www.regjeringen.no/nb/dep/hod/dok/hoeringer/hoeringsdok/2012/horing--endringer-i-psykisk-helsevernlov.html?id=704361
[11] CRPD Articles 3 (general principles), 5 (non-discrimination), 14 (right to liberty), 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment), 17 (protection of personal integrity), 19 (right to live in the community), 25 (right to health)
[12] Special Rapporteur on Torture, A/63/175, 2008, paras 48-49; see also Annex I- Forced psychiatric interventions as torture

Thus, in the case of earlier non-binding standards, such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (resolution 46/119, annex), known as the MI Principles, the Special Rapporteur notes that the acceptance of involuntary treatment and involuntary confinement runs counter to the provisions of the Convention on the Rights of Persons with Disabilities.[13]

The CRPD Committee has repeatedly called for the abolition of disability-based detention and the elimination of force in psychiatry:
The Committee recommends that the State party: review its laws that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities; repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability; and adopt measures to ensure that health-care services, including all mental-health-care services, are based on the informed consent of the person concerned.[14]

Lack of government collected data veils the practice of coercion in psychiatry

Complete and reliable government data and statistics on involuntary admission, non-consensual treatment and use of coercive means do not exist, as the state report confirms (para 214, see footnote 3).

Statistics from independent sources indicate however that Norway has a high incidence of involuntary admissions compared to other comparable countries. There are also major and unexplainable regional variations in the use of involuntary admissions in Norway.[15]

A report from 2008 shows that during the period 2001-2006 the incidents of deprivation of liberty in psychiatric establishments increased by more than 50% (measured in number of incidents in which people were being involuntarily brought into psychiatric institutions).[16] Another report from 2008 shows an increase in outpatient commitment by 50 % from 2002 to 2007.[17]

Without the collection of data on the practice of coercion in psychiatry, the government is impeded in formulating effective policies for alternative practices which do not use force and which are respectful of the human rights of persons with psychosocial disabilities.

Electroshock (ECT) administered without the free and informed consent of the individual

According to the Mental Health Act, the administration of electroshock (ECT) is not permitted without informed consent. However, ECT without informed consent is practiced and accepted by the authorities. This is being carried out according to the ”principle of necessity” and purportedly justified to prevent damage to life and health.

[13] Special Rapporteur on Torture, A/63/175, 2008, para 64
[14] CRPD Committee Concluding Observations on Spain, CRPD/C/ESP/CO/1, September 2011, paras 35-36; see also Concluding Observations on Hungary CRPD/C/HUN/CO/1, September 2012, paras 27-28; on China, CRPD/C/CHN/CO/1, September 2012, para 26; on Peru, CRPD/C/PER/CO/1, April 2012, paras 28-29; on Tunisia (CRPD/C/TUN/1), 15 April 2011, paras 24-25. More information in Annex 1.
[15] SINTEF* Health. Husum, T., Pedersen, P.B.Ø. and Hatling, T. Analysis of compulsion in the mental health system. Report, 2005. (* SINTEF is the largest independent research organisation in Scandinavia).
[16] SINTEF Health. Bremnes, R., Hatling,T. and Bjørngaard, J.H. Involuntary placement in the mental health system in the period 2001-2006. Report A4319, May 2008.
[17] SINTEF Health. Bremnes, R, Hatling, T and Bjørngaard J.H. Use of involuntary outpatient commitment 2007. Use of involuntary outpatient medication 2007. November 2008.

There is no monitoring by the government to ensure that the consent given before the administration of ECT is given freely and that the information provided is sufficient and correct. Testimony shared by individuals who have received ECT, and the written information provided by hospitals about the treatment, show that information about risk of cognitive damage and side-effects, including permanent memory loss and brain damage, is absent or under-communicated.

They also report that consent is given in an "un-free" situation during forced commitment or under the threat of force, as the only option available. Consent given by a third party, i.e. guardian or family also amounts to force. Our conclusion from the information/ experience we have is that in practice, ECT is rarely administered under the free and informed consent of the individual.

One case that has been presented in the media is that of "Hanne", who received 14 ECT treatments in 2006 under what she describes as mild coercion. "*The years from 2003 to 2006 are like a black hole. I received information that I could get temporary memory problems up to five months after the treatment. Now it has been three years. Losing your memory is a serious side effect. It is like losing a part of your life. I cannot remember giving birth, I cannot remember my wedding."*[18]

There are no official statistics on the extent of the use of forced ECT, nor ECT administered with informed consent. There are however clear indications that the use of ECT has increased substantially over the last 15 years[19]. There is reason to believe that there are regional variations regarding the extent of use, and on what indication ECT is administered.[20]

The CESCR Committee has recognised the gravity of ECT and similar forced treatments and the discriminatory nature on the basis of disability;

It also recommends that the State party incorporate into the law the abolition of violent and discriminatory practices against children and adults with disabilities in the medical setting, including deprivation of liberty, the use of restraint and the enforced administration of intrusive and irreversible treatments such as neuroleptic drugs and electro convulsive therapy (ECT).[21]

Forced medication

Forced medication is administered in hospitals and on an out-patient basis. There are no reliable statistics on either. The lack of data on formalized decisions regarding forced medication is only part of the problem to record the scope of coerced medication. Based on research and personal testimonies, the line between forced medication and voluntary medication is blurred. People report the threat of force, pressure, fear of additional punishment (seclusion and/or physical restraints) and lack of known options as reasons to take medication "voluntarily". This will not be registered as forced medication even if the authorities are able to produce good statistics on formal decisions.
One of WSO's members explained it like this;
"I found out that when the decision concerning outpatient commitment was up for evaluation, there existed no decision subjecting me to forced medication. For two years I attended the District Psychiatric Centre to be given injections, and I was threatened with the police if I did not show up, and NOW they tell me that this was not coercion."

In a master's thesis from 2011 that described nursing intervention towards voluntarily admitted patients at a psychiatric acute ward it is stated:

[18] Article in "Sykepleien" 4.12.2008. http://www.sykepleien.no/nyhet/116605/elektrosjokk:-hoyspent-behandling
[19] Medicine of today. 18.05.12. http://www.dagensmedisin.no/nyheter/mener-flere-bor-fa-elektrosjokk/
[20] Project Plan: National professional guidelines on use of electroconvulsive therapy (ECT). Health Directory 2012.
[21] CESCR Committee Concluding Observations on Moldova, E/C.12/MDA/CO/2, 2011, para 24

"The majority of respondents said that forced medication is the most commonly used coercive measure. The patient has no choice regarding medication even though he is voluntary admitted. A nurse explains that patients are forcibly medicated if he does not follow the nurse's guidelines and recommendations in relation to medication. He says nurses encourage patients to take medication but gives them really no choice even though it may sound like they do."[22]

When the force is not legally recognized but the individual experiences no choice, the infringements on human rights is just as great as if the decisions had been formalized.
There is no indication that the overall occurrence of forced medication in Norway is decreasing. Even though some local reports suggest a decrease in formal decisions on involuntary treatment because of outreach activity (state report, para 213), that does not necessarily mean that the use of coercion in practice has declined. The ACT (Assertive Community Treatment) teams follow the patient closely in their own home, where compliance to medication is one of the main objectives, thus leaving a high risk of informal coercion.

WSO is informed of numerous cases regarding forced medication, causing severe suffering for the persons affected. One of these persons is H.L, who is currently subject to out-patient commitment and forced medication.
She has been subjected to psychiatric interventions over a period of 7 years, and has invasive side effects caused by the medication, including excessive weight gain from 55 kg to 97 kg. H.L shared her testimony with WSO of how she experienced psychiatric coercion:
"The consequences of the use of coercion are large and overwhelming. You are deprived of all rights pertaining to your life, You lose your freedom, which is the bedrock of everything with the capacity to grow. You lose the opportunity to stay in your home, which is the basis from which you can work and which can be your sanctuary for both safety, rest and peace. You can only eat and get fresh air when others allow you to. You cannot sleep without others coming into your room up to three times every night. You feel invaded in all possible ways and develop an intense need to be left alone. You cannot cry even when it is quiet, because then they come to you with their medicine. Subsequently they send you home with more afflictions than you suffered from initially. (..) The medication works in such a way that they add to your disability. They cut short your nerve impulses, causing motor and sensory disorders like those of an old man, making you extremely tired/dulled, or robbing you of the ability to speak."

In the case of H.L, all the national legal remedies have been exhausted.
On 4 July 2012, H.L brought her case to Hålogaland Court of Appeal, the court ruled in favour of the state[23].
The Supreme Court rejected the appeal on 20 September 2012 on the grounds that the case would not have principal implications beyond this case.[24]

Norun.P.H shared her experiences with coercion on the national news in June 2012.[25] She was committed to a psychiatric hospital when she was 17 years, diagnosed with schizophrenia and medicated by force. She had severe side-effects from medication, including dullness of mind and extreme weight gain, but the hospital continued to increase and add to her medication instead of looking at other treatment options. She was submitted to coercion for two years before she was able to escape. Today Norun is an active student at the university who is not on medication and not experiencing mental health problems. However, she still suffers from the trauma caused by the forced treatment she was subjected to.

[22] Bäckström,H. The ambiguity of care given during the use of seclusion. 2011

[23] Hålogaland Court of Appeal, 04.07.2012.
[24] Supreme Court Appeals Committee HR-2012-01804-U
[25] NRK 27.06.2012 «Coercion in psychiatry» http://tv.nrk.no/serie/dagsrevyen/nnfa19062712/27-06-2012#t=3m53s , additional information given in a presentation 20.8.2012.

One of the conclusions from a recent Norwegian study[26], that compiled 100 scientific articles on the use of coercion in psychiatry, was that patients and health-personnel view coercive measures very differently. Researchers found consistently that staff often underestimate how stressful and demeaning it can be to be subjected to coercion. Harmful effects that are caused by infringements were also underestimated by clinicians.

Psychotropic drugs, particularly neuroleptics, can cause serious long-term effects, such as drastic weight gains, metabolic syndromes, diabetes, heart disease, neurological damage, brain damage, etc.[27] Common effects reported is that thoughts, feelings, experiences, and the ability to initiate change is affected, antipsychotics acts as a "universal brake" on mental function. Many patients describe such medication as a chemical straitjacket. Side effects include an increase in sudden death and total mortality rate.[28]

As has been advanced by the Special Rapporteur on Torture: *the administration in detention and psychiatric institutions of drugs, including neuroleptics that cause trembling, shivering and contractions and make the subject apathetic and dull his or her intelligence, has been recognized as a form of torture*.[29]

Effective humane alternatives to forced treatment exist and have yielded positive results confirmed by personal testimony and evaluative studies.[30] The state has an obligation to make these alternatives readily available and to eliminate practices which violate the rights of individuals and may constitute torture or ill-treatment.

The CRPD Committee has strongly recommended the adoption of:
measures to ensure that all health care and services provided to persons with disabilities, including all ***mental health care and services, is based on the free and informed consent of the individual concerned****, and that* ***laws permitting involuntary treatment and confinement, including upon the authorisation of third party decision-makers such as family members or guardians, are repealed****. It recommends the state party* ***to develop a wide range of community-based services and supports that respond to needs expressed by persons with disabilities, and respect the person's autonomy, choices, dignity and privacy, including peer support and other alternatives to the medical model of mental health.***[31]

Infringements in the mental health system

[26] Norvoll, R and Husum, T,L. Like night and day? About differences in understanding between dissatisfied users and staff on the use of coercion. 2011
[27] Food and Drug Administration (FDA). Package inserts and medwatch safety alerts on antipsychotics. http://www.fda.gov.
[28] Parks J., Svendsen D., Singer P., editors. Morbidity and mortality in people with serious mental illness. Alexandria: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council; 2006.
Gale C. R., Batty G.D., Osborn D.P., Tynelius P., Whitley E., Rasmussen F., Association of mental disorders in early adulthood and later psychiatric hospital admissions and mortality in a cohort study of more than 1 million men. *Arch Gen Psychiatry.* 2012 Aug;69*(8)*:823-31
[29] Special Rapporteur on Torture, A/63/175, 2008, para 63; see also Annex I- Forced psychiatric interventions as torture
[30] Lehman P, Stasny, P. Alternatives beyond psychiatry. 2007
[31] CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1, September 2012, para 38; The Committee is concerned with the imposition of rehabilitation and habilitation measures on persons with disabilities, especially persons with psychosocial or intellectual disabilities, without their informed consent. The Committee recommends that rights based approach to rehabilitation and habilitation be put in place and ensure that such programmes promote the informed consent of individuals with disabilities and respects their autonomy, integrity, will and preference. (CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1, September 2012, paras 39-40); Igualmente, le recomienda adoptar protocolos que garanticen el consentimiento libre e informado de todas las personas con discapacidad para recibir cualquier tratamiento médico. (CRPD Committee Concluding Observations on Argentina, CRPD/C/ARG/CO/1, September 2012, paras 42)

List of issues

27. With reference to the urgent appeal sent on 6 March 2009 jointly by the Special Rapporteur on violence against women, its causes and consequences, the Chairperson-Rapporteur of the Working Group on Arbitrary Detention, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment regarding Ms. E. H. A., please provide any updated information on steps taken to address the concerns and recommendations expressed in this communication (A/HRC/11/6/Add.1, paras. 448-456).

Two Norwegian cases concerning forced psychiatric interventions have been reported to the UN Special Rapporteur on Torture. [32]
In Norway's reply about these cases there is no information to what the authorities has done to properly investigate to ascertain the facts of the cases, nor to what actions has been taken to resolve the cases. In general, there appears to be a systematic lack of adequate reactions including investigation of allegations of ill-treatment in the mental health system.

Numerous stories about suffering, pain, fear, trauma, and the serious infliction of injuries have been told by persons who have experienced forced psychiatric interventions and their relatives. In a newly published study by sociologist Ragnfrid Kogstad, 335 Norwegian user/survivor narratives were analysed. The study concludes that *"mental health clients experience infringements that cannot be explained without reference to their status as clients in a system which, based on judgments from medical experts, has a legitimate right to ignore clients' voices as well as their fundamental human rights. (..)".*[33]

Norwegian authorities have, during recent years, been made aware of a number of human rights issues of concern in the mental health system. One of the persons who has been trying to bring attention to ill-treatment in psychiatry is human rights lawyer, Gro Hillestad Thune, who in 2008 published a book on 70 stories of infringements in psychiatry.[34] Users and survivors of psychiatry, their organisations, relatives, and human rights advocates have been speaking out about human rights violations in psychiatry in the media, in letters to the authorities, in conferences etc. Many are telling stories of not being heard, not being taken seriously when they complain to the authorities, and allege human rights violations, including ill-treatment, in the mental health system.

In 1999, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to Norway found that a person had been held under restraints in a psychiatric institution for an uninterrupted period of four months, and in 2005 they found that a person had been held under restraints for some 750 hours over a period of 40 days. The CPT concluded that such a state of affairs amount to ill-treatment and asked for measures to be taken to avoid repetition of such cases.[35]

On 30 October 2008, a whistle-blower, a nurse at the University Hospital of North-Norway, went on national television to speak about cases in which people had died due to the long-

[32] A/HRC/13/39/Add.1, page 277
http://www2.ohchr.org/english/bodies/hrcouncil/docs/13session/A.HRC.13.39.Add.1_EFS.pdf
A/HRC/16/52/Add.1, page 333
http://www2.ohchr.org/english/bodies/hrcouncil/docs/16session/A.HRC.16.52.Add.1_EFSonly.pdf
[33] Kogstad,R. Stories from other positions. With user experience from the mental health field and a valid voice in politics and formation of knowledge. 2011
[34] Thune, G.H. Infringements – searchlight on psychiatry, 2008. Abstrakt forlag, Oslo.
[35] Report to the Norwegian Government on the visit to Norway carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 13 to 23 September 1999, and Preliminary observations made by the delegation of European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) which visited Norway from 3 to 10 October 2005. Strasbourg: Council of Europe, 2005.

term use of restraints. *"There are examples of people being put in restraints during such a long period of time that they have gotten blood clots (thrombosis) and died because of it*", the nurse said.[36]

When patients make formal complaints they still have to remain in the custody of the health-personnel / hospital they have forwarded the complaint about. WSO receive testimonies from people that do not dare to lodge a formal complaint in fear of retribution and punishment from the personnel responsible. Many patients have little faith in the complaint system due to a low rate of cases pursued[37] and the experience that their credibility in general is denigrated.

The lack of investigation and prompt reaction from the government to allegations of ill-treatment and unjustified use of coercion is in our opinion related to the understanding of these actions as healthcare and treatment, and a lack of understanding for the serious suffering and trauma that can be caused by forced psychiatric interventions.
The failure to recognise such practices and treatment as forms of torture and ill-treatment, to ensure and facilitate a right to complain, and to proceed to a prompt and impartial investigation violates Articles 12 and 13 of CAT.

Ratification of the CRPD and equal recognition before the law of persons with disabilities

List of issues
30. Please state the measures taken towards the ratification of the Convention on the Rights of Persons with Disabilities.[38]

Currently, the government is considering ratification of the CRPD, but with a reservation/ declaration on articles 12, 14 and 25.
The proposed declarations are intended to restrict legal capacity for people with disabilities, and to permit forced care and treatment of persons, among these measures carried out to treat mental disorders. A reservation/declaration on Article 12 no doubt runs counter to the object and purpose of the CRPD, not to mention CAT and other human rights instruments, and the government should be strongly dissuaded from this course of action.
The CRPD-Committee has emphasized the importance of article 12 in its Concluding Observations (see below Annex II, p14-15).

Proposed questions to pose to the Norwegian delegation during the dialogue:

- What steps have been taken by the state to prevent ill-treatment based on discrimination of people with psychosocial disabilities in the mental health system, and to abolish discriminatory laws that facilitate such ill-treatment?

- What steps have been taken to ensure that ECT is administered only with the individual's free and informed consent? How will Norway ensure that forced ECT is not happening?

[36] TV2, 30 October, 2008. "Perilous psychiatry in Norwegian hospitals"; http://www.tv2.no/nyheter/livsfarlig-psykiatri-paa-norske-sykehus-2349293.html
[37] In 2010 5,5% of the complaints to the control-commission on forced commitment was granted pursuant. Complaints to the County Governor on forced medication was granted pursuant in 8 % of the cases.
[38] **State's Reply to the issues raised in paragraph 30 of the list of issues, CAT/C/NOR/6-7**
218. Norway signed the Convention on the Rights of Persons with Disabilities in 2007.
219. Norway considers it necessary to make sure that national laws are in compliance with the Convention, before ratifying the Convention.
220. The Norwegian Government has examined to what extent the Convention will necessitate changes in Norwegian law and practices. The Norwegian legislation on legal capacity is considered not to be in compliance with article 12 of the Convention. A new act on legal capacity has been passed, but has not yet entered into force.
221. Norwegian legislation and practices are otherwise considered to be in line with the Convention.

- What measures are being taken to ensure that all mental health services and treatment is provided to persons with disabilities on the basis of free and informed consent of the individual concerned, and to ensure that persons with disabilities, in the medical setting, are not subjected to discriminatory and coercive practices, including forced administration of ECT and psychiatric drugs, recognised as forms of torture or ill-treatment.

- What measures have been taken to ensure proper investigation of allegations of ill-treatment in the mental health system towards persons with psychosocial disabilities, and to ensure the protection of the complainants from retribution or punishment?

- What steps are being taken towards periodic, independent monitoring and inspection of human rights compliance in places of mental health treatment?

- What measures are being taken to prosecute, and if convicted, punish the alleged officers that subject persons with psychosocial disabilities to ill-treatment? What measures are being taken to ensure victims of ill-treatment in the mental health setting redress and compensation?

- What steps are being taken to ratify the CRPD and its Optional Protocol without any reservations or declarations?

WSO, WNUSP & IDA proposed recommendations for the Concluding Observations:

- Take steps to ratify the CRPD and its Optional Protocol, without reservations and/or declarations on any provisions, including Article 12.

- Take steps to ratify the Optional Protocol to the Convention against Torture.

- Undertake legislative reform and repeal legislation that authorises deprivation of liberty linked in legislation to "mental disorder", psychosocial or intellectual disability, or in other ways being based on disability. Notably, the Mental Health Act authorises deprivation of liberty and compulsory treatment based on psychosocial disabilities in contravention of the CRPD and needs to be abolished.

- Adopt measures to ensure that all health care and services provided to persons with disabilities, including all mental health services, are based on the free and informed consent of the individual concerned, and that the law does not permit involuntary confinement and involuntary treatment, including on the basis of consent provided by a legal guardian, and including involuntary outpatient treatment which is also a form of ill treatment which must be abolished. Ensure that humane and non-medication based treatment alternatives are made readily available.

- Incorporate into the law the abolition of violent and discriminatory practices against children and adults with disabilities in the medical setting, including the use of seclusion, restraint and the enforced administration of intrusive and irreversible interventions such as neuroleptic drugs, electroshock and sterilisation, recognised as forms of torture or other ill-treatment, in conformity with recommendations of the Special Rapporteur on Torture.[39]

- Ensure that allegations of torture or other ill-treatment provoke a prompt and impartial investigation by competent authorities in accordance with articles 12, 13 and 16 of the CAT, and ensure that ill-treatment and other abuses in the mental health system are remedied and prevented, and that such abuses do not take place undocumented and with impunity, under the pretext of "health care".

- Under its obligations to take effective measures to prevent torture and ill-treatment, the State must also enact and enforce criminal sanctions against perpetrators of psychiatric detention and compulsory treatment, and must provide redress to victims and survivors.

- Collect and compile statistics on the use of ECT, and ensure that information given by the authorities and health professionals about the procedure is correct and complete, and includes information on secondary effects and related risks such as heart complications, confusion, permanent neurological damage, loss of memory and even death.[40]

- Ensure effective legal remedies to obtain release from institutions where persons with disabilities may be held against their will.

[39] Report of Special Rapporteur on Torture, 28 July 2008, A/63/175, para 63.
[40] Report of Special Rapporteur on Torture, 28 July 2008, A/63/175

ANNEX I – Recognising forced psychiatric interventions as torture

When considering the risk of torture and other cruel, inhuman or degrading treatment or punishment in the mental healthcare setting it's necessary to take into account not only each intervention applied but the total amount of control the patients is submitted to.

The confinement is usually indefinite, meaning the length of confinement is decided solely by the health personnel in charge with no time limit that is defined in law or decided by court. The risk that patients emotional and physical reactions on being deprived of their liberty and non-compliance to treatment can lead to punishment in form of prolonged deprivation of liberty is substantial.

Forced treatment in form of neuroleptics aiming at changing a person's perceptions, feelings and behaviour is commonly used, and forced electroshock is practiced. Physical restraints and seclusion/ isolation are also commonly used interventions. There is no time limit for the use of coercive means or forced treatment.

One of WSOs members L.S, experienced deprivation of liberty, forced medication, the use of physical restraints and seclusion in a hospital in Oslo in 2006 explained it like this; *" I was locked up indefinitely, for all I knew I could stay there for the rest of my life. At the same time I noticed the changes from the drugs they gave me, so if I came back out I could have been a different person, lost myself. It made me so scared, and I experienced it as torture"*

T. Minkowitz has analyzed if, and under what conditions psychiatric interventions without consent may constitute torture;

"Severity of pain and suffering experienced by the victims varies, depending on the particular methods used, duration, context, and personal characteristics. (…) First person accounts attest to both physical and mental pain and suffering caused by non-consensual administration of neuroleptic drugs, electroshock, and other psychiatric interventions, at the time of the experience and extending long afterwards. Electroshock is experienced by many as a death of part of the self, due in part to its destruction of chunks of memory and identity. (..) Neuroleptic drugs can have a similar effect of loss or separation from self, causing terror and panic that may lead to desperate acts. Neuroleptic drugs have the signature effects of psychic apathy or numbing and movement disorders such as akathisia (extreme restlessness and agitation) with a psychological as well as physical manifestation. (..) The extent and type of suffering is comparable to other methods that have been understood to amount to torture. Aggrevating factors in the context and personal characteristics of the victims emphasize the violation. The context is usually under loss of liberty where length of detention is indeterminate and may depend on one's apparent compliance with arbitrary standards. (..) Most, but not all, are taken when they are in the midst of intense psychological experiences, so that the suffering caused by additional trauma can be unbearable."[41]

Minkowitz 'descriptions of pain and suffering caused by forced psychiatric interventions is to be found also in Norwegian first-hand accounts of experiences with such coercive treatment. That the abuse takes place in a medical context can make it more difficult gaining acceptance that it comes to degrading or inhuman treatment or torture;

"*The tragedy is that what begins as caring and shall ensure a patient's right to treatment, monitoring and mapping, is allowing for the use of police transport, forced medication, physical restraints and smooth cells (...). Actions that in other houses is called torture, abuse and punishment is given another sign when performed by doctors (...). Psychiatric patients have to deal with a health care system where the same hand that comforts and says it will help, in turn, puts them in the belts. Dealing with such a situation is inhumane and causes chaos in the human mind. When trauma is a fact, you have nowhere to go, except back where they caused you injury, but refuses to give it legitimacy. "*[42]

[41] Minkowitz.T. (2006-2007). *The United Nations convention on the rights of persons with disabilities and the right to be free from nonconsentual psychiatric interventions.* Syracuse J. Int'l L. & Com., Vol. 34:405

[42] Former psychiatric patient in the magazine Balance nr. 3/2001

ANNEX II- CRPD Committee Concluding Observations on informed consent, legal capacity, involuntary treatment and detention, medical experimentation and the right to live in the community

- **Informed consent**

The Committee advises the state party to adopt measures to ensure that all health care and services provided to persons with disabilities, including all mental health care and services, is based on the free and informed consent of the individual concerned, and that laws permitting involuntary treatment and confinement, including upon the authorisation of third party decision-makers such as family members or guardians, are repealed. It recommends the state party to develop a wide range of community-based services and supports that respond to needs expressed by persons with disabilities, and respect the person's autonomy, choices, dignity and privacy, including peer support and other alternatives to the medical model of mental health. (CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1, September 2012, para 38)

The Committee is concerned with the imposition of rehabilitation and habilitation measures on persons with disabilities, especially persons with psychosocial or intellectual disabilities, without their informed consent. The Committee recommends that rights based approach to rehabilitation and habilitation be put in place and ensure that such programmes promote the informed consent of individuals with disabilities and respects their autonomy, integrity, will and preference. (CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1, September 2012, paras 39-40)

Igualmente, le recomienda adoptar protocolos que garanticen el consentimiento libre e informado de todas las personas con discapacidad para recibir cualquier tratamiento médico. (CRPD Committee **Concluding Observations on Argentina,** CRPD/C/ARG/CO/1**, September 2012, paras 42)**

The Committee recommends that the State party: review its laws that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities; repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability; and adopt measures to ensure that health-care services, including all mental-health care services, are based on the informed consent of the person concerned. (CRPD Committee **Concluding Observations on Spain,** CRPD/C/ESP/CO/1**, September 2011, paras 35-36**).

The Committee recommends that the State party incorporate into the law the abolition of surgery and treatment without the full and informed consent of the patient, and ensure that national law especially respects women's rights under article 23 and 25 of the Convention. (CRPD Committee **Concluding Observations on Tunisia,** CRPD/C/TUN/CO/1**, April 2011, paras 28-29**)

The more intrusive and irreversible the treatment, the greater the obligation on States to ensure that health professionals provide care to persons with disabilities only on the basis of their free and informed consent. (**Special Rapporteur on Torture, A/63/175, para 59)**

States should issue clear and unambiguous guidelines in line with the Convention on what is meant by "free and informed consent", and make available accessible complaints procedures. (**Special Rapporteur on Torture, A/63/175, para 74)**

- **Legal capacity**

The Committee recommends that the State party use effectively the current review process of its Civil Code and related laws to take immediate steps to derogate guardianship in order to move from substitute decision-making to supported decision-making, which respects the person's autonomy, will and preferences and is in full conformity with article 12 of the Convention, including with respect to the individual's right, on their own, to give and withdraw informed consent for medical treatment, to access justice, to vote, to marry, to work, and to choose their place of residence. The Committee further

recommends the State party to provide training, in consultation and cooperation with persons with disabilities and their representative organizations, at the national, regional and local levels for all actors, including civil servants, judges, and social workers on the recognition of the legal capacity of persons with disabilities and on mechanisms of supported decision-making.
(CRPD Committee Concluding Observations on Hungary, CRPD/C/HUN/CO/1, September 2012, para 26)

The Committee welcomes the fact that Act 26/2011 amends regulations to contain provisions to reflect the right to accessibility when granting informed consent to medical treatment. It however regrets that guardians representing persons with disabilities deemed "legally incapacitated" may validly consent to termination or withdrawal of medical treatment, nutrition or other life support for those persons. The Committee wishes to remind the State party that the right to life is absolute, and that substitute decision-making in regard to the termination or withdrawal of life-sustaining treatment is inconsistent with this right.
The Committee requests the State party to ensure that the informed consent of all persons with disabilities is secured on all matters relating to medical treatment, especially the withdrawal of treatment, nutrition or other life support. (CRPD Committee **Concluding Observations on Spain,** CRPD/C/ESP/CO/1**, September 2011, paras 29-30**)

In keeping with the Convention, States must adopt legislation that recognizes the legal capacity of persons with disabilities and must ensure that, where required, they are provided with the support needed to make informed decisions. (**Special Rapporteur on Torture, A/63/175, para 73)**

- **Involuntary treatment**

The Committee calls upon the HKSAR to provide the necessary mental treatment based on free and informed consent of the person and counselling to these persons. The Committee recommends a regular assessment of their suicide risk. (CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1, September 2012, para 64)

Thus, in the case of earlier non-binding standards, such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (resolution 46/119, annex), known as the MI Principles, the Special Rapporteur notes that the acceptance of involuntary treatment and involuntary confinement runs counter to the provisions of the Convention on the Rights of Persons with Disabilities. (**Special Rapporteur on Torture, A/63/175, para 64**)

- **Involuntary detention**

The Committee notes with appreciation that the State party is dedicated to undertaking measures to provide reasonable accommodation to persons with disabilities that are deprived of their liberty. It also notes with appreciation that "personal liberty is assured by making use of the services voluntarily" (paragraph 87 of the State party's report: CRPD/C/HUN/1). However, the Committee is concerned about the situation faced by persons under guardianship, where the decision of institutional care is made by the guardian instead of the person him/herself, and guardians are authorised to give consent to mental health care services on behalf of their ward. The Committee further regrets that disability, in some cases, can be the ground for detention.

The Committee recommends that the State party review provisions in legislation that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities, and adopt measures to ensure that health care services, including all mental health care services, are based on the free and informed consent of the person concerned. (CRPD Committee Concluding Observations on Hungary, CRPD/C/HUN/CO/1, September 2012, paras 27-28)

The Committee recommends the abolishment of the practice of involuntary civil commitment based on

actual or perceived impairment. In addition, the Committee asks the state party to allocate more financial resources to persons with intellectual and psychosocial disabilities who require a high level of support, in order to ensure social support and medical treatment outside their own home when necessary. (CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1, September 2012, para 26)

The Committee notes with concern that article 11 of the General Health Law No. 26842 permits involuntary detention for people with "mental health problems", defined to include people with psychosocial disabilities as well as persons with a "perceived disability" (persons with a drug or alcohol dependence).

The Committee calls upon the State party to eliminate Law 29737 which modifies article 11 of the General Health Law, in order to prohibit the deprivation of liberty on the basis of disability, including psychosocial, intellectual or perceived disability. (CRPD Committee **Concluding Observations on Peru,** CRPD/C/PER/CO/1, April 2012, paras 28-29)

The Committee takes note of the legal regime allowing the institutionalization of persons with disabilities, including persons with intellectual and psychosocial disabilities ("mental illness"). It is concerned at the reported trend of resorting to urgent measures of institutionalization which contain only ex post facto safeguards for the affected individuals. It is equally concerned at the reported abuse of persons with disabilities who are institutionalized in residential centres or psychiatric hospitals.

The Committee recommends that the State party: review its laws that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities; repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability; and adopt measures to ensure that health-care services, including all mental-health-care services, are based on the informed consent of the person concerned. (CRPD Committee **Concluding Observations on Spain,** CRPD/C/ESP/CO/1**, September 2011, paras 35-36**)

The Committee recommends that the State party repeal legislative provisions which allow for the deprivation of liberty on the basis of disability, including a psychosocial or intellectual disability.

The Committee further recommends that until new legislation is in place, all cases of persons with disabilities who are deprived of their liberty in hospitals and specialized institutions be reviewed, and that the review include the possibility of appeal. (CRPD Committee **Concluding Observations on Tunisia,** CRPD/C/TUN/CO/1**, April 2011, paras 24-25**)

- **Medical experimentation**

The Committee is concerned that Act CLIV of 1997 on Healthcare provides for a legal framework for subjecting persons with disabilities whose legal capacity is restricted to medical experimentation without their free and informed consent, as consent may be given by their legal guardians. The Committee is also notes with concern that there is no independent medical examination body mandated to examine alleged victims of torture and guarantee respect for human dignity during the conduct of medical examinations, as stated by the Human Rights Committee (CCPR/C/HUN/CO/5). The Committee urges the State party to amend Act CLIV on Healthcare and abolish its provisions that provide a legal framework for subjecting persons with disabilities with restricted legal capacity to medical experimentation without their free and informed consent. The Committee recommends the State party to implement the recommendation made by the Human Rights Committee in 2010 (CCPR/C/HUN/CO/5) to "establish an independent medical examination body mandated to examine alleged victims of torture and guarantee respect for human dignity during the conduct of medical examinations."(CRPD Committee Concluding Observations on Hungary, CRPD/C/HUN/CO/1, September 2012, paras 29-30)

For those involuntarily committed persons with actual or perceived intellectual and psychosocial impairments, the Committee is concerned that the "correctional therapy" offered at psychiatric institutions represents an inhuman and degrading treatment. Further, the Committee is concerned that not all medical experimentation without free and informed consent is prohibited by Chinese law. The Committee urges that the state party cease its policy of subjecting persons with actual or perceived impairments to such therapies and abstains from involuntarily committing them to institutions. Further it urges the state party to abolish laws which allow for medical experimentation on persons with disabilities without their free and informed consent. (CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1, September 2012, paras 27-28)

Under article 15 of CRPD medical or scientific experimentation on persons with disabilities, including testing of medicines, is permissible only when the person concerned gives his or her free consent and when the very nature of the experiment cannot be deemed torture or cruel, inhuman or degrading treatment. (Special Rapporteur on Torture, A/63/175, para 58)

- **The right to live in the community**

The Committee recommends to take immediate steps to phase out and eliminate institutional-based care for people with disabilities. Further, the Committee recommends State party to consult with organisations of persons with disabilities on developing **support services for persons with disabilities to live independently in accordance with their own choice. Support services should also be provided to persons with a high level of support needs. In addition, the Committee suggests that the state party undertake all necessary measures to grant people with leprosy the medical treatment needed and to reintegrate them into the community**, thereby eliminating the existence of such lepers' colonies. (CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1, September 2012, para 32)

The Committee advises the state party to adopt measures to ensure that all health care and services provided to persons with disabilities, including all mental health care and services, is based on the free and informed consent of the individual concerned, and that laws permitting involuntary treatment and confinement, including upon the authorisation of third party decision-makers such as family members or guardians, are repealed. It recommends the state party to develop a **wide range of community-based services and supports** that respond to needs expressed by persons with disabilities, and respect the person's autonomy, choices, dignity and privacy, including peer support and other alternatives to the medical model of mental health. (CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1, September 2012, para 38)

The Committee urges the MSAR to prioritize the implementation of this right and shift from institutionalization to in-home or residential living as well as provide other community support services. (CRPD Committee Concluding Observations on China, CRPD/C/CHN/CO/1, September 2012, para 93)

The Committee calls upon the State party to ensure that an adequate level of funding is made available to effectively enable persons with disabilities to: enjoy the freedom to choose their residence on an equal basis with others; access a full range of in-home, residential and other community services for daily life, including personal assistance; and enjoy reasonable accommodation with a view to supporting their inclusion in their local communities. (CRPD Committee Concluding Observations on Hungary, CRPD/C/HUN/CO/1, September 2012, para 34)

The Committee urges the State party to initiate comprehensive programmes to enable persons with disabilities to access a whole range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community, especially in rural areas. (CRPD Committee **Concluding Observations on Peru,** CRPD/C/PER/CO/1, April 2012, para 33)

ANNEX III- About the organisations

We Shall Overcome (WSO) is a Norwegian NGO, run by and for users and survivors of psychiatry, established in 1968. WSO advocates for the human rights of users and survivors of psychiatry, the ratification and implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD), and bringing forced psychiatric practices and other infringements in the mental health system to an end. The organisation is a member of the World Network of Users and Survivors of Psychiatry (WNUSP).

Mette Ellingsdalen
mette.elling@gmail.com
Tel +47 908 59 796
www.wso.no

The **World Network of Users and Survivors of Psychiatry (WNUSP)** is an international organisation of users and survivors of psychiatry, advocating for human rights of users and survivors, and representing users and survivors worldwide.[43] The organisation has expertise on the rights of children and adults with psychosocial disabilities, including on the latest human rights standards set by the CRPD.[44] WNUSP is a member organisation of IDA and has special consultative status with ECOSOC.

Tina Minkowitz
tminkowitz@earthlink.net
Tel +1 518 494 0174
www.wnusp.net

The **European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP)** is the grassroots, independent representative organisation of mental health service users and survivors of psychiatry at a European level. ENUSP's members are regional, national and local organisations and individuals across 39 European countries. Since its foundation in 1991, ENUSP has campaigned for the full human rights and dignity of mental health service users and survivors of psychiatry and the abolition of all laws and practices that discriminate against us. ENUSP is currently a consultant to the European Commission, the European Union Fundamental Rights Agency, and the World Health Organization-Europe. ENUSP is a member of European Disability Forum (EDF) and European Patients' Forum (EPF) and part of the World Network of Users and Survivors of Psychiatry (WNUSP). Through WNUSP, our members were active in the drafting and negotiation of the UN Convention on the Rights of Persons with Disabilities.

Erik Olsen
erikpsyk@gmail.com
Tel +46 29630436
www.enusp.org

The **International Disability Alliance (IDA)** is the international network of global and regional organisations of persons with disabilities (DPOs), currently comprising eight global and four regional DPOs. Each IDA member represents a large number of national DPOs from around the globe, covering the whole range of disability constituencies. IDA's mission is to advance the human rights of persons with disabilities as a united voice of DPOs utilising the CRPD and other human rights instruments, and to promote the effective implementation of the CRPD, as well as compliance within the UN system and across the treaty bodies.

Victoria Lee
vlee@ida-secretariat.org
Tel +41 22 788 4273
www.internationaldisabilityalliance.org

[43] In its statues, "users and survivors of psychiatry" are self-defined as people who have experienced madness and/or mental health problems, or who have used or survived mental health services.
[44] WNUSP played a central role in the drafting and negotiation of the UN Convention on the Rights of Persons with Disabilities (CRPD).