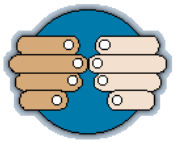

World Network of Users and Survivors of Psychiatry

International Disability Alliance (IDA)
Member Organisations:
Disabled Peoples' International, Down Syndrome International,
Inclusion International, International Federation of Hard of Hearing People,
World Blind Union, World Federation of the Deaf, World Federation of the DeafBlind,
World Network of Users and Survivors of Psychiatry,
Arab Organization of Disabled People, European Disability Forum,
Red Latinoamericana de Organizaciones no Gubernamentales de Personas con Discapacidad y sus familias (RIADIS), Pacific Disability Forum

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Joint submission by We Shall Overcome (WSO), World Network of Users and Survivors of Psychiatry (WNUSP) and the International Disability Alliance (IDA) for the examination of Norway (review of Norway's 6th Periodic ICCPR report), Human Rights Committee, 103rd Session (17 October – 4 November 2011)

We Shall Overcome (WSO), the World Network of Users and Survivors of Psychiatry (WNUSP) and the International Disability Alliance (IDA) have prepared the following information and recommendations for questions to the State party and for the Concluding Observations, in relation to the references to persons with disabilities provided in the State Report, List of Issues,[1] and Replies.[2] An annex listing the references to persons with disabilities found in the State Report and List of Issues is also included.

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).

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.[3] 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.[4] WNUSP is a member organisation of IDA and has special consultative status with ECOSOC.

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, with two other regional DPOs having observer status. 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

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[1] UN CCPR/C/NOR/Q/6
[2] UN CCPR/C/NOR/Q/6/Add.1
[3] 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.
[4] WNUSP played a central role in the drafting and negotiation of the UN Convention on the Rights of Persons with Disabilities (CRPD).

with disabilities as a united voice of DPOs utilising the CRPD[5] 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.

NORWAY

List of issues - Right to life and prohibition of torture and cruel, inhuman or degrading treatment (arts. 6 and 7)

4. Please explain the measures taken to combat murders and suicides by psychiatric patients. Furthermore, what measures have been taken to ensure that the use of unjustified coercive force on persons with mental disabilities in mental-health-care institutions is eliminated? Please provide data on the measures taken to (a) investigate the use of coercion and restraint, and (b) prosecute, and if convicted, punish the alleged officers that use unjustified coercive force on persons with mental disabilities.

Comments to issue no 4: Coercion in the mental health system

We welcome Norway's initial replies and attempt to raise awareness regarding the use of language and other measures to combat stereotypes, stigmatisation and discrimination of persons with psychosocial disabilities.[6] Despite this action, the Norwegian Government uses the term "suffering from mental illness", which can be pejorative. The term "psychosocial disabilities" is preferred because it moves away from the medical model of disability and refers to the interaction between impairments and various barriers which may hinder full and effective participation in society (in line with the social model of disability as set forth in the UN Convention on the Rights of Persons with Disabilities – CRPD, preamble and art. 1).

We agree with Norway's reply that the quality of national reporting on coercive admissions and the use of coercive means is not satisfactory. Complete and reliable data and statistics on involuntary admission, non-consensual treatment and use of coercive means do not exist. Statistics indicate however that Norway has a high incidence of involuntary admissions compared to other countries against which it is reasonable to compare. There are also major and unexplainable regional variations in the use of involuntary admissions in Norway.[7]

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).[8] Another report from 2008 shows that the over-all use of coercive means increased in the period 2001 – 2007.[9] The use of restraints increased by more than 20 %, and the use of seclusion ("shielding") increased 202 % (two hundred and two percent), in this period.

[5] International Disability Caucus (IDC), the network of global, regional and national organisations of persons with disabilities and allied NGOs, was a key contributor in the negotiation and drafting of the Convention on the Rights of Persons with Disabilities (CRPD).
[6] Psychosocial disability is the preferred term used by the organisations representing this constituency at the global level. The term is also used by the UN Committee on the Rights of Persons with Disabilities (CRPD) and the Office of the High Commissioner for Human Rights (OHCHR).
[7] 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).
[8] 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.
[9] SINTEF Health. Bremnes, R., Hatling, T. and Bjørngaard, J. H. Use of coercive means in the mental health system for 2001, 2003, 2005 and 2007. Report A8231, November 2008.

The Norwegian Government does not explain what measures have been taken to eliminate the use of unjustified coercive force in mental health institutions. Instead the Government refers to measures to ensure the "correct use of coercion".

Ensuring elimination of the use of unjustified coercive force against persons with disabilities begins with correctly identifying applicable norms of international law. The CRPD articulates the latest human rights standards with respect to persons with disabilities. Both the UN Special Rapporteur on Torture and the Office of the High Commissioner for Human Rights (OHCHR) have come to the conclusion that, unlike earlier non-binding standards (such as the "Mental Illness"-principles of 1991), the CRPD does not accept involuntary confinement of persons with disabilities in psychiatric or social care institutions or non-consensual psychiatric treatment as a lawful practice.[10] It is noted by the UN Special Rapporteur on Torture that non-consensual psychiatric treatment and involuntary confinement in psychiatric institutions runs counter to the CRPD and may constitute torture or other ill-treatment.[11] Also the prolonged use of restraints and seclusion may itself constitute torture or other ill-treatment.[12] The CRPD Committee has recommended repeal of legislative provisions which allow for the deprivation of liberty on the basis of disability, including psychosocial or intellectual disability, and recommended to incorporate into the law the abolition of treatment without full and informed consent.[13]

Deprivation of liberty

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".[14] 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*

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."[15]

[10] Interim Report of the Special Rapporteur on Torture and other cruel, inhuman and degrading treatment or punishment, (Special Rapporteur on Torture) U.N. Doc. A/63/175 (July 28, 2008), paragraph 44; Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities, U.N. Doc. A/HRC/10/48, January 26, 2009, see especially paragraphs 48-49; Dignity and Justice for Detainees Week Information Note No. 4: Persons with Disabilities (OHCHR Information Note).
[11] Interim report A/63/150. 28. July 2008.
[12] Interim report A/63/150. 28. July 2008.
[13] Concluding observations of the Committee on the Rights of Persons with Disabilities on the initial report of Tunisia (CRPD/C/TUN/1), adopted 15 April 2011, para 25 and 29, available at http://www2.ohchr.org//SPdocs/CRPD/5thsession/CRPD-C-TUN-CO-1_en.doc
[14] Mental Health Act 1999 § 3-3 first section no. 3
[15] 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

Deprivation of liberty based on such criteria is discriminatory and runs counter to the provisions of the CRPD (art. 5 and 14), which Norway has signed, but not yet ratified. Though not being legally bound by the CRPD, Norway is nevertheless obliged under other binding human rights treaties (including ICCPR arts. 2 and 26) not to discriminate based on disability and to ensure that the law prohibits such discrimination.

Right to be free from torture or cruel, inhuman or degrading treatment or punishment

The Norwegian Mental Health Act also authorises non-consensual psychiatric treatment,[16] including forced drugging (which is specifically contravened by CRPD art. 12, 15, 17 and 25d). Numerous stories about suffering, pain, fear, trauma, and the serious infliction of injuries, have been told by persons who have experienced forced medication and their relatives.[17] The forced administrations of psychiatric drugs represent, among other human rights violations, a serious violation of the right of a person with psychosocial disabilities to respect for his/her physical and mental integrity on an equal basis with others (CRPD art. 17). The UN Special Rapporteur on Torture states that forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics, for the treatment of a mental condition needs to be closely scrutinised, and that "depending on the circumstances of the case, the suffering inflicted and the effects upon the individual's health may constitute a form of torture or ill-treatment"[18].

Norwegian legislation does not permit the administration of electroshock (ECT) without informed consent, yet such practice is nevertheless accepted by the authorities; it is being carried out and is purportedly justified by the "principle of necessity". There are no official statistics on the extent of forced ECT (nor ECT administered with informed consent).

The proposed revision of the Mental Health Act[19] 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.

Lack of investigation and prosecution of ill-treatment

We note that Norway has not provided data on the measures taken to a) investigate the use of coercion and restraint, and b) prosecute, and if convicted, punish the alleged officers that use unjustified coercive force on persons with psychosocial disabilities.

Users and survivors of psychiatry have brought civil cases before Norwegian courts regarding coercive treatment and incarceration in mental health institutions, alleging violation of their right to liberty, respect for private and family life, and/or freedom from torture and other ill-treatment.[20] It is however reasonable to assume that there would be several more such cases if legal aid had been made more readily available in cases regarding alleged human rights violations.

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

[16] Treatment can by Norwegian law, 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.
[17] See e.g. Blomberg, 1990; Kogstad, 2004; Øye, 2005; Pedersen, 2006; Lauveng, 2005 og 2006; Norvoll, 2007; Vaaland, 2007; Thune, 2008, Tranøy, 2008; Kogstad, 2009.
[18] Manfred Nowak (July 2008), *Protecting Persons with Disabilities from Torture*. Interim report A/63/150. 28. July 2008. http://www2.ohchr.org/english/issues/disability/docs/torture/A_63_175_en.doc
[19] Law Committee referred to in State reply p. 8.
[20] E.g. Supreme Court decisions; Rt. 2002 p. 1646 and Rt. 2004 p. 583, Borgating Court of Appeal, decision 3. September 2009, District Court, Oslo Tingrett, decision 29. May 2007.

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.[21] 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. Two Norwegian cases concerning forced psychiatric interventions have been reported to the UN Special Rapporteur on Torture.[22] In general, there appears to be a systematic lack of investigation of the use of coercion and restraint, as well as alleged ill-treatment.

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.[23]

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-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.[24]

Recommendations for questions to pose to the State party

- We call the Committee’s attention to the government’s failure to provide the relevant requested information on measures taken to ensure that the use of unjustified coercive force on persons with mental disabilities in mental health institutions is eliminated, to provide data on measures taken to investigate the use of coercion and restraint, and to prosecute, and if convicted, punish the alleged officers that use unjustified coercive force on persons with psychosocial disabilities. We urge the Committee to remind the government that failure to keep and provide these data hinders effective monitoring of the rights of persons with psychosocial disabilities.

- We recommend the Committee to ask the State party what measures are being taken to ensure that health care 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.

[21] Thune, G.H. Infringements – searchlight on psychiatry, 2008. Abstrakt forlag, Oslo.
[22] UN Special Rapporteur on Torture, 2010. Summary of information, including individual cases, transmitted to Governments and replies received – A/HRC/13/39/Add.1, and UN Special Rapporteur on Torture, 2011. Human Rights Council-Communications to and from Governments – A/HRC/16/52/Add.2.
[23] 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.
[24] TV2, 30 October, 2008. “Perilous psychiatry in Norwegian hospitals”; http://www.tv2.no/nyheter/livsfarlig-psykiatri-paa-norske-sykehus-2349293.html

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

- Take steps to ratify the CRPD and its Optional Protocol, without reservations and/or declarations.

ICCPR articles 3 and 7
- Address the heightened risk for women and children with disabilities of becoming victims of domestic violence and abuse, and adopt urgent measures to ensure that both services and information for victims are made accessible to persons with disabilities.

ICCPR articles 2, 7, 9, 10 and 26
- 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 (in order to comply with CRPD art. 4 and 14). 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.

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

- 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 treatment, including medical and scientific experimentation on the basis of consent provided by a legal guardian.

- 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 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.[25]

- 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 reparations 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, loss of memory and even death.[26]

ICCPR articles 16 and 26
- Reform the law in accordance with Article 16, ICCPR and Article 12 of the Convention on the Rights of Persons with Disabilities (CRPD), including by repealing the new Act on guardianship, to guarantee the equal recognition before the law of persons with disabilities, including the adoption of measures to ensure that having a disability does not directly or

[25] Report of Special Rapporteur on Torture, 28 July 2008, A/63/175, para 63.
[26] Interim report A/63/150. 28. July 2008.

indirectly disqualify a person from exercising his or her legal capacity autonomously, and to ensure that persons with disabilities have access to support that they may need to exercise legal capacity on an equal basis with others, respecting the will and preferences of the person concerned.[27]

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[27] See also report of Special Rapporteur on Torture, 28 July 2008, A/63/175, paras 73 and 44.

ANNEX - Selected references to persons with disabilities in the State report and replies to the List of Issues:

State report

Coercive measures and deprivation of liberty in health care
Health care for patients objecting to health care while lacking the necessary capacity to consent

62. A new chapter 4 A about health care for **patients objecting to health care while lacking the necessary capacity to consent**, has been added to the Patients' Rights Act. These are **patients who, on account of physical or mental disorder, senile dementia or mental retardation**, are clearly incapable of understanding what the consent entails. The new chapter came in to force on 1 January 2009. The criteria for evaluating whether a patient has the necessary capacity to consent are stipulated in chapter 4 of the Act. This new legislation is limited to somatic health-care**. In the area of mental illness, coerced intervention is sanctioned separately under the Mental Health Care Act.**

63. The purpose of the new provisions is to provide necessary health care in order to prevent significant harm to health and to prevent and limit the use of force. The health care must be provided in such a way that it ensures respect for the individual's physical and mental integrity and should as far as possible be in keeping with the patient's right to self-determination.

64. Before health care to which the patient objects may be provided, attempts must have been made to gain the patient's confidence, unless it is obvious that such attempts are pointless. If the patient maintains his objection, or if the health personnel know that the person concerned is very likely to maintain his objection, an administrative decision may be made regarding health care if failure to provide health care may lead to significant harm to the patient's health, the health care is deemed to be necessary, and the measures are proportionate to the need for health care. Even if these conditions are fulfilled, health care may only be provided when, after an overall assessment, this clearly appears to be the best solution for the patient.

65. Administrative decisions regarding health care pursuant to this chapter may only be made for up to one year at a time. The Act also stipulates provisions regarding the right of the patient and others to information about the decision, the right to complain about the decision etc. If a health care decision is not appealed and the health care continues, the County Board of Health Supervision must, when three months have elapsed since the decision was made, of its own volition assess whether there is still need for the health care.

Use of coercive measures towards mentally retarded persons

66. As mentioned in paragraph 70-71 of Norway's fifth periodic report, the Storting, by Act of 19 December 2003 No 134 added a permanent chapter 4A to the Act relating to Social Services. The chapter contains provisions relating to the rights of, and the restriction and control of the use of coercion and force towards, certain **categories of mentally retarded persons**.

67. The **use of coercive measures** is being followed closely by the offices of the county governors and the Norwegian Board of Health Supervision. The legislation is under evaluation by the Norwegian Directorate of Health. The use of coercive measures has been reviewed by Nordland Research Institute and the findings are presented in NF-report No 1/2008.

Deprivation of liberty in connection with mental health care

68. Reference is made to Norway's fifth periodic report paragraph 87-97. Some **amendments to the Mental Health Care Act** came into force on 1 January 2007. The main amendments are as follows:

69. Prohibition against transfer from voluntary to compulsory mental health care: According to section 3-4 the prohibition does not apply in cases where discharge means that the patient constitutes an obvious and serious risk to his or her own life and those of others. In connection with supervision, a written account must be sent to the supervisory commission drawing particular attention to the fact that a decision regarding transfer has been made.

70. Segregation: According to section 4-3 an administrative decision on segregation shall be made if segregation is maintained for more than 24 hours. Before the amendment the limit was 48 hours.

71. Serious eating disorder: According to section 4-4 nutrition can, as part of the treatment of a patient with a serious eating disorder, be given without the consent of the patient, provided that this is considered to be absolutely necessary.

Coercion in mental health-care - changes in practice

72. **Coercive treatment of mental illness**, emergency ward and safety measures have been the object of special attention from the authorities since 2006, but will still need further follow-up from the health authorities and the treatment system.

73. Although the validity of data is questionable, **international statistics indicate a high frequency of use of coercion in mental health-care in Norway compared to other countries**. Variations in reported data between and within the Norwegian health regions clearly show a potential for reducing the amount of coercive admission and treatment.

74. "**The Action plan for reduced and controlled use of coercion in mental health-care**" was launched in June 2006. The plan has four main goals: Increased voluntariness, safeguarded use of coercion, increased knowledge and better documentation on the use of coercion.

75. In 2008 a national network for development of knowledge and for research on the **use of coercion in mental health-care** was established at the University of Tromsø. The project "User-oriented alternatives to coercion" carried out by SINTEF Health in cooperation with 6 emergency wards, was finished in 2008. The project has shown promising possibilities for reducing coercive treatment in hospitals. Measures have also been taken to improve documentation of coercion, inter alia the new guidelines for registration of patient decision-making applied in the electronic patient journal. An autonomous working group has evaluated the need for the treatment criterion in the Norwegian Mental Health Care Act. The group has also reviewed and elaborated the action plan mentioned above. The group expresses concern about the high and varying figures for the use of coercion in Norway and has proposed several measures to be taken by the health authorities and treatment units. The Ministry of Health and Care Services has launched a process for following up the report.

Protection of whistle-blowers in psychiatric institutions

76. In a shadow report to Norway's fifth report several Norwegian Human rights' organisations recommend that whistle-blowers in psychiatric institutions should be given extra protection against negative sanctions.

77. On 1 January 2007 new general provisions in the Working Environment Act concerning the protection of whistle-blowers entered into force. These provisions in the Working Environment Act apply to all employment relationships. According to Section 2-4 an

employee has a right to report censurable conditions at the undertaking. The employee is to follow an appropriate procedure when such a concern is being raised. In any case, the employee has the right to report in accordance with the duty to report censurable conditions or the undertaking's routines for reporting such conditions. The same applies to reporting to supervisory authorities or other public authorities. According to the provision the employer has the burden of proof that a report has been made in breach of the provision.

78. Section 2-5 states that retaliation against an employee who makes a report pursuant to Section 2-4 is prohibited. If the employee submits information that gives reason to believe that such retaliation has taken place, it shall be assumed that retaliation has taken place unless the employer substantiates otherwise. This applies correspondingly to retaliation against an employee who makes known that the right to report pursuant to Section 2-4 will be invoked, for example by providing information. Anyone who has been subject to retaliation in breach of these provisions may claim compensation without regard to the fault of the employer.

Children of persons suffering from mental illness, substance abuse problems or serious illness

79. **Children of persons suffering from mental illnesses, substance abuse problems and of those suffering from serious illnesses** in general are vulnerable and in need of particular attention and follow-up by care providers. In order to strengthen the legal position of children of the above-mentioned patients, the Government has initiated changes in the Patient Rights Act expected to enter into force in 2010.

Experimental treatment and clinical trials

80. Act of 20 June 2008 No 44 on medical and health research (the Health Research Act) was enacted by the Storting 5 June 2008 and came into force 1 July 2009. The purpose of the Act is to promote good and ethically sound medical and health research. The Act applies to all medical and health research on human beings, human biological material or personal health data. A research project must be approved in advance by a regional committee for medical and health research ethics.

81. According to the Health Research Act, consent must be obtained from participants in medical and health research, unless otherwise laid down in law (Section 13). Consent must be informed, voluntary, express and documented. The patient must be given information concerning the purpose, methods, risks, discomfort, consequences and any other information of significance for the validity of the consent. Consent to take part in a research project may be withdrawn at any time.

82. For a **research participant who is legally incapacitated, physically or mentally incapable of giving consent or is a minor, an informed, voluntary, express and documented consent must be obtained from a legally authorised representative**. Research including **people who lack competence to consent** may only be done if the potential risks or disadvantages for the person are insignificant, the individual involved is not averse to it and there is reason to assume that the results of the research may be of use to the person concerned or other people with the same age-specific disorder, disease, injury or condition. For minors, it is in addition a requirement that similar research cannot be done on people who are not minors. And for **people who lack competence to consent, it is a requirement that there is no reason to believe that the person concerned would have been averse to participating in the research project if they had had the capacity to consent, and that similar research cannot be done on people who have the capacity consent**.

Health care in prisons

168. Prisoners have the same patient rights as the population in general, limited by security restrictions only. Surveys made in Norwegian prisons reveal a significantly **higher frequency**

of mental disease symptoms within the prison population than in the general population. Occasionally, problems arise concerning the provision of satisfactory assistance to **prisoners with acute mental illnesses**, and Norway has, as a result, received criticism from the European Committee for the Prevention of Torture (CPT).

169. The Government's aim is to provide adequate treatment for **prisoners with mental problems** as well as for prisoners with problems concerning substance abuse. **There are currently five to six prisons where a health care service for prisoners with mental diseases is provided within the prison facilities. In the remaining prisons, community mental health care services come to the prisons by appointment or the prisoner is transported to an outside clinic.**

170. Close cooperation between the justice and health care authorities has been established to strengthen the **treatment program availability for prisoners with mental diseases**. The need for separate resource departments for this group of prisoners is also being examined at this time.

171. Special measures are taken by the health and justice authorities in order to meet certain health challenges among prisoners. Some examples are:

- In the course of 2009 a total of 9 units for coping with substance abuse will be established in Norwegian prisons.
- The opportunity to serve a sentence in health-care institutions providing treatment for drug abuse and **mental illness** will be strengthened further.

Article 16

186. Legal capacity is today merely regulated in the Act on legal guardianship 22nd April 1927 and in the Act on legal incapacity 28th November 1898. In White Paper No 110 (2008-2009) the Government has put forward a bill with a proposal of a **new Act on guardianship.** This new law will replace the existing acts from 1898 and 1927.

187. The proposed act marks a distinct shift in attitude towards **persons with special needs, mental diseases or disabilities**. The act stresses that such vulnerable persons are not just "objects" of charity and social protection, but also persons with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as far as possible. The proposed act also identifies areas where adaptations have to be made for these persons to effectively exercise their rights. According to the proposal it will be possible to legally incapacitate a person, but never to a greater extent than absolutely necessary and always tailored to the person's circumstances. Also, when a person is legally incapacitated in a certain field, it is stressed that the person shall be heard and that the wishes and preferences of the person shall be taken into account as far as possible. The person himself shall also be entitled to effective access to the courts to claim alterations or abolishment of the incapacity-order.

188. The proposed legislation is also meant to fulfil the obligations in the **Convention on the Rights of Persons with Disabilities**, which entered into force 3rd May 2008. It is in particular the Convention article 12 and 13 that are relevant in this respect.

250. A new Anti-Discrimination and Accessibility Act, giving protection against discrimination on the ground of **disability**, entered into force on 1 January 2009, cf. the Core Document paragraphs 207 to 214. An English translation of the Act is enclosed (appendix 2).

251. In May 2009 the Government presented its Action plan for universal design and increased accessibility 2009-2013, see the Core Document paragraphs 244 to 245.

252. Norway signed the **UN Convention on the Rights of Persons with Disabilities** on 30 March 2006. Ratification of the convention will require amendments in legislation, and the Government is now assessing these issues. The Government is planning to present its proposal for ratification to the Storting in 2010. Norway has not signed the optional protocol. The question of signature/ratification is under consideration.

Replies to the List of Issues

Right to life and prohibition of torture and cruel, inhuman or degrading treatment (arts. 6 & 7)
28. Initial remarks regarding language use in efforts to combat the stigmatisation and discrimination of persons with mental illness

29. The Government wishes to strongly emphasise that the vast majority of persons suffering from a mental illness represent no higher a risk of violent or lethal behavior than other people do. Substance abuse and in particular excessive consumption of alcohol constitute a much higher risk of severe violence. Furthermore, suicide among persons with mental illness should under no circumstances be equated with murders, given the fact that most suicides are an isolated tragic act ending a life perceived as unlivable. Therefore, the Government strongly appeals to all media, organisations, agencies and the public not to communicate any flawed, generalised connection between either homicide and mental illness or homicide and suicide. In order to reduce stigmatisation and to fight discrimination, this warning should be paramount in all forms of public and private communication affecting the lives and future prospects of persons with mental illness as well as their carers and families.

Measures to reduce and ensure correct use of coercion in mental health care
33. In May 2010 a committee was appointed by the Government to review the provisions in the Mental Health Act regarding detention, restraints and coercive treatment in order to reduce and ensure correct use of force. On 17 June 2011, the committee submitted a report on increased self-determination and legal security. The report suggests that coercive means still have a justified place in health legislation in order to secure essential care for severely ill persons. Nevertheless, the committee concludes that the Mental Health Act should set narrower, more clearly defined limits for the use of force, partly in the light of the current geographical differences in the way the legislation is implemented. Thus the committee recommends certain changes in the legislation and control system in order to ensure the highest possible correct threshold for admitting and treating patients with mental illness. One example is a new legal requirement that a patient's capacity to consent to health care be assessed and documented before a decision can be made regarding involuntary health care. According to this proposal, a patient must have clearly demonstrated a lack of this capacity in order for coercive care to be justified, pursuant to chapter 4 a of the Patient Rights Act. The report is now being followed up by the Ministry of Health and Care Services and will be submitted for public consultation after the summer of 2011.

34. For 2010/2011 the Ministry of Health and Care Services has required the Regional Health Authorities to submit regional and local plans regarding reduced and correct use of coercion and detention in mental health services. The Directorate of Health has also been asked to establish a set of measures at the national level to support the efforts of the Regional Health Authorities to reduce the use of coercion. Together, the national, regional and local plans constitute a new national strategy on reduced and correct use of coercion in the mental health services. The main reason underlying this new strategy is that in the past few years, the national efforts to reduce and ensure correct coercive health care have not achieved significant results despite repeated, clear signals from the Ministry to the Regional Health Authorities. Furthermore, the quality of the national reports on coercive admission and use of coercive means is not satisfactory; improving the quality of data and reporting routines is therefore one of the goals of the strategy.

35. Other important steps to improve mental health services have been taken with a goal of increasing the availability and proximity of the services. In the past five years, approximately 150 outreach teams have been established to meet people's needs at an early stage and to ensure a closer follow-up when necessary. There is still a lack of good outcomes research, although there are local reports on reductions in the number of involuntary admissions and coercive treatment as a consequence of increased outreach activity. The concept of patient-determined admission to local psychiatric institutions appears to reduce the use of detention among severely ill persons.