
**Information for the review of Norway's 8th Periodic report to the
UN Committee against Torture,
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Submitted by:

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We Shall Overcome (WSO) is a Norwegian NGO/DPO¹, run by and for users and survivors² of psychiatry, established in 1968. WSO advocates for the human rights of users and survivors of psychiatry, the 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), an international organisation of users and survivors of psychiatry who has special consultative status with ECOSOC.

¹ DPO - Disabled People's Organisations; are representative organizations or groups of persons with disabilities, where persons with disabilities constitute a majority of the overall staff and board, and are well-represented in all levels of the organization.

² "Users and survivors of psychiatry" are self-defined as people who have experienced mental health problems, psychosocial disabilities, or who have used or survived mental health services, including survivors of forced psychiatric interventions.

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1. Introduction

The Norwegian NGO/DPO We Shall Overcome (WSO) has prepared the following information to give input to the UN Committee against Torture in advance of its review of Norway's 8th periodic report 24-25 April 2018. The submission highlights principal areas of concerns regarding disability-specific acts of torture and other cruel, inhuman or degrading treatment in Norwegian law and practice.

We welcome this opportunity to address these human rights issues and hope the Committee will take up the questions presented with the Norwegian delegation. We will have representatives from WSO attending the examination. Please do not hesitate to contact us for any further information or questions.

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2. Deprivation of liberty, forced treatments and use of coercive means in the mental health system as discriminatory, disability-specific forms of torture and other ill-treatment

The principle of non-discrimination is a general principle in the protection of human rights and fundamental to the interpretation and application of the UN Convention against Torture. Non-discrimination is included within the definition of torture itself in article 1, paragraph 1, of the Convention, which explicitly prohibits specified acts when carried out for “any reason based on discrimination of any kind...”. The Committee against Torture has emphasized that the discriminatory use of mental or physical violence or abuse is an important factor in determining whether an act constitutes torture, and that protection of certain minority or marginalized populations especially at risk of torture is part of the States obligation to prevent torture or ill-treatment.³

Persons with perceived psychosocial disabilities are especially at risk of ill-treatment carried out through coercive psychiatric procedures. Persons with psychosocial disabilities face discrimination, stigma and marginalization and are subject to emotional and physical abuse in mental health facilities.⁴ The discrimination includes deprivation of liberty based on perceived impairments, rejection of our will and preferences as “incompetent” and ill-treatment masked as treatment.

Norway’s ratification of the UN Convention on the Rights of Persons with Disabilities (CRPD) in June 2013 brought new hope of bringing forced psychiatric interventions to an end. CRPD prohibits detention on mental health grounds, as well as forced psychiatric treatments. The UN CRPD Committee, has spoken clearly both in its General Comment No. 1, in its guidelines on CRPD Art. 14, and in its Concluding Observations; there can be no legitimate detention in any kind of mental health facility, and forced treatment by psychiatric and other medical professionals is a violation of the right to equal recognition before the law, as well as an infringement of the rights to personal integrity (CRPD art. 17); freedom from torture (CRPD art. 15); and freedom from violence, exploitation and abuse (CRPD art. 16).

3. Coercion in the mental health system, lack of prevention of ill-treatment (art. 2 and 16) – Norway’s reply to LoIPR para 12

We welcome Norway’s initial replies and the governments expressed wish of mental health services to be available on a voluntary basis. We also welcome the ordering to establish medication-free treatment programs in all regional health enterprises, including help of withdrawing from psychotropic medication.⁵

³ CAT, General Comment 2, para 20 and 21.

⁴ UN Special Rapporteurs on the rights of persons with disabilities, Catalina Devandas-Aguilar, and on the right to health, Dainius Pûras; Call on States to eradicate all forms of non-consensual psychiatric treatment. “*Dignity must prevail*” – *An appeal to do away with non-consensual psychiatric treatment*, World Mental Health Day, 10 October 2015. <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16583&LangID=E>

⁵ State report paras 82 and 89.

However, despite decades of critique and concerns from national and international human rights monitoring mechanisms, Norway insist on maintaining laws, policies and practices that institutionalize and forcibly treat people with perceived psychosocial disabilities, and thus systematically violate fundamental human rights, including the right to non-discrimination and to be free from torture and other ill-treatment.

In their policies and national strategy plans, the Norwegian Government focuses on the “correct” use of psychiatric coercion (National Strategy on Reduced and Correct Use of Coercion)⁶, as if such a standard exists. As described above, forced psychiatric interventions are discriminatory practises, amounting to ill-treatment, and there could therefore be no “correct use”. Instead, Norway should focus on ensuring elimination of such unjustified coercive practises, in line with CAT articles 2 and 16.⁷

The Norwegian government deems psychiatric coercion legitimate and claim; “appropriate use of coercion can save lives and constitute good care”.⁸ Such approach negate the equal capacity and rights of persons with psychosocial disabilities to make our own decisions at all times and have our physical and mental integrity respected on an equal basis with others. It further ignores the severe harms caused by psychiatric coercion. Not a single place in the State report do the Norwegian government mention the severe pain, suffering, trauma and irreparable damage to life, health and integrity caused by psychiatric detention and non-consensual treatment. There is an urgent need for recognizing the severity of the harm done and the suffering inflicted on the victims, and for this knowledge and awareness to be implemented in national policies, law and practice.

The suffering of the victims of forced psychiatry have been recognized by several UN monitoring mechanisms, including by the CRPD committee who in its General Comment 1 makes reference to people using mental health systems who have experienced deep pain and trauma as a result of forced treatment.⁹ In a joint statement issued last year by the Special Rapporteurs on the rights of persons with disabilities and on the right to health the Rapporteurs calls on states to eradicate all forms of nonconsensual psychiatric treatment as a matter of urgency, and says that the international community needs to acknowledge the extent of these violations, which are broadly accepted and justified in the name of psychiatry as medical practice. The Rapporteurs states that the concept of “medical necessity” behind non-consensual placement and treatment falls short of scientific evidence and sound criteria, that the legacy of the use of force in psychiatry is against the principle of “first do no harm” and should no more be accepted.¹⁰

⁶ National Strategy for reduced and correct use of force in mental health services, Ministry of Health and Care Services, 19 March 2010 (Oppdragsbrev av 19. mars 2010 fra Helse- og omsorgsdepartementet til de regionale helseforetak); see State report, para 84.

⁷ CAT art. 2 set forth the obligation of State parties to take effective legislative, administrative, judicial or other measures to prevent acts of torture and other ill-treatment.

⁸ State report para 84.

⁹ CRPD, GC 1, para 42.

¹⁰ UN Special Rapporteurs on the rights of persons with disabilities, Catalina Devandas-Aguilar, and on the right to health, Dainius Pûras; Call on States to eradicate all forms of non-consensual psychiatric treatment. “Dignity must prevail” – An appeal to do away with non-consensual psychiatric treatment, World Mental Health Day, 10 October 2015. <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16583&LangID=E>

In the CAT List of Issues Prior to Reporting (LoIPR) para a, Norway is asked to provide an update on “whether the use of restraints and the enforced administration of intrusive and irreversible treatments such as neuroleptic drugs and electroconvulsive therapy has been abolished in law.”¹¹ Regrettably, these practices are still legitimized through Norwegian law and practice and the government does not give any indications on how and when these practices amounting to ill-treatment will be abolished.

In LoIPR para 12 b, Norway is asked to provide an update on: “Ensuring that every competent patient, (...), is fully informed about the treatment to be prescribed and is given the opportunity to refuse treatment or any other medical intervention.” Norway reply by putting forward a legal reform containing “making incapacity to consent a condition for use of coercion (capacity-based model)”, which do not bring domestic legislation in compliance with international human rights norms and the principle of non-discrimination.

Legal capacity is an inherent right accorded to all people, including persons with disabilities, it is a universal attribute inherent to all persons by virtue of their humanity.¹² Every person is therefore *legally* competent to refuse treatment, and mental health treatments should only be provided based on the free and informed consent of the person concerned. States cannot restrict the legal capacity of persons with disabilities and must rather protect it against any interference in all aspects of life, including decisions related to medical treatment.¹³ The Norwegian government is conflating legal capacity (a person’s ability to hold rights and duties and to exercise those rights and duties) and mental capacity (a person’s decision-making skills), when adopting legislation that restrict legal capacity based on perceived deficiencies in decision-making skills¹⁴ (functional approach).¹⁵ Article 12 of the CRPD does not permit such discriminatory denial of legal capacity, but rather requires that support be provided in the exercise of legal capacity, and that such support respect the will and preferences of the person concerned.¹⁶ In circumstances where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the “best interpretation of will and preferences” must replace the “best interest” determinations.¹⁷

In LoIPR para 12 c, Norway is asked to provide an update on: “Whether the Mental Health Act has been amended to introduce stricter procedural requirements... (..)”.

Unfortunately, stricter procedural safeguards will not solve the fundamental problem of discriminatory legislation authorizing disability-based detention and forced interventions. If procedural safeguards are put in place instead of a serious initiative to abolish forced

¹¹ CAT/C/NOR/QPR/8, para 12

¹² CRPD GC 1 para 14; Report by the UN Special Rapporteur on the Rights of Persons with Disabilities, A/HRC/37/56, 2017, para 14.

¹³ A/HRC/37/56, para 24.

¹⁴ See para 5 below about the amendments to the Norwegian Mental Health Act.

¹⁵ Such approach is flawed for two key reasons: a) it is discriminatorily applied to people with disabilities; and b) it presumes to be able to accurately assess the inner-workings of the human mind, when the person does not pass the assessment, it then denies him/her a core human right – the right to equal recognition before the law; GC 1 para 15.

¹⁶ CRPD GC 1 para 15.

¹⁷ CRPD GC 1 para 21.

commitment and treatment, they simply judicialize these harmful and discriminatory practices committed against persons with disabilities, and allow them to continue to be practiced with impunity, involving courts or other tribunals as well as medical personnel in committing acts that amount to torture and ill-treatment.¹⁸

While it is necessary to provide effective mechanisms by which people held against their will in institutions can obtain their release, these procedural mechanisms must be informed of their obligation to immediately release all those who request to leave, and to immediately take action to stop coercive interventions such as restraint, solitary confinement, and nonconsensual administration of mind-altering drugs and electroshock.

4. Follow-up on recommendations from human rights monitoring mechanisms

In 2013, the UN Committee on Economic, Social and Cultural Rights recommended Norway to “incorporate into the law the abolition of the use of restraint and the enforced administration of intrusive and irreversible treatments such as neuroleptic drugs and electroconvulsive therapy”.¹⁹

As already mentioned, Norway has not followed up on this recommendation.

In 2014, during the Universal Periodic Review of the Human Rights Council, Norway got recommendations on the need to ensure that criteria for detention in legislation and in practice are non-discriminatory and to “remove any criteria referring to disability or serious mental disorder”, along with recommendations to withdraw Norway’s interpretative declarations to the CRPDⁱ and to ratify the Optional Protocol to the Convention.²⁰

Norway has not followed up on these recommendations.

In 2015 the Commissioner for Human Rights of the Council of Europe expressed his concern about the use of coercion in the mental health system and urged Norwegian authorities to reform legislation so that it applies objective and non-discriminatory criteria for deprivation of liberty which are not specifically aimed at people with psychosocial disabilities. The Commissioner underscored that “all people with disabilities have the right to enjoy the highest attainable standard of health without discrimination and the care provided to them should be based on free and informed consent in line with Article 25 of the CRPD.” The Commissioner urged the government to adopt a more pro-active stance in implementing its obligations under the CRPD in close cooperation with people with disabilities and organizations representing them. In the Commissioner’s opinion, the withdrawal of Norway’s interpretative declarations concerning the CRPD would signal a new approach. The Commissioner also encourages Norway to sign and ratify the Optional Protocol to the CRPD

¹⁸ WNUSP and CHRUSP submission to CAT, 2013, Comments to the Committee against Torture on the standards applicable to psychiatric institutions and mental health services, para 2a.

¹⁹ CESCR Concluding Observations, E/C.12/NOR/CO/5, para 19.

²⁰ See Outcome of the Review, Report of the Working Group, 131.9, and Addendum; <http://ohchr.org/EN/HRBodies/UPR/Pages/NOsession19.aspx>

on an individual complaints mechanism which would improve the access of people with disabilities to external review of their concerns.²¹

Norway has not followed up on these recommendations.

Norway's national, independent CRPD monitoring mechanism, the Equality and Anti-discrimination Ombud, has concluded that the Norwegian Mental Health Act is not in compliance with the CRPD and that it discriminates persons with psychosocial disabilities. The Ombud recommends law reform and withdrawal of Norway's interpretative declarations to the CRPD.²²

Proposed recommendations for the Concluding Observations

- The State party should incorporate into the law the abolition of the use of restraint and the enforced administration of intrusive and irreversible treatments such as neuroleptic drugs and electroconvulsive therapy.

5. The Mental Health Act

In January 2017 the Parliament adopted a number of amendments to the Mental Health Act, including the additional criteria for "compulsory mental health care" requiring that "the patient lack the capacity to consent", unless there is perceived to be imminent and serious danger to his or her or others life or health.²³ As already mentioned, this constitutes a functional approach to legal capacity that runs counter to the CRPD.

Also the UN Working Group on Arbitrary Detention underscores this in its adopted Principles and Guidelines; "Perceived or actual deficits in mental capacity, namely the decision-making skills of a person that naturally vary from one to another, may not be used as justification for denying legal capacity. Understood as the ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency)".²⁴ Despite the amendments, the Mental Health Act is still inherently discriminatory and still authorizes ill-treatment through forced psychiatric interventions.

²¹ Report by Nils Muižnieks, Council of Europe Commissioner for Human Rights, following his visit to Norway, from 19 to 23 January 2015; [https://wcd.coe.int/ViewDoc.jsp?Ref=CommDH\(2015\)9&Language=lanEnglish](https://wcd.coe.int/ViewDoc.jsp?Ref=CommDH(2015)9&Language=lanEnglish)

²² LDO, 2013; CRPD: Rett til frihet, personlig sikkerhet og likeverdige helsetjenester for personer med psykososiale funksjonsnedsettelse. Innspill til norske myndigheter, p. 25; http://www.ldo.no/globalassets/brosjyrer-handboker-rapporter/rapporter_analyser/crpd--2013/rapportcrpd_psykiskhelsevern_pdf.pdf; LDO, 2015. "CRPD 2015: Ombudets rapport til FNs komité for rettighetene til mennesker med nedsatt funksjonsevne – et supplement til Norges første periodiske rapport"; http://www.ldo.no/globalassets/03_nyheter-og-fag/publikasjoner/crpd2015rapport.pdf

²³ Mental Health Act No. 62 of 2 July 1999 section 3-3.

²⁴ UN Basic Principles and Guidelines on remedies and procedures on the right to anyone deprived of their liberty to bring proceedings before a court, UN Working Group on Arbitrary Detention, A/HRC/30/37, para 106b (text as adopted with footnotes WGAD/CRP.1/2015; <http://www.ohchr.org/Documents/Issues/Detention/DraftBasicPrinciples/March2015/WGAD.CRP.1.2015.pdf>)

a. Deprivation of liberty in mental health facilities

Persons with perceived psychosocial disabilities in Norway are subjected to imposition of preventive detention for public safety reasons, and paternalistic detention said to be in the person's best interest. Such regimes are not typically imposed on the general population and would rightly be resisted as arbitrary, vague and detrimental to civil liberties if it were. Thousands are detained in Norwegian mental health facilities each year, locked up for indefinite time and segregated from society.²⁵ Involuntary confinement in psychiatric institutions is traumatising and harmful in itself, and has been recognized as a form of torture and ill-treatment.²⁶

Detention based on mental health grounds constitutes adverse treatment targeted at persons with psychosocial disabilities, depriving us of the right to enjoy liberty on an equal basis with others. Involuntary commitment in mental health services is always discriminatory as it is based on actual or perceived impairment ("serious mental disorder"), and it amounts to arbitrary deprivation of liberty.²⁷ The UN Convention on the Rights of Persons with Disabilities sets forward an absolute ban on deprivation of liberty based on impairment or health grounds.²⁸ This includes where there are additional criteria used to justify the detention, including alleged need for care or treatment or deemed dangerous to self or others.²⁹

Contrary to this, the 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".³⁰ 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*

²⁵ Official statistics indicate around 8000 involuntary admissions (for 5600 persons) in 2014 (these are the most recent statistics made available by the health authorities). However the quality of national reporting is not satisfactory and complete data do not exist. A report from the Norwegian Directorate of Health (Helsedirektoratet) shows an increase in the number of days that adults were deprived of liberty in mental health facilities from 2013 to 2014 with 4 % (to 351 177 days), and also an increase in the number of involuntary admissions with 4 %. Helsedirektoratet, Bruk av tvang i psykisk helsevern for voksne i 2014, IS-2452, March 2016.

²⁶ A/63/175, paragraphs 38, 41, 64-65; A/HRC/22/53, paragraph 89(d), Statement of Special Rapporteur on Torture Juan Mendez to the Human Rights Council, 4 March 2013.

²⁷ CRPD GC 1, Guidelines art. 14 para 6.

²⁸ CRPD Guidelines art. 14, para 6, 8, 10.

²⁹ Ibid, para 13.

³⁰ Mental Health Act No. 62 of 2 July 1999 section 3-3.

on account of his or her mental disorder.

The patient lacks the capacity to consent, cf. the Patient and User Rights Act § 4-3. This condition does not apply to the obvious and serious risk to his or her own life or health or those of others.”³¹

Deprivation of liberty based on these criteria, regardless of due process guarantees and legal safeguards, constitutes disability-based discrimination and runs counter to the provisions of the CRPD articles 5, 12 and 14. All involuntary commitment in any kind of mental health facility carries with it the denial of the person’s legal capacity to decide about treatment and admission to a health care facility, and therefore violates the Convention, regardless of any assessments claiming such detention is deemed to be “necessary” or in the persons “best interest”.

b. Forced treatments

Involuntary treatments in mental health services violates a number of fundamental human rights, including the right to be free from torture and other ill-treatment.

Violent medical practices like forced electroshock, forced drugging, restraint and solitary confinement constitutes discriminatory and harmful interventions that can cause severe pain and suffering, as well as deep fear and trauma, in its victims.

Former UN Special Rapporteurs on Torture Manfred Nowak and Juan E. Méndez has recognized that non-consensual psychiatric treatment meets the criteria for inhuman and degrading treatment or torture;³²

“Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment.”³³

Administration of neuroleptic drugs against a person’s will, the impact on consciousness, physical and mental capabilities, and physical sensations amounts to severe pain and suffering that, given the discriminatory motivation (which is sufficient alone, but is

³¹ 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>

³² UN Special Rapporteur on Torture, interim report, *Protecting Persons with Disabilities from Torture*, A/63/175, July 2008, paras 38, 40, 41, 47, 61-65; UN Special Rapporteur report, *Applying the torture and ill-treatment protection framework in health-care settings*, A/HRC/22/53, February 1, 2013, paras 81 and 89.

³³ UN Special Rapporteur on Torture, A/HRC/22/53, 2013, para 64. See also; UN Special Rapporteur on Torture, A/63/175, paras. 44, 47, 61, 63; Human Rights Committee, communication No. 110/1981, *Viana Acosta v. Uruguay*, paras. 2.7, 14, 15.

nevertheless often combined with purposes relating to coerced change of behavior or punishment) satisfies the criteria for torture.³⁴

i. Forced medication

Forced medication is administered in hospitals and on an out-patient basis.

There is no reliable data on how many persons that are subject to forced medication in Norway, or how long they are forcibly medicated.³⁵ The lack of data on formalized decisions regarding forced medication is only part of the problem to record the scope of coerced medication. Research and personal testimonies has shown that the line between forced medication and voluntary medication is blurred. People report the threat of force, pressure, fear of additional punishment (detention, seclusion and/or physical restraints) and lack of known options as reasons for “complying” with taking medication. Such occurrences would not be registered as forced or non-consensual drugging even if the authorities were able to produce good statistics on formal decisions.

The National Preventive Mechanism (NPM) have documented during their visits that patients who were forcibly medicated mostly had negative experiences that were described as “horrible”, “cruel” and “torture”. Several patients showed unpleasant adverse reactions such as headache, apathy and weight gain, as well as increased symptoms of hallucination and confusion. Other findings was loss of trust to the staff after forced medication, pressure to consent to medication to avoid forced medication or other sanctions.³⁶

The pain and suffering inflicted on the persons that are subject to forced medication has been reported through personal testimonies and research. Psychotropic drugs, particularly neuroleptics, can cause serious long-term effects, such as drastic weight gains, metabolic syndromes, diabetes, heart disease, neurological damage, brain shrinkage, etc.³⁷ Common effects reported are that thoughts, feelings, experiences, and the ability to initiate change is affected, neuroleptics act as a “universal brake” on mental function. Many patients describe

³⁴ See Tina Minkowitz, The United Nations Convention on the Rights of Persons with Disabilities and the right to be free from nonconsensual psychiatric interventions, *Syracuse Journal of Law and Commerce*, Vol. 34, No. 2, 2007.

³⁵ Omfang av tvang, Tvangsforskningsnettverket, 2017: http://www.tvangsforskning.no/noekkel tall_tvang/cms/83
Bruk av tvang i psykisk helsevern for voksne i 2014, Helse direktoratet: <https://helse direktoratet.no/Lists/Publikasjoner/Attachments/1161/Rapport%20om%20tvang%20IS-2452.pdf>

³⁶ NPMs reports after visits to Sørlandet Hospital and Akeshus University Hospital

³⁷ Food and Drug Administration (FDA). Package inserts and medwatch safety alerts on antipsychotics.

<http://www.fda.gov>.

Bentall, R, & Morrison, A. (2002). More harm than good: the case against using anti-psychotic drugs to prevent severe mental illness. *Journal of Mental Health*, Volume 11(4), pp. 351-356;

Read, J., Mosher, L.R. og Bentall, R.P. (2004). *Models of madness*. London: Routledge;

Whitaker, R. (2010). *Anatomy of an epidemic. Magic bullets, Psychiatric drugs, and the Astonishing Rise of Mental Illness in America*;

Peter Breggin. (2008). *Brain-disabling Treatments in Psychiatry: Drugs, Electroshock, and the Psycho pharmaceutical Complex*. Springer Publishing Company, New York.

such medication as a “chemical straitjacket”. The harmful effects include an increase in sudden death and total mortality rate, and shortened lifespan.³⁸

A large part of WSOs members are or have been subject to forced medication, and live with the serious consequences. One member described his situation like this in a side-event held for the CRPD-committee in 2015 about CRPD Article 15: Its Potential to End Impunity for Torture in Psychiatry³⁹:

“It is as if 9 years of my life have disappeared. It is very traumatic. I wish I could suppress it and move on. But someone else has taken control over my life. I love freedom and independence. Now I find myself totally depending on the social security system, with a constant threat of coercion hanging over me. One flick of the pen and I am once again deprived of my liberty and forced to take psychotropic drugs. I cannot live like this anymore. It is torture.”

Another of our members describe her experience like this;

«Well, «stabilizing» meant staring into the wall 24/7, whilst people came regularly into my room to pressure me to take drugs or force me to take drugs with their hands or needles. It was always about the drugs. I remember like it was yesterday, the humiliation of grown-up men pulling my pants down to give me injections in my butt-cheek, when I refused the medicine that distorted my mind.»⁴⁰

ii. Electroshock (ECT)

According to the Norwegian 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 (serious) damage to life and health.

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

³⁸ Parks J., Svendsen D., Singer P., editors. (2006). Morbidity and mortality in people with serious mental illness. Alexandria: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council;

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;

Ray, W., and Meador, K. (2002). Antipsychotics and sudden death. British Journal of Psychiatry, Volume 180, pp. 483-484;

³⁹ During the 13th session of the Committee on the Rights of Persons with Disabilities, World Network of Users and Survivors of Psychiatry (WNUSP) held a public side-event on “CRPD Article 15: Its Potential to End Impunity for Torture in Psychiatry”, the quote is from one of four speakers, with the title “Experience of forced psychiatric drugging and electroshock (ECT)”. The side-event can be seen here; <http://www.treatybodywebcast.org/crpd-13-wnusp-side-event-on-article-15-english-audio/>

⁴⁰ Testimony given at the side-event «Violence against Women and Girls with Disabilities – Intersectional and Double Violence in Medical and Institutional Settings”, 19 August 2015 Palais Wilson.

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.

The NPM findings from Akershus university hospital also show that consent not always is free and informed; "There was nerveless findings from different sources, including interviews with patients, that raised the concern if the consent to ECT was given fully voluntary, and whether consent was collected with too much persuasion. Several of the patients had problems to recollect anything about the circumstances around the ECT-treatment."⁴¹

The UN Special Rapporteur on Torture has underscored that ECT must only be administered with the free and informed consent of the persons concerned, and that forced ECT constitutes ill-treatment;

"(..), it is of vital importance that ECT be administered only with the free and informed consent of the person concerned, including on the basis of information on the secondary effects and related risks such as heart complications, confusion, loss of memory and even death."⁴²

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 two decades.⁴³

The use of electroshock without valid free and informed consent has grave consequences for the people subject to it, some of whom is in our organization. Testimony about this is previously brought before the UN CRPD Committee;

«Electroshock is a violent intervention both physical and mental. (..) Loss of memory and cognitive function is common. Our members testifies about personality change, loss of memories, loss of cognitive function and ability to store new memories. We testify of lost lives. For me the most serious effect was loss of vocabulary for speaking and writing, problems with concentration, problems with learning and storing information. (..) For many people the damage is greater than what I experienced; the total loss of memory from your former life; of giving birth to your children, of getting married, of your education and work

⁴¹ NPM report on visit to Akershus university hospital, 2017

⁴² UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 2008; A/63/175, para 61.

⁴³ Medicine of today. 18.05.12. <http://www.dagensmedisin.no/nyheter/mener-flere-bor-fa-elektrosjokk/>

related competencies, of your friends and family. To have 1- 5 - 25 years of your memory erased by electroshock....”⁴⁴

Y (55 years) received ECT in 2011. He was not informed about the risks, and experienced grave memory-loss and permanent head-ache after only 5 shocks. In 2017 he explains his experience like this:

“It took many years before I understood the extent of the damage. I lost belonging, identity, I sort of don’t know where I am. It is terribly hard to cope with. I feel like I don’t belong anywhere, because I don’t have any belonging to things, it is a huge void. To create a future you need to know your past.”⁴⁵

c. Coercive means

i. Physical restraints

A court-case from 2015 high-lights the totality of the use of force one person can be subject to under the current Norwegian legislation, and the lack of effective remedies.

Court decisions are from Oslo District Court 21. november 2014⁴⁶, Borgating Court of appeal 23. march 2015,⁴⁷ and 20 May 2015 the Supreme Court Appeal Committee rejects the appeal on the grounds that the Appeal Committee “cannot see that the appeal has views to succeed”.⁴⁸ By this decision, all domestic remedies have been exhausted, and have failed.

Summary of the case:

A woman Y, 31 year old, brings the administrative decision of the supervisory commission concerning “compulsory mental health care” before the Oslo District Court, and then appeals the case to the Borgating Court of Appeal. She had been deprived of her liberty since 2006, in different closed psychiatric wards. Various measures had been forced upon her such as shielding, isolation from other patients, holding, forced intravenous nutrition, feeding by gavage, restrictions in her connections with the outside world, restraints and surveillance day and night. Since 2014, she had been held in restraints, 24 hours a day. At night she was strapped to a bed, at daytime her hands were either strapped to a chair, or to a table. If she

⁴⁴ Testimony given by former chair of We Shall Overcome (WSO), Mette Ellingsdalen; During the 14th session of the Committee on the Rights of Persons with Disabilities, World Network of Users and Survivors of Psychiatry (WNUSP) held a public side-event on “Violence against Women and Girls with Disabilities – Intersectional and Double Violence in Medical and Institutional Settings”, 19 August 2015. The side-event can be seen here; <http://www.treatybodywebcast.org/crpd-14-public-side-event-on-violence-against-women-and-girls-with-disabilities-intersectional-and-double-violence-in-medical-and-institutional-settings-world-network-of-users-survivors/>

⁴⁵ <https://www.vg.no/nyheter/innenriks/psykisk-helse/vg-avsloerer-ga-elektrosjokk-166-ganger-uten-pasientenes-godkjenning/a/24150018/>

⁴⁶ Oslo District Court, 21 November 2014; 14-163619TVI-OTIR/04.

⁴⁷ Borgating Court of Appeal, 23 March 2015; LB-2015-13924.

⁴⁸ Supreme Court Appeal Committee, 20 May 2015; HR-2015-1091-U.

needed to go to the toilet, two staff members went with her. When she took a shower she was watched over by staff members.

Y had on several occasions inflicted potentially fatal injuries upon herself. She stated a clear wish to die.

Borgating Court of Appeal does no assessments of the potential harm caused by the coercive regime. The court acknowledged that during Y's stay at the hospital "her eating disorder has become far worse, and that her condition is now life-threatening", and that "her self-harming has also become significantly worse both in frequency as well as intensity".

Borgating Court of Appeal acknowledge in its decision that Y "during a longer period of time has been subjected to an extreme coercive regime". When the court gave its judgement 23. March 2015 Y had been deprived of liberty for almost 9 years. She had been in restraints and under surveillance 24 hours a day continuously for more than 1 year.

The court does conclude that the use of restraints in this case "will obviously be perceived as cruel, inhuman and degrading", but deem the use nevertheless necessary and legitimate.

The court summary concludes that there is no violation of the prohibition of torture as set forth by the UN Convention against Torture (CAT) Art. 16 para 1, nor of the alleged violations of the European Human Rights Convention (EHRC Articles 3 and 8). The court rules in favour of the state, and the "compulsory mental health care" is maintained

Though it is mentioned in the verdict from the Borgating Court of Appeals that Y asserts that the treatment of her "entails discrimination of her as a person with disabilities", the court makes no assessments of the discriminatory aspects of the case, nor of CRPD compliance, and does not make any decision regarding violations of the convention. When the court concludes that "the use of restraints is exclusively based on the need to protect her against serious harm or illness with fatal outcome", the court has lost the discriminatory aspects out of sight. Y is subjected to involuntary commitment based on the threshold criteria "serious mental disorder", an inherently discriminatory criteria based on disability. Y would not have been subjected to the coercive regime she is currently under, including the use of restraints, if she was not perceived to have a disability. The use of restraints and other forced interventions cannot be seen disconnected from this. The whole coercive regime is based on discriminatory grounds, in violation of the CRPD

The court demonstrates a lack of understanding and awareness of international disability rights law and human rights obligations, as well as a legitimization of severe violations of personal integrity and conditions amounting to ill-treatment

Even though the extensive use of physical restraints in this case is extreme, it is far from being a singular incidence.

In 2016 conducted investigative journalists in the newspaper VG a thorough investigation into the use of physical restraints in Norwegian hospitals. 25 % of the patients that was

subject to mechanical restraints was restrained more than 8 hours⁴⁹. They documented one case where a person had been subject to physical restraint 70 days and nights⁵⁰, and another case where a person had been restrained 64 days and nights.⁵¹

NPM has in their findings documented that the use of physical restraints is wide-spread, used beyond the criteria of emergency situations, used as a preventative measure and used for prolonged periods.⁵²

The WHO has in their «Quality Rights guidance and training tools» a module called "Strategies to end the use of seclusion, restraint and other coercive practices";

- Seclusion and restraints cause physical, emotional and mental harm. As we have seen, restraints sometimes cause physical harm such as broken bones and even death. Also, the psychological impact and trauma of seclusion and restraint is profound and long-lasting.
- Evidence shows that seclusion and restraint can make feelings of frustration and anger worse, resulting in more harmful behavior. People using services unsurprisingly tend to view seclusion and restraint as punitive (for example for not doing 'what they are told' including failing to follow instructions to take their medication) and this can increase feelings of frustration towards mental health and related staff or others.⁵³

ii. Isolation/Shielding

Isolation is regulated as a coercive mean in the Mental Health Act § 4.8, and has a time limit on 2 hours. Shielding/segregation, that is considered a treatment-intervention in the law (Mental Health Act § 4.3) and not a coercive measure, has administrative decisions that last two weeks, but there is no limit on how many consecutive decisions one person can have.

The NPM has documented that segregation can in practice be isolation⁵⁴. Our members have for years described their experience with shielding as isolation. They describe the lack of contact with other patients, the experience of punishment, the fear of showing emotions that can lead to more force and the deprivation of stimulation as ill-treatment and torture.

⁴⁹ <https://www.vg.no/nyheter/innenriks/tvang-i-psykiatrien/holdes-i-belter-i-hundrevis-av-timer/a/23669706/>

⁵⁰ St.Olavs Hospital in 2015, 1855 hours.

⁵¹ Østfold Hospital in 2015, 1549 hours.

⁵² The Norwegian NPM's submission to the UN Committee against Torture's 63rd session – Information regarding the Norwegian Government's implementation of the Convention

⁵³ WHO Quality Rights guidance and training tools; Strategies to end the use of seclusion, restraint and other coercive practices. Topic 4: Challenging assumptions about seclusion and restraint. WHO 2017

⁵⁴ The Norwegian NPM's submission to the UN Committee against Torture's 63rd session – Information regarding the Norwegian Government's implementation of the Convention

Suggested questions to pose to the State party:

- Ask the Norwegian Government to provide information on what measures have been taken to abolish legislative provisions that authorize detention on mental health grounds or in mental health facilities.
- Ask the Government to provide information on what measures have been taken to ensure that all mental health services is based on the free and informed consent of the person concerned and to abolish all legal provisions that authorize any forced or non-consensual interventions or treatments in the mental health setting.
- Ask the Government to provide information on what steps have been undertaken to replace forced treatment and commitment by a wide range of services in the community that meet the needs expressed by persons with disabilities, and that respect the person's autonomy, choices and dignity, including peer support and other alternatives to the medical model of mental health.

Proposed recommendations for the Concluding Observations:

- Recognize the immediate obligation to stop ill-treatment from being carried out through forced psychiatric interventions, undertake necessary action to repeal legislation that authorizes forced psychiatric treatment and detention, and develop laws and policies that replaces coercive regimes with services that fully respect the autonomy, will and equal rights of persons with disabilities.
- Take effective measures to ensure that no one is involuntarily placed in psychiatric institutions or subjected to mental health treatment without the free and informed consent of the person concerned;
- Ensure that all individuals currently confined in psychiatric institutions are regularly and effectively informed of their rights, including the right to leave and the right to refuse any or all treatment

6. Lack of prompt and impartial investigation (art. 12, 13 and 16) – Urgent Appeals to Norway

In January 2017, Norway received an Urgent Appeal concerning a case of mental health detention and forced psychiatric treatments from the UN Working Group on Arbitrary Detention, the UN Special Rapporteur on the Rights of Persons with Disabilities and the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.⁵⁵

⁵⁵ Urgent Appeal;

<https://spcommreports.ohchr.org/TMResultsBase/DownloadPublicCommunicationFile?gId=22955>

The UN Special Procedures mandate holders states “it is highly concerning that no adequate actions seems to have been taken by the appropriate national mechanisms to investigate Mr. X’s serious allegations (...)”. The rapporteurs further states that the facts of the case “appear to be in contravention of the rights of persons with disabilities not to be arbitrarily deprived of their liberty and the right to equal recognition before the law as enshrined, inter alia, in articles 9 and 14 of the International Covenant on Civil and Political Rights, ratified by Norway on 13 September 1972, and the provisions of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ratified by Norway on 09 July 1986.”

“The convention on the Rights of Persons with Disabilities, ratified by Norway on 03 June 2013, provides further guidance to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities. Article 14 in conjunction with article 5 of the Convention prohibits unlawful and arbitrary detention on grounds of disability, including forced confinement to psychiatric facilities. In addition, article 12 of the Convention guarantees the rights of persons with disabilities to make autonomous decisions and have those decisions respected.”

(..)

“The deprivation of liberty in psychiatric hospitals and the denial of legal capacity related to consent for treatment, as in the present case, is likely to also inflict severe mental pain and suffering on the individual, thus falling under the scope of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and article 15 of the Convention on the Rights of Persons with Disabilities. Similarly, the forced administration of drugs, including antipsychotic therapy, inside psychiatric hospitals or in the context of forced outpatient treatment, may constitute a form of torture or other cruel, inhuman or degrading treatment (see A/63/175, para 63; CRPD/C/DOM/CO/1, para 27). The same applies to the use of coercive measures including the use of electroconvulsive therapy (ECT), mechanical and chemical restraints, and the use of isolation and seclusion for persons with psychosocial disabilities (see A/HRC/22/53, para 63; A/66/268, paras 67-68, 78; CRPD/C/SRB/CO/1; CRPD/C/THA/CO/1).”

“These provisions impose an immediate obligation on the States to immediately discontinue these practices and reform laws and policies allowing for deprivation of liberty and forced treatment on the basis of disabilities by replacing these practices with services in the community that meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity, and privacy.”

The rapporteurs urged the Norwegian Government to safeguard the above-mentioned rights of Mr. X in compliance with international instruments, and to take all necessary interim measures to halt the alleged violations and prevent their re-occurrence.

In Norway’s reply to the UN mandate holders the Government dismiss the case by stating that it “fails to see that this case requires it to take particular measures and that it warrants

an urgent appeal to Norway”, without any sign of initiating a prompt and impartial investigation as obligated by CAT articles 12, 13 (and 16).⁵⁶

More than a year has passed since the Urgent Appeal, and Mr. X, who is a member of WSO, has remained under forced psychiatric interventions, including neuroleptic medication without free and informed consent.

Norway has also on earlier occasions received Urgent Appeals concerning forced psychiatric interventions from the UN Special Rapporteur on Torture, the UN Working Group on Arbitrary Detention, the UN Special Rapporteur on health, and the UN Special Rapporteur on Violence against Women.⁵⁷ There are few signs that any of these Urgent Appeals has led to effective investigations, or provided the victims with effective remedies and redress.

Suggested questions to pose to the State party:

- What steps are taken to adopt effective measures to prevent the recurrence of the acts described in the Urgent Appeal of January 2017.⁵⁸

Proposed recommendations for the Concluding Observations:

- The Committee against Torture urges the State party to ensure a prompt and impartial investigation of the circumstances of X’s case, and to provide details and results of such inquiries.
- The State Party should take all necessary measures to guarantee that the rights and freedoms of Mr. X are respected, and to ensure his immediate release from forced psychiatric treatment.⁵⁹

7. Lack of effective remedies and reparations

There are several barriers to access to justice with regard to ill-treatment of persons with psychosocial disabilities in Norway;

When ill-treatment is carried out in the name of medical treatment, authorized by domestic legislation and enforced by national law, then there are no real protection or access to effective remedies. There are no redress for victims, no accountability for perpetrators. The ill-treatment goes with impunity.

⁵⁶ Norway’s reply; <https://spcommreports.ohchr.org/TMResultsBase/DownloadFile?gId=60255>

⁵⁷A/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

⁵⁸ *Guarantees of non-repetition* should include taking measures to combat impunity, prevent future acts, as well as reviewing and reforming laws contributing to or allowing these violations.

⁵⁹ In accordance with CRPD Committee Guidelines on Art. 14, para 24, as well as with Guideline 20 of the UN Basic Principles and Guidelines on remedies and procedures on the right to anyone deprived of their liberty to bring proceedings before a court, adopted by the Working Group on Arbitrary Detention on 29 April 2015.

As the case from the Urgent Appeal and the Borgating court case illustrate, there are a lack of effective remedies. While persons with psychosocial disabilities constantly challenge the discrimination and ill-treatment of forced psychiatric treatments and detention in the courts, the legal system of Norway has failed to provide basic human rights protections for this population.

Proposed recommendation for the Concluding Observations:

- Ensure that individuals have access to an effective mechanism to obtain release from any confinement or forced interventions in mental health service settings.

8. Forced abortion and sterilization of women with disabilities

Norway has failed to ensure all women and girls with psychosocial and intellectual disabilities the fundamental right to exercise choice and control over their bodies. Discriminatory laws are authorizing procedures, including forced abortion and sterilization, infringing on their sexual and reproductive integrity.

According to Norwegian law, women with psychosocial or intellectual disabilities can be subjected to forced abortion on the application of a guardian.⁶⁰ The woman's consent needs only to be obtained if "it may be assumed that she is capable of understanding the significance of the operation".⁶¹

According to Norwegian law, sterilization requires consent from a legal guardian when a person is having "a serious mental disorder or serious intellectual disability or serious mental impairment", and a legal guardian can apply for sterilization without the persons consent when the person is deemed not able to make a decision about the intervention.⁶²

Both the CEDAW and CRPD Committees have made recommendations calling for the protection of women with disabilities from forced sterilization and for these practices to be abolished in the law.⁶³

The UN Special Rapporteur on the rights of persons with disabilities has classified forced sterilization as a pattern of systemic violence being carried out on women and girls with disabilities, causing irreversible harm under the guise of "best interest", and has called on States to immediately repeal all legislation allowing for the administration of any procedures

⁶⁰ Woman who are perceived to have "a severe mental disorder or an intellectual impairment to a considerable degree".

⁶¹ Act concerning Termination of Pregnancy of 13 June 1975 No. 50.

Unofficial translation of the Act; <http://app.uio.no/ub/ujur/oversatte-lover/data/lov-19750613-050-eng.pdf>

⁶² Sterilisation Act of 3 June 1977 No. 57.

Persons perceived to have "a serious mental disorder or an intellectual disability or being mentally impaired". According to Norwegian law, the person concerned can request sterilization from the age of 25 years (and earlier on specific terms, upon application). However, exceptions applies for persons with psychosocial, mental or intellectual disabilities.

⁶³ CEDAW/C/JOR/CO/5, para 46; CRPD/C/PER/CO/1, para 35; CRPD/C/ESP/CO/1, para 38.

impacting on the sexual and reproductive health and rights of women and girls without their free and informed consent.⁶⁴

Suggested questions to pose to the State party:

- How many women with disabilities have been subjected to abortion and/or sterilization without free and informed consent since the entering into force of the current legislation authorizing these interventions?
- What steps are taken to repeal all legislation allowing for the administration of abortion, sterilization and any other procedures impacting on the sexual and reproductive rights of women and girls without their free and informed consent?

Proposed recommendations for the Concluding Observations:

- The State party should initiate a prompt, independent and thorough investigation into cases of forced abortion and sterilization, and provide the victims of such human rights violations with an effective remedy for the damage sustained, including fair and adequate compensation.
- The State party should ensure that non-consensual abortion and sterilization is prohibited and incorporate into the law the abolition of such practices.

ⁱ Norway's declarations to the UN CRPD;

"Article 12

Norway recognises that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Norway also recognizes its obligations to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity. Furthermore, **Norway declares its understanding that the Convention allows for the withdrawal of legal capacity or support in exercising legal capacity, and/or compulsory guardianship**, in cases where such measures are necessary, as a last resort and subject to safeguards.

Articles 14 and 25

Norway recognises that all persons with disabilities enjoy the right to liberty and security of person, and a right to respect for physical and mental integrity on an equal basis with others. Furthermore, **Norway declares its understanding that the Convention allows for compulsory care or treatment of persons, including measures to treat mental illnesses**, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards."

⁶⁴ Statement by the UN Special Rapporteur on the Rights of Persons with Disabilities, 24 October 2017; "Forced sterilization of young women with disabilities must end, UN rights expert says".