List of Issues on Norway

Submission to the 10th Pre-Sessional Working Group of the Committee on the Rights of Persons with Disabilities, 24-27 September 2018

Submitted by:

We Shall Overcome (WSO)

Oslo, Norway

www.wso.no

We Shall Overcome (WSO) is a Norwegian DPO[1], run by and for users and survivors[2] 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. WSO works at both national and international levels. 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] WSO is a representative organization of persons with (psychosocial) 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.

1. Introduction

We Shall Overcome (WSO) has prepared the following information to give input to the List of Issues on Norway to be adopted during the 10th Pre-Session of the UN Committee on the Rights of Persons with Disabilities, 24-27 September 2018. WSO will also submit an alternative report for the review of Norway's 1st periodic report.

We will have representatives from WSO attending the country briefing Monday 24 September. Please do not hesitate to contact us for any further information or questions.

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Articles 1-4: Purpose, General Principles and Obligations

Incorporation of the CRPD into Norwegian law

Norway has not yet incorporated the CRPD into domestic law, which is hindering full and effective realization of the rights set forth in the Convention and access to justice (see Article 13 below). The CRPD needs to be incorporated with the same status as the UN treaties ICCPR, ICESCR, CRC and CEDAW (as well as the European Convention on Human Rights), which are all incorporated into the Human Rights Act.[3] In case of conflicting legislation, the treaties incorporated in the Human Rights Act takes precedence over provisions in domestic legislation.

Declarations made upon ratification of the CRPD[4]

Norway upholds its declarations on Articles 12, 14 and 25 of the CRPD.[5] These declarations are discriminatory and a major obstacle for proper implementation of the convention and access to justice (see Articles 12, 13 and 14 below).

In 2014, during the Universal Periodic Review of the Human Rights Council, Norway got recommendations to withdraw its interpretative declarations to the CRPD.[6] In 2015 the Commissioner for Human Rights of the Council of Europe 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.[7] Norway has not yet followed up on these recommendations.

Ratification of the Optional Protocol to CRPD (OP CRPD)

Persons with disabilities need strengthened legal protection against discrimination and other human rights violations. Ratifying the optional protocol will give individuals and groups who

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[3] Law on the strengthening of human rights in Norwegian law, 21 May, No. 30, 1999.
[4] 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."
[5] Initial report of Norway to the CRPD, 2015, CRPD/C/NOR/1, paras 76 and 111.
[6] See Outcome of the Review; Report of the Working Group, 131.9, Addendum, and Norway's Responses to Recommendations.
[7] 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

are claiming to be victims of violations of CRPD provisions a much needed opportunity to have their cases examined and evaluated by the CRPD committee.

In 2010 Norway accepted the UPR recommendation to consider the possibility of signing and/or ratifying the OP CRPD.[8] In 2014, Norway got further UPR recommendations to ratify the Optional Protocol to the Convention.[9] Also the Council of Europe HR Commissioner has encouraged Norway to sign and ratify the Optional Protocol to the CRPD.[10]

Suggested questions for the List of Issues:

Please provide information on:

- The steps taken to incorporate the CRPD into domestic law.
- Any plans to repeal Norway's interpretive declarations on article 12, 14 and 25, and why these declarations are still upheld despite being in violation of the object and purpose of the Convention.
- When Norway plans to move forward on ratifying the Optional Protocol to the Convention and the time frame for such ratification process.

Article 5: Equality and non-discrimination

Persons with disabilities are subjected to discrimination in all areas of society.[11] Persons with psychosocial or intellectual disabilities are particularly targeted for involuntary practices and legislation restricting the right to self-determination. Such discrimination includes deprivation of liberty based on actual or perceived impairments, and rejection of the persons will and preferences as labelled "incompetent" to make decisions. It is of particular concern that Norway is upholding discriminatory legislation authorizing detention based on perceived mental health conditions, restrictions on adult's legal capacity and forced treatments (see Articles 6, 12, 14, 15, 16 and 17 below). Fundamental changes in Norwegian law are required, along with other measures, to combat disability-based discrimination and fulfill the obligations set forth by the CRPD.

Suggested questions for the List of Issues:

- Please describe any plans for a comprehensive strategy, based on human rights principles, to combat discrimination against persons with disabilities in Norway.

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[8] Consider the possibility of signing and/or ratifying (Argentina)/ratify (Chile) the Optional Protocol to the Convention on the Rights of Persons with Disabilities; Accepted, A/HRC/13/5/Add.1.

[9] See Outcome of the Review, Report of the Working Group, 131.10 and 131.14, Addendum and Norway's Responses to Recommendations.

[10] 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

[11] Equality and Anti-Discrimination Ombud's supplementary report to the CRPD, 2015, p. 6; http://www.ldo.no/globalassets/brosjyrer-handboker-rapporter/rapporter_analyser/crpd-2015/crpd-rapport-english.pdf

- Please provide information about the plan and timetable for the revision of existing laws and policies and their legal harmonization with the principles and provisions of the Convention.

Article 6: Women with disabilities

Violence against women

Women with disabilities experience multiple and intersecting forms of discrimination and violence, including forced medical and psychiatric interventions. Intrusive medical practises like forced sterilization, forced electroshock, forced medication, restraints and solitary confinement continue to be practiced, and there are reasons to believe that some of these practices are disproportionally affecting women. Also, some practises can be especially re-traumatizing for women with previous experience of sexual or other violence, like to be put in restraints or being held down, while your clothes are pulled away to forcibly inject you with psychotropic drugs.

Violence against women with psychosocial disabilities might start with sexual assaults or other forms of **gender-based** violence and continues with forced psychiatric interventions or other forms of **disability-based** violence. Women's' reactions to violence can become an entry point to intrusive and coercive psychiatric measures. Psychiatric diagnoses can take away women's' power to name their own experiences, mask violence against women, and create a basis for mental health detention and forced treatment. When the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) did a mapping of an acute psychiatric ward they found that more than half of the patients were victims of sexual abuse.[12]

The UN Special Rapporteur on Violence against Women has acknowledged forced institutionalization, and forced intake of psychotropic drugs and other forced psychiatric treatment as violence against women and girls with disabilities. Certain forms of violence may be considered as ill-treatment, among them involuntary sterilization and abortion, any medical intervention performed without free and informed consent, administration of electroshock treatment and the use of chemical, physical and mechanical restraints, isolation and seclusion.[13]

[12] Study is cited in a white paper to the Parliament; Meld. St. 15 (2012-2013). Forebygging og bekjempelse av vold I nære relasjoner; https://www.regjeringen.no/no/dokumenter/meld-st-15-20122013/id716442/?q=over+halvparten+av+pasientene+ved+avdelingen&ch=2

[13] CRPD Committee, General Comment No. 3 (2016) on women and girls with disabilities, CRPD/C/GC/3, para 32.

Forced abortion and sterilization of women with disabilities

According to Norwegian law, women with psychosocial or intellectual disabilities can be subjected to forced abortion on the application of a guardian. [14] 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".[15]

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.[16]

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.[17] 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 impacting on the sexual and reproductive health and rights of women and girls without their free and informed consent.[18]

Suggested questions for the List of Issues:

- Please provide gender disaggregated data on the use of electroshock (ECT), including ECT administered without free and informed consent. Given that women have a substantially lower seizure threshold than men and might be more exposed to permanent brain injuries of ECT[19], please provide statistics on the number of women who have applied for compensation for injuries caused by ECT to the Norwegian System of Patient Injury Compensation (NPE), and the number of cases where compensation was awarded.

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

[15] 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

[16] Sterilization 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.

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

[18] 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".

[19] In Dr. Harold Sackheims research more women than men experienced long-term injuries (82 % of the women and 18 % of the men); Sackheim, H.A., J. Prudic, R. Fuller, J. Keilp, P.W. Lavori og M. Olfson. The cognitive effects of electroconvulsive therapy in community settings. Neuropsychopharmacology 32(1):244-54, jan. 2007. Epub: 23. aug. 2006.
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=16936712&query_hl=2&itool=pubmed_docsum

Please also provide gender-specific data on ECT injuries, type of injuries, and how such data are systematically collected.

- 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?

Article 12: Equal recognition before the law

Declaration on Article 12

Norway declared upon its ratification of the CRPD that substituted decision-making can be used as a last resort. This interpretation is contrary to the object and purpose of the convention as it fails to recognize the standard of full and equal legal capacity that is guaranteed to **all** persons with disabilities under the CRPD. The understanding also conflict with the interpretations made by the CRPD Committee.[20] In line with the government's position, Norway has not yet abolished substituted decision-making and upholds legislation placing restrictions on the legal capacity of adult persons with disabilities.

Deprivation of legal capacity through guardianship legislation

Through the Guardianship Act a person could be formally deprived of legal capacity wholly or partially due to cognitive or psychosocial disabilities.[21] In addition, persons with cognitive or psychosocial disabilities can be declared not competent to give consent and thereby de facto deprived of legal capacity to act.[22]

Deprivation of legal capacity through health legislation

The Patients' and Users' Rights Act chapter 4A authorizes compulsory somatic treatments based on functional capacity standards (person perceived not competent to give consent and refuse treatment).[23]
The Mental Health Act authorizes deprivation of liberty based on psychosocial disabilities, forced treatments and use of coercive means (see Articles 14, 15, 16 and 17 below).[24]

The Health and Care Services Act authorizes use of coercion based on intellectual disabilities.[25]

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[20] CRPD Committee, General Comment No. 1 (2014) on Article 12: Equal recognition before the law, CRPD/C/GC/1.
[21] Act relating to Guardianship (Guardianship Act), LOV-2010-03-26-9, Section 22.
[22] Act relating to Guardianship (Guardianship Act), LOV-2010-03-26-9, Section 33.
[23] Act relating to Patients' and Users' Rights (Patients' and Users' Rights Act), LOV-1999-07-02-63.
[24] Act relating to the Provision and Implementation of Mental Health Care (Mental Health Act), LOV-1999-07-02-62.
[25] Act relating to Municipal Health and Care Services, etc. (Health and Care Services Act), Lov-2011-06-24-30.

Exemption from accountability in criminal cases

A person can be exempt from criminal responsibility based on being deemed to not have the capacity to be held criminally accountable on grounds of psychosocial or (severe) intellectual disability.[26] Further, the person can be sentenced to "compulsory mental health care" or "compulsory care".

Suggested questions for the List of Issues:

- What steps are taken to repeal outdated, discriminatory legislation and practices restricting legal capacity of persons with disabilities? What steps are taken to develop laws and policies to replace regimes of substitute decision-making by supported decision-making which respects the person's autonomy, will and preferences?
- Please provide information on steps taken to remove functional capacity standards throughout Norwegian law.
- Please provide information on any plans to abolish involuntary protection measures for adults, and plans to abolish incompetency to be held responsible, as well as security measures based on criminal non-responsibility.

Article 13: Access to justice

There are several barriers to access to justice with regard to disability-specific acts of arbitrary detention and ill-treatment in Norway;

Lack of effective remedies and reparations

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

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.[27]

In this case all domestic remedies were exhausted while the person, Mr. X, was under "compulsory mental health care" from 2013 to 2015, and they all failed. This is not at all surprising, as domestic remedies are systematically failing when people are subjected to

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[26] The Criminal Code, LOV-2005-05-20-28.

[27] Urgent Appeal; https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=22955

violations of the CRPD through forced psychiatric interventions. When cases are brought in front of court, domestic remedies are unlikely to bring effective relief, since the violations are authorised by domestic law and not recognised as discriminatory, unlawful acts.

The UN Special Procedures mandate holders states in the Urgent Appeal that "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 (…)" and 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 (…)

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).[28]

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.[29] There are few signs that any of these Urgent Appeals has led to effective investigations, or provided the victims with effective remedies and redress.

Norway's interpretative declarations to the CRPD, and lack of incorporation of the Convention in Norwegian law, creates barriers to access to justice

The Supreme Court has given limited weight to the CRPD in a case concerning the right to legal capacity to manage one's own financial affairs.[30] The Supreme Court underscores that the Norwegian declaration on Article 12 is clearly contrary to the CRPD Committee's interpretation. Nevertheless, due to lack of incorporation of the CRPD into Norwegian law and Norway's declaration, the Supreme Court concludes that the present case is such that the court decision must be based on domestic legislation even if it is contrary to international human rights obligations.

Another Supreme Court decision underscores how the interpretative declarations prevent persons with psychosocial disabilities from effectively using the rights set forth by the CRPD to bring forced psychiatric interventions to an end.[31] Making reference to the interpretative

[28] Norway's reply; https://spcommreports.ohchr.org/TMResultsBase/DownLoadFile?gId=60255
[29] A/HRC/13/39/Add.1, page 277
http://www2.ohchr.org/english/bodies/hrcouncil/docs/13session/A.HRC.13.39.Add.1_EFS.pdf
A/HRC/16/52/Add.1, page 333
http://www2.ohchr.org/english/bodies/hrcouncil/docs/16session/A.HRC.16.52.Add.1_EFSonly.pdf
[30] Supreme Court 20 December 2016, HR-2016-2591-A.
[31] Supreme Court 16 June 2016, HR-2016-1286-A.

declaration on Article 14 and the legislators position that it was not deemed necessary to amend the Norwegian Mental Health Act in connection with the CRPD ratification, the Supreme Court finds that there is no basis for generally concluding that the Convention prohibits involuntary commitment and treatment.

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.

Suggested questions for the List of Issues:

- Please provide information on how Norway will ensure that individuals have access to an effective mechanism to obtain immediate release from any confinement or forced interventions in mental health service settings.[32]
- Please provide information on the steps taken to follow up on the Urgent Appeal of January 2017, to ensure prompt and impartial investigation of the circumstances of X's case. Please provide details and results of such inquiries. What steps are taken to adopt effective measures to prevent the recurrence of the acts described in the Urgent Appeal of January 2017.[33]

Article 14: Liberty and security of the person

Declaration on Article 14 (and 25)

The declaration concerning Article 14 (and 25), is in particular targeting persons with psychosocial disabilities (as the one group specifically mentioned) for limitations of the right to liberty and respect for physical and mental integrity on an equal basis with others. Norway's understanding fails to recognize that CRPD Article 14 prohibits law from using disability (including psychosocial) as a reason for detention, and fails to recognize that Articles 12 and 25 (d) is ensuring treatment, including mental health services, to be based on the free and informed consent of the person concerned.

Deprivation of liberty in mental health facilities

Thousands are detained in Norwegian mental health facilities each year, locked up for indefinite time and segregated from society.[34] Involuntary confinement in psychiatric

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[32] 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.

[33] *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.

[34] 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. Helsedirektoratet, Bruk av tvang i psykisk helsevern for voksne i 2014, IS-2452, March 2016.

institutions can be traumatising and harmful in itself, and has been recognized as a form of torture and ill-treatment.[35] Involuntary commitment in mental health services is always discriminatory as it is based on actual or perceived impairment, and it amounts to arbitrary deprivation of liberty.[36] The CRPD sets forward an absolute ban on deprivation of liberty based on impairment or health grounds.[37] 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.[38]

Contrary to this, the Norwegian mental health legislation authorises administrative deprivation of liberty based on psychosocial disabilities ("serious mental disorder") and perceived lack of "decision-making capacity", combined with the additional alternative requirements "need for care and treatment" or "danger to self or others".[39] 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".

Amendments to 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.[40] Introducing a legal reform that is making "incapacity to consent" a condition for use of coercion (capacity-based model), do not bring domestic legislation in compliance with international human rights norms and the principle of non-discrimination. It constitutes a functional approach to legal capacity that runs counter to the CRPD.[41] Legal capacity is an inherent right accorded to all people, including persons

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[35] 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.

[36] CRPD GC 1, Guidelines art. 14 para 6.

[37] CRPD Guidelines art. 14, para 6, 8, 10.

[38] Ibid, para 13.

[39] Mental Health Act No. 62 of 2 July 1999 section 3-3.

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.

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."

[40] Mental Health Act No. 62 of 2 July 1999 sections 3-2, 3-3 and 4-4.

[41] 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

with disabilities, it is a universal attribute inherent to all persons by virtue of their humanity.[42] 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.

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 skills (functional approach).[43] 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.[44]

Despite the amendments, the Mental Health Act is still inherently discriminatory and still authorizes ill-treatment through forced psychiatric interventions.

In 2014, Norway got UPR 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".[45]

Suggested question for the List of Issues:

- Please provide information on what measures will be taken to abolish legislative provisions that authorize deprivation of liberty on mental health grounds and/or based on functional capacity standards.

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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)". 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)

[42] 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.

[43] 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.

[44] CRPD GC 1 para 15.

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; CRPD GC 1 para 21.

[45] See Outcome of the Review, Report of the Working Group, 131.167, and Addendum; http://ohchr.org/EN/HRBodies/UPR/Pages/NOSession19.aspx

Article 15, 16, 17: Freedom from torture and other ill-treatment, exploitation, violence and abuse, and respect for physical and mental integrity

Forced psychiatric treatments

Involuntary treatments in mental health services violates a number of fundamental human rights, including the right to have one's physical and mental integrity respected and 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.

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.[46] 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.[47]

A large part of WSOs members are or have been subject to forced medication, and live with the serious consequences.

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

[46] Omfang av tvang,Tvangsforskningsnettverket,2017: http://www.tvangsforskning.no/noekkeltall_tvang/cms/83
Bruk av tvang i psykisk helsevern for voksne i 2014, Helsedirektoratet:https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/1161/Rapport%20om%20tvang%20IS-2452.pdf

[47] NPMs reports after visits to Sørlandet Hospital and Akeshus University Hospital

"principle of necessity" and purportedly justified to prevent (serious) damage to life and health.
There are no official statistics on the extent of the use of forced ECT, nor ECT administered with informed consent.

There is no monitoring by the government to ensure that the consent given before the administration of ECT is given freely and that the information provided is sufficient and correct. Testimony shared by individuals who have received ECT, and the written information provided by hospitals about the treatment, show that information about risk of cognitive damage and side-effects, including permanent memory loss and brain damage, is absent or under-communicated. They also report that consent is given in an "un-free" situation during forced commitment or under the threat of force, as the only option available.

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."[48]

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.[49]

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".[50] Norway has not followed up on this recommendation.

Suggested questions for the List of Issues:

- Please 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.
- 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.

[48] NPM report on visit to Akershus university hospital, 2017

[49] Testimony about this is previously brought before the UN CRPD Committee, during the 14th session, 19 August 2015.

[50] CESCR Concluding Observations, E/C.12/NOR/CO/5), para 19.