Submission to the 21st session of the Committee on the Rights of Persons with Disabilities, 11 Mar – 5 Apr 2019

Review of Norway´s Initial report

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 people with psychosocial disabilities, 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 review of Norway´s initial report to the UN Committee on the Rights of Persons with Disabilities, 25th -26th march 2019.

This report is prepared solely by people with psychosocial disabilities.

We Shall Overcome is also part of The Civil Society Coalition Norway that has submitted a joint alternative report.

We will have representatives from WSO attending the country briefing 25th march. Please do not hesitate to contact us for any further information or questions.

Contactpersons :

Hege Orefellen; h.j.orefellen@nchr.uio.no

Liv Skree; liv.skree@hotmail.com

Mette Ellingsdalen; mette.elling@gmail.com

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Adress: Østerdalsgate 1L, 0658 Oslo

Tel: +47 22 41 35 90

Website: www.wso.no

E-mail : post@wso.no

Summary

Norway claim in their reply to LoI (9) that they are committed to fulfilling its obligations under the Convention. Never the less few steps have been taken by the government after the ratification to fulfill the paradigm-shift promised by the CRPD.

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).

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.

Norways interperative declarations confirms that the government don't even aim to ensure equal rights to self-determination for persons with psychosocial or intellectual disabilities. The shift from substituted desiscion making to supported decision making, has not yet started, or even been acknowledged as necessary to comply with the Convention.

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. Involuntary confinement in psychiatric institutions can be traumatising and harmful in itself, and has been recognized as a form of torture and ill-treatment. 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.

Involuntary treatment

Persons with psychosocial disabilities in Norway are severely harmed by a wide range of forced interventions on a regular basis. 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.

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 is no redress for victims, no accountability for perpetrators. The ill-treatment goes with impunity.

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stripped of dignity
naked to the bone
defined, categorized, locked up, locked out
rejected as a human being

then they rape my soul

five men hold me down
while one gives the injection

this is their drill
simple procedure
they know best how to
deprive someone of their courage to live

Merete Nesset, Survivor of forced psychiatry, 2013

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

Norway´s reply List of Issues 9.

Norway upholds its declarations on Articles 12, 14 and 25 of the CRPD. [4] 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).

[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

In 2014, during the Universal Periodic Review of the Human Rights Council, Norway got recommendations to withdraw its interpretative declarations to the CRPD.[5] 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.[6] Norway has not yet followed up on these recommendations.

Ratification of the Optional Protocol to CRPD (OP CRPD)

Norway´s reply List of Issues 1.D

Persons with disabilities need strengthened legal protection against discrimination and other human rights violations. Ratifying the optional protocol will give individuals and groups who 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.[7] In 2014, Norway got further UPR recommendations to ratify the Optional Protocol to the Convention.[8] Also the Council of Europe HR Commissioner has encouraged Norway to sign and ratify the Optional Protocol to the CRPD.[9]

Proposed recommendations for the Concluding Observations:

- Secure the legal status of CRPD by incorporating it into the Norwegian Human Rights Act.
- Recognise the object, purpose and obligations of the Convention and withdraw the declarations on article 12, 14 and 25.
- Ratify the Optional Protocol to the Convention.

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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] See Outcome of the Review; Report of the Working Group, 131.9, Addendum, and Norway's Responses to Recommendations.

[6] 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

[7] 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.

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

[9] 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

Article 5: Equality and non-discrimination

Persons with disabilities are subjected to discrimination in all areas of society.[10]
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.

Proposed recommendation for the Concluding Observations:

- Initiate a comprehensive strategy, based on human rights principles in line with the CRPD, to combat discrimination against persons with disabilities, including persons with psychosocial disabilities, that recognise and repeal discriminatory legislation and ensure that deprivation of liberty and forced interventions are never based on discriminatory grounds.

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

[10] 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

psychiatric ward they found that more than half of the patients were victims of sexual abuse.[11]

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.[12]

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. [13] 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".[14]

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.[15]

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.[16] 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

[11] 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

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

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

[14] 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

[15] 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.

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

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

Proposed recommendation for the Concluding Observations:

- Abolish legislation allowing forced administration of abortion, sterilization and any other procedures impacting on the sexual and reproductive rights of disabled women and girls without their free and informed consent.
- 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.

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 conflicts with the interpretations made by the CRPD Committee.[18] 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.[19] 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.[20]

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).[21]

[17] 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".
[18] CRPD Committee, General Comment No. 1 (2014) on Article 12: Equal recognition before the law, CRPD/C/GC/1.
[19] Act relating to Guardianship (Guardianship Act), LOV-2010-03-26-9, Section 22.
[20] Act relating to Guardianship (Guardianship Act), LOV-2010-03-26-9, Section 33.
[21] Act relating to Patients' and Users' Rights (Patients' and Users' Rights Act), LOV-1999-07-02-63.

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).[22]

The Health and Care Services Act authorizes use of coercion based on intellectual disabilities.[23]

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.[24] Further, the person can be sentenced to "compulsory mental health care" or "compulsory care".

Proposed recommendation for the Concluding Observations:

- Repeal discriminatory legislation on use of coercion and secure legal capacity and the right to self-determination, including the right to use supports that respects the persons autonomy, will and preferences in exercising legal capacity and the right to refuse such supports, based on the free and informed consent of the person concerned.

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 is 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.[25]

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

[22] Act relating to the Provision and Implementation of Mental Health Care (Mental Health Act), LOV-1999-07-02-62.
[23] Act relating to Municipal Health and Care Services, etc. (Health and Care Services Act), Lov-2011-06-24-30.
[24] The Criminal Code, LOV-2005-05-20-28.
[25] 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).[26]

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.[27] 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.[28] 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.[29] Making reference to the interpretative

[26] Norway's reply; https://spcommreports.ohchr.org/TMResultsBase/DownLoadFile?gId=60255
[27] 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
[28] Supreme Court 20 December 2016, HR-2016-2591-A.
[29] 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.

Proposed recommendation for the Concluding Observations:

- Ensure that individuals have access to an effective mechanism to obtain immediate release from any confinement or forced intervention in mental health setting
- Initiate prompt and impartial investigation of human rights violations and provide victims access to effective remedies and redress.

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.[30] Involuntary confinement in psychiatric institutions can be traumatising and harmful in itself, and has been recognized as a form of torture and ill-treatment.[31] 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.[32] The CRPD sets forward an absolute ban on deprivation of liberty based on impairment or health grounds.[33] This includes where there are additional criteria

[30] 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.
[31] 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.
[32] CRPD GC 1, Guidelines art. 14 para 6.
[33] CRPD Guidelines art. 14, para 6, 8, 10.

used to justify the detention, including alleged need for care or treatment or deemed dangerous to self or others.[34]

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".[35] 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

Norway´s reply List of Issues 11.C

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.[36] 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.[37] 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

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[34] Ibid, para 13.

[35] 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."

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

[37] 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)". 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)

humanity.[38] 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).[39] 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.[40]

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".[41]

Proposed recommendation for the Concluding Observations:

- Abolish legislative provisions that authorize deprivation of liberty on mental health grounds and/ or based on actual or perceived impairment, estimated outcome or functional capacity standards.
- Ensure the availability to a wide range of voluntary services in the community that meet the needs expressed by persons with disabilities, that respect the persons autonomy, choices and dignity, including peer-support, medication-free services and other alternatives to the medical model of mental health.

[38] 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.

[39] 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.

[40] 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.

[41] 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.

Forced drugging

I have lost my memory and self-respect because of psychiatric drugs that kill my body and soul. It is very visible that I have used chemical substances handed out by psychiatry. Nerve damage in the arms and legs. Gray and faded hair. Overweight. Worn down. Dirty clothes. Skewed neck. Drooling. Slow motion. Now I don't want to be bullied and mistreated any more. Now I want to be protected from psychiatry and not be pushed more chemicals that are not meidicne at all but pure nerve poison.

WSO-member, female, 39 years old

Forced medication is administered in hospitals and on an out-patient basis. There is no time limit in the law for how long people can be forecefully drugged. For many people this goes on for years, and for some a life-time. The average life expectancy of people diagnosed with «psychosis» or «schizofrenia» is approximately 20 year less than the general population.[42]

There is no reliable data on how many people that are subject to forced medication, or for how long.

In addition to persons forcibly drugged trough formal desicions, there is also an unknown number of people that experience involuntary use of medication due to lack of choice. People report that the threat of force, pressure, fear of additonal punishment (detention, seclusion and/ or physical restraints), and lack of available options as a reason for «complying» with taking medication.

The harmful effects of neuroleptic drugs is well documented. It includes dullness and apathi, uncontroled muscular movement (tardive dyskinesia), extreme weight gains, metabolic syndrome, diabetes, heart disease, neurological damage, extreme restlessness and discomfort (akathisia), loss of menstruation and sexual interest, increase in sudden death and total mortality rate.

Testimonies from people that have experienced forced drugging tells about serious long-term psycho-social and mental harm like; long-term trauma, loss of dignity, living in constant fear that it will happen again, lack of trust in self and others, hopelessness, isolation, loss of skills, alienated from your body and mind, living in constant alarm, distrust in doctors, distrust and alienation from society and more.

[42] Investigation, treatment and monitoring of people with psychotic Conditions, National Guidelines, IS-1957, Norwegian Directorate of Health 2013. See page 37, Item 5.7: https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/326/Nasjonal-faglig-retningslinje-for-utredning-behandling-og-oppfolging-av-personer-med-psykoselidelser-IS-1957.pdf

The National Preventive Mechanism against torture (NPM)[43] have documented during their visits at Norwegian hospitals that patients who were forcibly medicated mostly had negative experiences that where described as «horrible», «cruel» and «torture». Several patients showed unpleasant adverse reactions such as headache, apathy, and weightgain, 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.[44]

A large part of WSOs members are or have been subject to forced drugging, 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 Psychiatry[45]:

"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. »[46]

Electroshock (ECT)

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The numbers on undesireable incidents reported by the government is related to what is considered undesireable events byt the medical staff executing ECT, and does not include what is considered undesireable effects by the person that is subject to ECT. There is no monitoring body where it is possible to report harm following ECT (neither for doctors or persons affected), like memory-loss, learning-difficulties, personality changes etc. Further there is no monitoring body to review that the information given to the patient before ECT is correct, balanced, and incluing the risk for side-effects, or that the consent is given freely and without pressure.

Forced electroshock

[43] National Preventive Mechanism against torture and other inhuman or degrading treatment or punishment, established in 2014 after Norway ratified OPCAT.

[44] NPM reports after visits to Sørlandet Hospital (2015) and Akershus University Hospital (2017)

[45] 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/

[46] Testimony given at the side-event «Violence against Women and Girls with Disabilites – Intersectional and Double Violence in Medical and Institutional Settings", 19 August 2015 Palais Wilson.

According to the Norwegian Mental Health Act, the administration of electroshock (ECT) is not permitted without informed consent. Regardless forced electroshock is administered as an exception, according to the "principle of necessity" with reference to the General Civil Penal Code[47], and purportedly justified to prevent (serious) damage to life and health.

There is no official available statistic on the use of ECT, neither forced or with consent.

The NPM (national preventive mecanism under Opcat) reported on ECT administred on the grounds of necessity in 2017, and among their findings where: «ECT administered on grounds of necessity entails a high risk of inhuman or degrading treatment. Findings made during the NPM's visits in 2017 have shown that ECT administered on grounds of necessity is a very invasive form of treatment. The Ombudsman has identified cases where mental health professionals have found that patients have suffered serious cognitive side effects following ECT, and where the patients cannot remember having had the treatment. One clear finding was that patients who had undergone ECT on grounds of necessity are also subject to other invasive coercive measures during their treatment, such as the use of a restraint bed for the administration of ECT. The NPM also found cases where the use of force had escalated following a course of ECT on grounds of necessity. The overall scope of the use of force in connection with the administration of ECT on grounds of necessity leads to a high risk of patients being subject to inhuman and degrading treatment."[48]

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. Testimonies 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.

This is also confirmed by the findings of the NPM; "Examples were also found on voluntary admitted patients undergoing ECT after being subject to a range of other coercive measures, without any documentation of the significance of this for the validity of the original consent. Findings were also made at a number of hospitals that led to concerns that patients who had formally consented to ECT did not receive sufficient verbal and written information about the treatment, including about the expected effect and possible side-effects."[49]
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 testify about personality change, loss of*

[47]

[48] Norwegian Parlamentary Ombudsmann Annual Report 2017 Document 4:1
[49] Norwegian Parliamentary Ombudsman Annual Report 2017 Document 4:1

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-related competencies, of your friends and family. To have 1- 5 - 25 years of your memory erased by electroshock…."[50]

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

Coercive means

Physical restraints

In 2016 investigative journalists in the newspaper VG conducted a thorough investigation into the use of physical restraints in Norwegian hospitals. They discovered under-reporting of close to 1000 incidences in the official statistics.[52] 25 % of the patients that was subject to mechanical restraints was restrained more than 8 hours[53]. They documented one case where a person had been subject to physical restraint 70 days and nights[54], and another case were a person had been restrained 64 days and nights.[55] The findings was confirmed by the government.

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.[56]

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[50] 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 Disabilites – 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/

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

[52] The reported number for 2014 was 2802 incidences, and VG discovered when looking at the source-material 3768 incidenses.

[53] https://www.vg.no/nyheter/innenriks/tvang-i-psykiatrien/holdes-i-belter-i-hundrevis-av-timer/a/23669706/

[54] St.Olavs Hospital in 2015, 1855 hours.

[55] Østfold Hospital in 2015, 1549 hours.

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

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 2014[57], Borgating Court of appeal 23. march 2015,[58] 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".[59] 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 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

[57] Oslo District Court, 21 November 2014; 14-163619TVI-OTIR/04.
[58] Borgating Court of Appeal, 23 March 2015; LB-2015-13924.
[59] Supreme Court Appeal Committee, 20 May 2015; HR-2015-1091-U.

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.

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. [60]

Isolation / seclusion (Shielding)

"I have personal experience of being "shielded" and have experienced it as very distressing to be separated from my co-patients. In fact, I have experienced being secluded as an intervention in my life that would have led to, if I had the opportunity, me ending my life in the seclusion ward"

B. I. Pedersen, 2018 [61]

[60] 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
[61] Søkelyset 40, 2018. S.29. «Skjerming virker mot sin hensikt»

Seclusion ("shielding") is regulated in Section 4-3 of the Mental Health Care Act, while isolation is regulated as a coercive mean in Section 4-8. In reality the lines between isolation and seclusion are blurred, and people often report experiences of "shielding" as isolation and/or punishment.[62]
Psychiatric institutions use '*shielding*' to: keep disabled persons wholly or partly segregated from others, restrict movement outside and impose restrictions on activities and social interaction. The practice of "shielding" often results in situations similar to isolation, where fresh air and social contact with equals is only a privilege (or reward) and not a right.

The NPM write in their report to the Torture-committee in 2018; "A key finding from the visits carried out in 2017 was that many mental health care hospitals practised extensive segregation of patients. Patients were often segregated in unsuitable premises, with very limited opportunity for human contact and activity. The NPM expressed concern on several occasions that this measure, in practice, resembled isolation. ….
… A systematic review of literature in 2015 concluded that there was little knowledge of the effect of segregation in Norway. Patient studies indicate that the coercive elements of segregation are stronger than and are perceived as being more isolation-like than treatment purposes would indicate. The implementation of segregation measures that provide so little opportunity for human contact that they, in practice, constitute isolation pose a high risk of inhuman and degrading treatment." [63]

Proposed recommendation for the Concluding Observations:

- Incorporate into the law the abolition of enforced administration of intrusive and irreversible treatments such as neuroleptic drugs and electroconvulsive therapy (ECT), and ensure that all mental health services are based on the free and informed consent of the person concerned.

- Abolish the use of mechanical restraint, and seclusion/isolation against psychosocially disabled persons in mental health facilities.

- Recognize the immediate obligation to stop ill-treatment from being carried out through forced psychiatric interventions, and ensure these interventions are rapidly stopped, and that victims receive protection against any reoccurrence.

[62] NOU (Norwegian Official Report) 2011:9 Økt selvbestemmelse og rettsikkerhet.
[63] The Norwegian NPM's submission to the UN Committee against Torture's 63rd session – Information regarding the Norwegian Government's implementation of the Convention