ROYAL NORWEGIAN
MINISTRY OF FOREIGN AFFAIRS

The Norwegian Government refers to the joint urgent appeal of 30 January 2017 [redacted], received from the Working Group on Arbitrary Detention, the Special Rapporteur on the rights of persons with disabilities and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The Norwegian Government's responses to the questions in the urgent appeal are given below. The responses include a description of the Norwegian legislation on compulsory mental health care, information about national independent complaints and monitoring mechanisms and an account of the steps that have been taken to reduce the use of coercion in mental health care and ensure that coercive measures are used appropriately. The Government also gives its views on the Norwegian legislation's compatibility with international human rights law. As further commented below, the interpretation of the human rights conventions used by Special Procedures as a basis for the urgent appeal, is not one with which the Government agrees.

The Government answers the questions from Special Procedures in general terms. It regrets not being able to discuss details of an individual case. Information on specific cases is subject to duty of confidentiality; the Government does not have access to this information and cannot comment on it. Norway has established special appeals and supervisory arrangements for cases concerning patients and those concerning compulsory mental health care, and special procedures for judicial review of cases concerning compulsory mental health care.

[redacted]

Against the above background, the Government fails to see that this case requires it to take particular measures and that it warrants an urgent appeal to Norway.

Question 1 ("Please provide any additional information and/or comment(s) you may have on the above-mentioned allegations"):

In the joint urgent appeal, Special Procedures express grave concern about "[redacted] Special Procedures make reference to "an immediate obligation of the States to immediately discontinue these practices and reform laws and policies allowing for deprivation of liberty and forced treatment on the basis of disabilities by replacing these practices with services in the community that meet needs expressed by persons with disabilities and respect for autonomy, choices, dignity and privacy". In this context, they refer to the International Covenant on Civil and Political

Rights, Articles 9 and 14, the provisions of the Convention against Torture and other Cruel, Inhuman and Degrading Treatment and Punishment, the Convention on the Rights of Persons with Disabilities (CRPD), Article 14 in conjunction with article 5 and Article 12, and the International Covenant on the Economic, Social and Cultural Rights, Article 12.

From the wording of the joint urgent appeal, it seems clear to the Norwegian Government that the interpretation of the above-mentioned treaty provisions used as a basis by Special Procedures, is not one with which the Norwegian Government agrees. The Government would therefore like to start by pointing out that these conventions do not prohibit compulsory mental health care.

As regards the CRPD, Articles 12 and 14, Norway made the following interpretative declarations upon ratification:

> "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.
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> 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."

The Norwegian Government also refers to its submission on the draft General Comment on the CRPD Article 12 adopted by the Committee on the Rights of Persons with Disabilities, which is available online.[1]

In its initial report to the Committee on the Rights of Persons with Disabilities, published on 7 December 2015, Norway stated the following:[2]

> "111. Persons with disabilities have a right to liberty and security of the person on an equal basis with everyone else in Norway. They must not be subjected to arbitrary treatment. Norway's interpretation of Article 14 of the Convention (see also Article 25) is that the Convention does not lay down a prohibition against necessary compulsory admission or treatment of persons with mental illness as long as any deprivation of liberty and treatment is justified by objective criteria that go beyond the existence of a

[1] http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx (submission no. 54)
[2] The report is available online: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fNOR%2f1&Lang=en

mental illness. Therefore, in its interpretative declaration made upon ratification of the Convention, Norway declared: "[...] 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 due process protection." The Government maintains this interpretative declaration and deems it to be in line with the wording in Article 14 and in accordance with the prevalent understanding of the Convention among the States Parties. The fact that the declaration accords with the prevalent understanding of the Convention among the States Parties is reflected in the States Parties' reports to the Committee on the Rights of Persons with Disabilities and with the Committee's concluding remarks to these reports.

112. The UN Committee on the Rights of Persons with Disabilities has made general comments on Article 12 of the Convention. These comments also concern Articles 14 and 25. Norway submitted its response to these comments, in which it gives further justification for why the Government maintains its interpretative declarations regarding Articles 12, 14 and 25. Regarding Article 14, Norway has stated: "Article 14 No. 1 b) affirms that "the existence of a disability shall in no case justify a deprivation of liberty", and Norway fully agrees with this. However, this provision may not be read as signifying that the existence of a mental disorder may not be one of several criteria for the use of non-consensual institutionalisation and treatment. Article 14 prohibits legislation and practices where the existence of a disability alone justifies the deprivation of liberty or compulsory treatment. This interpretation of the Convention is also supported by state practice of the State Parties to the Convention.

113. While agreeing that mental health services should as far as possible be based on voluntary consent, and that it should be a goal for the national health care services to minimize the use of compulsory care and treatment to the extent which is absolutely necessary, Norway is of the opinion that the Convention allows for legal provisions that enable compulsory care or treatment of mentally ill persons, given that these provisions meet a number of strict criteria.

114. As already mentioned, the existence of a mental illness or disability is not in itself sufficient to allow deprivation of liberty or compulsory treatment. However, compulsory care and treatment may be appropriate when this is necessary in the individual case, for instance when persons are incapable of making decisions about their treatment and/or present a serious risk of harm to themselves or other people, and when no less intrusive means are likely to be effective. The treatment given should be in accordance with generally acknowledged medical standards. The decision to submit a person to compulsory care or treatment should be subject to strict legal safeguards, and the patient should have access to review of the decision by an impartial body. Compulsory care and treatment which meets these criteria cannot be considered unlawful or arbitrary deprivation of liberty under Article 14 of the Convention."

The Norwegian Government would also like to draw the attention of Special Procedures to General Comment No. 35 on the liberty and security of person, paragraph 19, from the Human Rights Committee, which shows that the Human Rights Committee is also of the view that compulsory mental health care can be applied as a measure of last resort when accompanied by adequate procedural and substantive safeguards:

"19. The existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others. It must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law. The procedures should ensure respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual. States parties must offer to institutionalized persons programmes of treatment and rehabilitation that serve the purposes that are asserted to justify the detention. Deprivation of liberty must be re-evaluated at appropriate intervals with regard to its continuing necessity. The individuals must be assisted in obtaining access to effective remedies for the vindication of their rights, including initial and periodic judicial review of the lawfulness of the detention, and to prevent conditions of detention incompatible with the Covenant."

Question 2 ("Please provide information on the legal grounds for [redacted] Please indicate how these provisions are compatible with international human rights norms and standards"):

The legal basis for compulsory mental health care

The examination and treatment of persons suffering from mental illness without their consent is governed by Norway's Act relating to the provision and implementation of mental health care (the Mental Health Care Act, hereafter referred to as 'the Act').

The purpose of the Act, as set out in section 1-1, is to ensure that mental health care is applied and implemented in a satisfactory manner and in accordance with the fundamental principles of the rule of law, and that the measures described in the Act are based on patients' needs and respect for human dignity.

Section 3-5, first paragraph, of the Act states that compulsory mental health care may be provided on an in-patient basis in an institution. Patients may be detained against their will and brought back if they escape, if necessary by force.

Compulsory mental health care may also be provided on an out-patient basis if this is a better alternative for a patient (section 3-5, third paragraph, of the Act). In such cases, patients may be instructed to attend an out-patient clinic for treatment. If necessary, they may be fetched by force.

Section 3-3 of the Act describes the conditions for the application of compulsory mental health care. The main legal basis is that a patient must be suffering from a serious mental disorder and that application of compulsory mental health care is necessary to prevent the prospects of his or her health being restored or significantly improved from being considerably reduced, or it is highly probable that the condition of the person concerned will

significantly deteriorate in the very near future, or the patient constitutes an obvious and serious risk to his or her own life and health or those of others.

In addition, voluntary mental health care must have been tried to no avail, or it must be obviously pointless to try this.

The patient in question must have been examined by two physicians, one of whom must be independent of the institution responsible for the application of compulsory mental health care.

The patient must also have been given an opportunity to state an opinion.

The institution must be approved for compulsory mental health care, and be professionally and materially capable of offering the patient satisfactory treatment and care.

With the exception of cases where a patient constitutes an obvious and serious risk to the life or health of others, compulsory mental health care may only be applied if this clearly appears to be the best solution for the person concerned. In assessing this, special weight must be given to how great an impact the compulsory intervention will have on the person concerned.

The legal basis for treatment without consent

Patients under compulsory mental health care may be treated without their own consent (section 4-4, first paragraph, of the Act). Such treatment must be clearly in accordance with professionally recognised psychiatric methods and sound clinical practice.

As a general rule, examination and treatment that constitute a serious intervention may not be carried out without the patient's consent (section 4-4, second paragraph, of the Act). There are exceptions to this, for example for compulsory medication. If a patient receives medication without consent, only preparations that are registered in Norway may be used, and in commonly used doses. Medication may only be carried out using medicines which have a favourable effect that clearly outweighs the disadvantages of any side effects (section 4-4, second paragraph, of the Act).

Electroconvulsive therapy (ECT) is one treatment that is considered to be a "serious intervention". As a general rule, it may therefore not be used without the patient's consent. However, exemptions may be made from the requirement for consent in life-or-death situations.

Examination and treatment without the patient's consent may only take place when an attempt has been made to obtain consent to the examination or treatment, or it is obvious that consent cannot or will not be given. If it is not obviously impossible, there is also a requirement to consider whether other voluntary measures may be offered as an alternative to examination and treatment without the patient's consent (section 4-4, third paragraph, of the Act).

Treatment without the consent of the patient may only take place after the patient has been sufficiently examined to provide a basis for judging his or her condition and need for

treatment. Such treatment may only be initiated and implemented when it is highly likely that it will lead to the cure or significant improvement of the patient's condition, or will avoid significant deterioration of the patient's condition (section 4-4, fourth paragraph, of the Act).

Decisions on treatment without consent may be appealed to the County Governor (section 4-4, seventh paragraph, of the Act).

To enhance self-determination and legal safeguards and reduce the use of coercive measures, the Storting (Norwegian parliament) has recently adopted amendments to the rules on compulsory mental health care. These include a provision that compulsory mental health care may not be applied if the patient is competent to give consent. Nor may patients who are competent to give consent be treated or given medication without their own consent. Nevertheless, these provisions do not apply if the patient constitutes an obvious and serious risk to his or her own life or to others life or health. See further details in the answer to question 6.

The use of coercive measures in compulsory mental health care

The use of restrictions and coercive measures during compulsory mental health care must be limited to what is strictly necessary. As far as possible, the patient's views on such measures must be taken into account. Only measures that have such a favourable effect that this clearly outweighs their disadvantages may be used (section 4-2 of the Act).

Mechanical restraints that hamper patients' freedom of movement, including belts and straps and clothing specially designed to prevent injury, may only be used if this is absolutely necessary to prevent patients from injuring themselves or others, or to avert significant damage to buildings, clothing, furniture or other objects. Milder measures must have been tried before coercive measures, and must have proved to be obviously without effect or inadequate (section 4-8, first paragraph, of the Act).

Patients who are subjected to coercive measures must be kept under continuous supervision. If a patient is strapped to a bed or a chair, nursing staff must remain in the same room as the patient unless the patient objects to this (section 4-8, third paragraph, of the Act).

Coercive measures must be used for as short a time as possible and in a way that shows as much care and compassion for the patient as possible (section 26 of the Mental Health Care Regulations).

Norway considers the provisions on the use of coercive measures in the Mental Health Care Act to be compatible with the CRPD and other international human rights instruments that are binding on Norway. In this context, we refer to Norway's interpretative declaration regarding Articles 14 and 25 of the CRPD and Norway's submission on the draft General Comment on the CRPD from the Committee on the Rights of Persons with Disabilities. See the answer to question 1 above for further information.

Question 3 (" [redacted]

[redacted]

Every institution with patients who are under compulsory mental health care must have an independent supervisory commission attached to it (sections 6-1 and 6-3 of the Act).

Each supervisory commission must be chaired by a lawyer who is qualified to serve as a judge, and must otherwise consist of a physician and two other members, all of them with personal deputies. One of the two latter permanent members must be a person who has personally been under mental health care or is or has been a close relative of a patient or who has had an occupation or function that involved representing the interests of patients (section 6-2 of the Act).

Whenever a person is placed under compulsory mental health care, the relevant supervisory commission is required on its own initiative and as soon as possible to assure itself that the correct procedure has been followed and that the decision on compulsory mental health care is based on an assessment of the conditions that must be satisfied for such care to be applied. The supervisory commission investigates this by reviewing the case documents (section 3-8 of the Act and section 57 of the Mental Health Care Regulations).

Patients and their next-of-kin may appeal a decision to apply or maintain compulsory mental health care to a supervisory commission (section 3-3, third paragraph, of the Act).

If no appeal is made against the application of compulsory mental health care, the supervisory commission is required after three months to assess, on its own initiative, whether there is a need for compulsory care (section 3-8, second paragraph, of the Act, and section 58 of the Mental Health Care Regulations).

Decisions made by a supervisory commission in cases concerning the application or maintenance of compulsory mental health care may be brought before a court of law under special procedural rules, which are among other things intended to ensure that such cases are dealt with promptly. The Norwegian state bears all the costs of such cases (section 7-1 of the Act, and sections 36-1, 36-5 and 36-8 of the Civil Procedure Act).

Question 4 ("Please provide information about the existence of national independent complaints and monitoring mechanisms, which are mandated to visit places where persons with disabilities are or might be deprived of their liberty, to prevent and to act on situations of human rights abuses and violations."):

Please also refer to the answer to question 3.

The supervisory commissions are responsible for carrying out supervision of the use of coercive measures during compulsory mental health care (section 63 of the Regulations). The commissions are required to visit institutions that are approved for compulsory mental health care at least once a month. Some of these visits should be unannounced (section 62 of the Mental Health Care Regulations).

During its visits, a supervisory commission is required to review records, among other things of treatment without the consent of the patient and the use of coercive measures. Patients must be given the opportunity to lodge appeals against decisions made under the Mental Health Act, and otherwise to raise matters of importance in connection with their stay at the institution. The commission must notify the County Governor if it finds that there are circumstances of a serious nature at an institution. Otherwise, the commission can raise the matter with the management of the institution or the mental health professional responsible for the decision (section 63 of the Mental Health Care Regulations).

The Act relating to public supervision of health and care services (section 2) requires the County Governors to supervise health and care services in their areas, including mental health services. The Norwegian Board of Health Supervision has overall responsibility for supervision of health and care services. If it is found that institutions are run in a way that may have adverse consequences for patients or others, or is otherwise unacceptable, the Board has the power to issue orders to rectify matters. This also applies to institutions in the mental health care sector. The Norwegian Board of Health may also impose administrative sanctions on health personnel. As part of their supervisory activities, the County Governors and the Norwegian Board of Health may require access to confidential information and to institutional premises (section 6-2 of the Specialist Health Service Act).

In connection with Norway's ratification of the Optional Protocol to the UN Convention against Torture, the Parliamentary Ombudsman was given the mandate to act as the national preventive mechanism (NPM) against torture and other cruel, inhuman or degrading treatment or punishment (Parliamentary Ombudsman Act, section 3a). An autonomous NPM has now been established at the Office of the Parliamentary Ombudsman to carry out these tasks.

The NPM undertakes regular visits to places of detention, for example mental health care institutions. These visits may be announced or unannounced. On the basis of its findings during such visits, the NPM is expected to make recommendations with a view to preventing torture and other cruel, inhuman or degrading treatment or punishment.

The NPM is entitled to access to all places of detention and to hold private conversations with persons who are deprived of their liberty. The NPM is also entitled to access to all necessary information of significance for conditions during deprivation of liberty. During its visits, the NPM seeks to reveal any factors that may increase the risk of violations of personal integrity through their own observations and conversations with persons who are detained.

Question 5 ("Please explain what community support services and treatment alternatives respectful of the rights, will and preferences of persons with disabilities [redacted]"):

The application of compulsory mental health care is not permitted unless voluntary mental health care has been tried to no avail, or it is obviously pointless to try this (section 3-3, first paragraph, 1, of the Act).

Question 6 ("Please provide information regarding the legislative reform processes and other measures that have been taken to ensure that health care, including medical treatment, is always provided with the free and informed consent of the person with disabilities, and to avoid and prevent coercion in the mental health services."):

Legislative committee to review rules on coercion

The Government has appointed a legislative committee to conduct an overall review of the regulation of coercion in health and care services in Norway and the need for revision and modernisation of the legislation. The aim is to enhance legal safeguards and reduce the use of coercion.

The committee has been asked to propose the legislative amendments needed to meet current and future needs in the Norwegian health and care services. The new rules should promote the Government's objective of creating patient and user-centred health and care services. They should also facilitate close coordination between different types of institutions and between municipal health and care services and specialist health care services.

Every person has a right to liberty and security of person and to respect for their physical and mental integrity. Compulsory care or treatment must only be used as a final resort when circumstances make this necessary, and when the measures implemented are subject to legal safeguards.

The committee is therefore to review whether the current rules on the use of coercion are sufficiently compatible with these goals and principles.

The committee is also to review the legislation in relation to Norway's international obligations, including those under the UN Convention on the Rights of Persons with Disabilities, and assess whether amendments are needed to fulfil these obligations.

The commission is to review rules on a number of matters, including the purpose of the legislation, definitions of coercion and conditions for using coercive measures, competence to give consent, administrative procedures, appeals and review of decisions, judicial control, and legal assistance.

The committee is chaired by Professor of Law Bjørn Henning Østenstad from the University of Bergen. Other members represent users and families, various professions and different parts of the health and care services.

The committee is to submit its report to the Ministry of Health and Care Services by 1 September 2018.

Amendments to the Mental Health Care Act

The Storting has recently adopted amendments to the Mental Health Care Act that will give stronger legal safeguards and enhance self-determination for patients who are subjected to compulsory care or treatment.

Patients who are competent to give consent will be entitled to terminate treatment or refuse to accept an offer of treatment. Exemptions have been proposed for cases where there is a serious risk of suicide or to others' life or health.

Patients will also be more clearly entitled to state an opinion before decisions are made on matters including treatment without the patient's consent and the use of belts or other restraints and coercive measures. Particular importance is to be attached to patients' statements on previous experience of the use of coercion.

Health personnel will also be required to evaluate the use of coercion, including compulsory medication and the use of physical restraints, with the patient after the event. After an evaluation, health personnel will be required to record the patient's views on the coercive measures.

In addition, patients will have wider rights to free legal advice. They will be entitled to legal advice without having to pay a fee, and will receive free legal advice without means testing in the case of appeals to the County Governor concerning decisions on treatment without the patient's consent (compulsory medication, for example).

The amendments relating to free legal advice enter into force on 1 July 2017, and the other amendments on 1 September 2017.

Other steps to reduce the use of coercion and ensure that coercive measures are used appropriately

One important objective for the Government is to reduce the use of coercion in the mental health services, ensure quality assurance of the use of coercion and improve the registration and reporting of decisions on coercive measures.

As part of the effort to reduce the use of coercion, the Government is requiring the regional health authorities to hold meetings with patients and user organisations to discuss their experience of the use of coercion. These are to be organised in cooperation with Norway's national competence centre on experiential knowledge (Nasjonalt senter for erfaringskompetanse innen psykisk helse).

The health authorities have ordered the supervisory commissions to give greater weight to the user perspective, assess the grounds for using coercive measures more critically and take the patient's overall situation better into consideration when assessing individual decisions on the use of coercive measures. The commissions have also been requested to play a more active part in supervising patients' welfare.

Hospitals are required to provide complete and accurate reports of the use of coercive measures and to establish systems to ensure reliable registration of data.

A complete overview of the use of coercive measures in 2015 and 2016 was made available on 4 May 2017.[3]

From 2017 trends in the use of both coercive measures (straps and belts, restraint by medical personnel, short-term seclusion in a locked room, involuntary medication with sedatives) and compulsory admission for treatment will be monitored by means of quality indicators and publication of data every four months on the website www.helsenorge.no.

In 2015, the Ministry of Health and Care Services introduced a requirement for the regional health authorities to establish medication-free treatment options in specialist mental health care institutions for patients who are interested in this or who wish for help in reducing their use of medication. The Ministry has been following this up closely.

Medication-free treatment options are now established in all the health regions.

Question 7 ("Please explain what decision making support is available to persons with disabilities that are seeking to make health related choices"):

The Patients' and Users' Rights Act (section 4-3, third paragraph) requires health personnel, on the basis of the patient's age, mental state, maturity and experience, to do their best to enable the patient himself or herself to consent to health care. This provision also applies to patients in the mental health care system.

Patients must be given the information necessary to obtain an insight into their health condition and the content of the health care, and must be informed of possible risks and side effects (Patients' and Users' Rights Act, section 3-2).

Information must be adapted to the capabilities of the recipient, such as age, maturity, experience and cultural and linguistic background. Information must be provided in a considerate manner. As far as possible, health personnel must ensure that the patient has understood the content and significance of the information (Patients' and Users' Rights Act, section 3-5).

10 May, 2017

[3] The overview is available online: https://helsenorge.no/kvalitet-seksjon/Sider/Kvalitetsindikatorer-rapporter.aspx?kiid=KI_PHV_Tvangsmiddelvedtak