Norges nasjonale institusjon
for menneskerettigheter

UN Committee on the Rights of Persons
with Disabilities
Secretariat of the Committee
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Supplementary information from the Norwegian National Human Rights Institution to the UN Committee on the Rights of Persons with Disabilities in relation to the 10th pre-session discussion of Norway on 24 September 2018

Reference is made to the Committee's invitation to provide country-specific information prior to the List of Issues to Norway's 1st periodic report at the Committee's 10th pre-session.

The Norwegian National Human Rights Institution (hereinafter: NIM) was established 1 July 2015 as an independent institution under new legislation adopted by Parliament. NIM has a specific mandate to protect and promote international human rights in Norway, as well as to monitor how the authorities respect their international human rights obligations. Submitting supplementary reports to international human rights treaty monitoring bodies is an essential tool for an NHRI to fulfil its mandate.

In March 2017, we were granted A-status by GANHRI, thus recognising that NIM is fully compliant with the UN Paris Principles.

In relation to the Convention on the Rights of Persons with Disabilities (CRPD), it is notable that NIM has a statutory Advisory Council which meets quarterly to provide input and advise to our human rights work. The Council has fourteen members, including the Norwegian Federation of Organisations of Disabled People (FFO), an umbrella organisation with 82 member organisations, and the Equality and Anti-Discrimination Ombudsman, which is specifically mandated to monitor implementation of CRPD.

We hereby take the opportunity to draw your attention to six issues which we suggest that the Committee include in the List of Issues to Norway. We will prepare an updated submission prior to the Committee's dialogue with the state.

Our submission does not reflect all relevant human rights challenges in Norway within the scope of the International Convention on the Rights of Persons with Disabilities

Yours sincerely
On behalf of the Norwegian National Human Rights Institution

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This letter is electronically approved and valid without signature

Contents

1. Declarations of interpretation of the Convention

Reference is made to CRPD articles 12, 14/25 og 33.

Upon ratification of CRPD in 2013, Norway submitted two declarations on the interpretation of certain aspects of articles 12 and 14 in conjunction with article 25 of the Convention.

The Declaration on the interpretation of article 12 regarding equal recognition before the law, states that persons may be deprived of their legal capacity or be supported in exercising their legal capacity and consequently be subjected to guardianship, if it is necessary, as a measure of last resort and subject to procedural safeguards.

The Norwegian Supreme Court, in a judgement of 20 December 2016 (HR-2016-2591-A), stated that the Declaration on article 12 contradicts the interpretation of the CRPD Committee in General Comment no. 1. The Court reiterated its previous jurisprudence whereby General Comments from treaty bodies in general are to be given "significant weight" in the interpretation of treaties. The Court also held that section 22 of the Guardianship Act, which allows deprivation of legal capacity in economic matters, may be contrary to the Convention. However, due to the lack of incorporation of the CRPD Convention in domestic law, the Supreme Court was compelled to apply section 22 of the Guardianship Act without due regard to the interpretation of article 12 in General Comment no. 1.

The Declaration on the interpretation of articles 14 and 25, regarding the rights to liberty and security and to health, states that coercive psychiatric care and treatment of persons with mental disabilities is in conformity with the Convention, if it is necessary as a measure of last resort and subject to procedural safeguards. Thus, the Declaration is not in accordance with the interpretation by the CRPD Committee in their guidelines on the interpretation of article 14.

Since then, the Government in 2016 amended the Mental Health Care Act, Article 3-3, presumably to bring it closer to the CRPD Committee's interpretation of CRPD article 14. This amendment only affects persons with mental disabilities who are able to consent. Involuntary care for these individuals was prohibited, except in circumstances when they represent a serious risk to their own life or the health or life of others.

Suggested questions:

- What is the position of the State on the interpretation of CRPD article 12 considering the aforementioned Supreme Court decision?
- In light of legislative amendments, does the State consider withdrawing, wholly or in part, its declared interpretation of articles 14 and 25?

2. Discrimination and living conditions for Samí indigenous persons with disabilities, national minorities and other vulnerable groups

Reference is made to CRPD articles 5, 24, 25, 27, and 28.

A government-sponsored study to provide research-based knowledge for the implementation of CRPD shows that welfare institutions have insufficient understanding of Sámi culture. This increases the risk that Sámi persons with disabilities may not have their rights sufficiently protected.[1] The study found that living conditions for persons with disabilities living in Sámi areas were poorer than other comparable populations when it concerns housing, education, work, leisure, economy and health. They were also more exposed to violence and harassment than other groups, and Sámi women with disabilities were more exposed than men with disabilities. In some areas, there are substantial differences in living conditions for Sámi persons with disabilities compared to the living conditions for persons with disabilities without Sámi background, especially when it concerns mental health and harassment.

Recommendations based on the study, include measures against harassment, preventive measures and treatment of mental health and to adapt suitable living and other services to Sámi persons with disabilities.

To our knowledge there is no specific research with regard to persons with disabilities belonging to other minorities and vulnerable groups, such as Roma and Tater/Romani. However, taking into consideration other human rights challenges faced by such groups, there is a need to ascertain whether they also face poorer living conditions than comparable groups without minority backgrounds.

Suggested questions:

- Which steps will the state take to reduce discrimination of Sámi persons with disabilities?
- What information can the state provide with regard to the living conditions for persons with disabilities belonging to national minorities and other vulnerable groups?

3. The Act on Guardianship in practice

Reference is made to CRPD article 12 and the State Report paras. 75-93.

The question at present is whether the Guardianship Act, as it is practiced, is in compliance with CRPD as ratified by Norway.[2] This would require that substituted decision-making is only used "when necessary, as a last resort and subject to safeguards".

[1] Gjertsen, Fedreheim, Fylling, Kartlegging av levekårene til personer med utviklingshemming i samiske områder, Avdeling vernepleie, UIT, The Artic University of Norway, 2017, p. 8 ff.

[2] See point 1

The purpose of the Guardianship Act is to ensure that persons who need help and have a recognized diagnosis, for example different intellectual impairments or dementia, have their interests taken care of by an appointed guardian. As a rule, the person under guardianship must agree to the guardianship, its scope and the guardian. In specific situations, however, self-determination does not need to be respected if the person does not understand the issue at hand (lacks decision making competence). Based on medical opinion, the county governor decides whether a person has decision making competence. Guardianships may also include full or partial restriction on legal capacity; such a decision is to be established by a court and does not require the consent of the person under guardianship. The County Governor is the local authority for guardianship matters.[3]

A PhD study evaluating the guardianship practice concerning persons with intellectual impairment in one county in Norway, found that in 165 out of 167 cases from 2015, the county governor found that the person had legal capacity. [4] However, in almost 50 per cent of the cases, persons with intellectual impairment were declared not competent to make decisions because of their disability status. The study concluded that the Norwegian system denies the self-determination of persons with intellectual impairment solely based on their disability status, and that denial becomes more of a general rule and is not used as a last resort.

In 2018, the Legal Department of the Ministry of Justice and Public Security stated that a person can only be placed under guardianship against his or her will by deprivation of legal capacity established by a court.[5] This is so regardless of whether the person has decision-making competence or not. However, a broad assessment of the person's wishes is not required, and if there is nothing to suggest differently, there is reason to assume that a guardianship is not contrary to the wishes and will of the person.

Studies indicate that in most cases, the mandates of guardians are broad and generic, and not adapted to the needs of the person under guardianship.[6] The mandates often concern both economic and personal matters. In many instances, the county governor does not map the needs of the person, or documentation is lacking on whether the person has been given the possibility to express her or his view.[7]

An additional issue is that many guardians have guardianship for too many persons. In 2017, 32 guardians had guardianship for more than 100 persons, and 325 guardians had

[3] Guardianship Act section 4.

[4] Skarstad, K., 2018. Ensuring human rights for persons with intellectual disabilities? *The International Journal of Human Rights*, 22(6), pp.774–800. Skarstad bases her conclusion on an analysis of all guardianship decisions (in total 167) made by the county governor in Oslo and Akershus in Norway in 2015 concerning adults with intellectual impairment. To ensure verifiability, the results were triangulated with interviews and other national sources.

[5] Legal Opinion issued by the Legal Department, JDLOV-2018-119.

[6] The Auditor General's report on the implementation of the new Guardianship Law. Dokument 3:6 (2017-2018), chapters 4.2.3 and 7.2; Skarstad (2018).

[7] (op cit) Dokument 3:6 (2017-2018), chapters 2.1, 4.2.2-4.2.3; Skarstad (2018).

21-100 guardianships.[8] There is lack of knowledge about how guardians conduct their work in such circumstances. Furthermore, the county governors do not systematically carry out supervision of the guardians. The county governors also lack sufficient knowledge concerning the training of guardians, and most county governors ask for national guidelines on how to carry out supervision of the guardians, how to assess a person's competence to consent and how to ensure individual adaptation of guardianships.[9] The Parliament has decided that national guidelines shall be issued.

Suggested questions:

- Could the State Party submit information on how it will ensure that substituted decision-making is used only as a last resort?
- Could the State Party specify how it will ensure that the mandates of guardians are not broader than necessary and are individually adapted to the needs of persons under guardianship?
- Could the State Party submit information on how it will ensure training of guardians? What steps have been taken to issue national guidelines concerning the supervision of guardians, the competence to consent and individual adaptation of guardianships?

4. Use of coercion and persons with disabilities

4.1. Use of coercion in mental healthcare

Reference is made to the State Report paras. 115-118 and 128-129.

The Government's National Strategy for Increased Voluntariness in the Mental Health Services (2012-2015) did not lead to the desired reduction in the use of coercion.[10] Thus, in 2016 the Government adopted a number of amendments to the Mental Health Care Act and established a Commission for the review of legislation on the use of coercion (Tvangslovutvalget).

The amended Act, Article 3-3, holds that patients with the capacity to consent cannot be treated against their will, except in circumstances when they represent a serious risk to their own life or the health or life of others. The Act also strengthens procedural safeguards, such as extending the time for examination before using forced medication (5 days), free legal aid council (up to 5 hours) when challenging treatment without consent and obliging health professionals to consult with another qualified professional (but not requiring institutionally independent) prior to decision on non-consensual treatment.[11]

[8] https://www.vergemal.no/getfile.php/4126567.2573.wwjpkmwtnsuiui/A%CC%8Arsmelding-vergema%CC%8Al-2017-oppslag.pdf, p. 30.

[9] (op cit) Dokument 3:6 (2017-2018), chapters 2.3-2.4, 4.6, 5.3.2, 7.3-7.4.

[10] CCPR/C/NOR/7 para. 113, submitted in 2017.

[11] CCPR/C/NOR/7 para. 114.

Reports on practice, as documented by the National Preventive Mechanism (NPM) visiting ten different institutions in 2015-2018, [12] emphasise the need to strengthen procedural safeguards for the patients, including more thorough written documentation of coercive treatment and focus on considering less intrusive measures before using force.

Furthermore, the use of coercive electroconvulsive treatment (ECT) in mental health care is of particular concern. There is no clear legal basis in formal law or regulation for the use of non-consensual ECT and the authorities have no complete factual overview on the use of coercive ECT.[13] It is expected that the ongoing legislative review on use of coercion in the health sector, including in mental health care, will address this and other issues. The report of this governmental commission is due in June 2019.

Suggested questions:

- Could the State Party explain what efforts are taken to decrease use of coercive force and prevent unjustified use of coercive force, in particular what efforts are taken to strengthen training of staff, prioritise alternative and less intrusive methods, as well as strengthening procedural guarantees and control?
- Could the State Party explain how they will address the issue of coercive use of ECT?

4.2. Use of coercion and persons with intellectual impairment

Reference is made to State Report paras. 110-114 and paras. 124-125.

The Health and Care Services Act chapter 9 allows the use of coercion and force against persons with intellectual impairment to protect against serious harm to themselves or others and aims to prevent and limit the use of coercion. Coercion and force may be used as a) harm-reducing measures in emergency situations, b) as planned harm-reducing measures in repeated emergency situations, or c) as measures to satisfy the health care user or patient's fundamental needs for food and drink, clothing, rest, sleep, hygiene and personal safety, including training initiatives.[14]

Upon ratification of the CRPD, Norway declared its understanding that articles 14 and 25 of the CRPD "allow for compulsory care or treatment of persons, including measures to treat mental illnesses, when circumstances render treatment of this kind necessary as a

[12] See the website of the NPM: https://www.sivilombudsmannen.no/besoksrapporter/?type_institusjon=psykisk-helsevern&period.

[13] Norwegian Directorate of Health, *"Nasjonal faglig retningslinje om bruk av elektrokonvulsiv behandling – ECT*" (National Guidelines on the Use of Electroconvulsive Treatment – ECT") , June 2017 and visits conducted by the NPM.

[14] Health and Care Services Act section 9-5.

last resort, and the treatment is subject to legal safeguards". In 2016, a governmental commission concluded that the rules on use of coercion and force against persons with intellectual impairment under the Health and Care Services Act discriminate against persons with intellectual impairment because they apply only to persons with intellectual impairment.[15] The commission recommended replacing the rules with general rules, which do not require a diagnosis. Another governmental commission (Tvangslovutvalget) is currently evaluating the rules on the use of coercion in the health sector. The commission's report is due by June 2019.

In practice, the use of coercion and force against persons with intellectual impairment is high and has increased. In 2017, 1503 decisions on planned use of coercion and force were approved.[16] The Norwegian Board of Health Supervision is concerned with the increase in use of coercion and force against persons with intellectual impairment.[17] Furthermore, decisions on the use of coercion and force seem to be weak and to lack explicit considerations of the right of persons with intellectual impairment to self-determination. An examination of 121 coercive-care decisions from 2015 from the County Governor in Oslo and Akershus indicates that the right of persons with intellectual impairment to self-determination is insufficiently protected.[18]

An additional issue is that qualified personnel is lacking. In most cases where coercion or force is used, the measures are conducted by unskilled personnel. Thus, dispensation from the right to qualified personnel when coercion or force is used as a planned measure, seems to be the general rule. In 2017, dispensation from the educational requirement was applied for in 1175 cases. Dispensation was grated in 1093 cases.[19]

Suggested questions:

- Could the state explain the increase in use of coercion and force against persons with intellectual impairment? How will the state counter this trend?
- How will the state ensure more qualified personnel?

4.3. Use of coercion and older persons in nursing homes

Reference is made to the State Report paras. 126-127.

[15] Official Norwegian Report 2016: 17 *På lik linje*, chapters 12.7.1 and 19.

[16] https://www.helsetilsynet.no/globalassets/upload/publikasjoner/aarsrapporter/aarsrapport2017.pdf , p. 13.

[17] (ibid) p. 56.

[18] (op cit) Kjersti Skarstad (2018): Ensuring human rights for persons with intellectual disabilities?, The International Journal of Human Rights, DOI: 10.1080/13642987.2018.1454903.

[19] https://www.helsetilsynet.no/globalassets/upload/publikasjoner/aarsrapporter/aarsrapport2017.pdf p. 56 (table 17).

According to chapter 4 of the Patient's Rights Act, healthcare can only be given with the consent of the patient unless the use of coercion is justified on legal grounds. In 2009, the new provision 4A in the Act came into force. This provision holds that involuntary healthcare can only be justified towards patients who lack decision competence and resist healthcare, in order to avoid serious harm to the patient. It should be noted that approximately 80% of 40,000 residents in nursing homes are diagnosed with dementia and encompassing disabilities.

The Norwegian Board of Health conducted a systemic audit of practices in nursing homes in 103 municipalities in the period 2011-2012.[20] The audit revealed extensive use of coercion contrary to the provisions in Chapter 4A. It also found that the provisions, including guidelines on its implementation, were not well known to healthcare professionals, including the need to adopt a written decision when using coercive treatment.

A thematic report from the former National Institution in 2014 supported this finding and questioned whether the extensive use of forced measures against residents of Norwegian nursing homes was in line with our human rights obligations under Article 8 of the EHCR.[21] The report recommended, among other things, that the authorities undertake a detailed mapping of the problem in consultation with affected individuals. A recent study by Statistics Norway on behalf of NIM, further documented the lack of registration of the use of coercive healthcare.[22] Only half of the municipalities had in 2017 reported on instances of coercive healthcare in spite of the legal obligation to do so since 2009.

Suggested questions:

- What steps will the State take to verify, examine and possibly remedy the extensive use of coercive healthcare against older persons in nursing homes?

[20] "Summary of National Supervision in 2011 and 2012 with Compulsory Health Assistance for Patients in Nursing Homes" from April 2013.

[21] "Thematic report: Human rights in Norwegian nursing homes" (2014), Norwegian Centre for Human Rights at the University of Oslo (NHRI 2001-2015). The report also suggested that documented practices also could be problematic in light of ECHR article 3 and ICESCR article 12.

[22] "Human Rights Situation of residents in nursing homes», B. Otnes, Statistics Norway, Document 2018/28.