

Information to the UN Committee against Torture (CAT)
85th session (16 November – 4 December 2026)
Review of Norway's 9th Periodic Report
CAT/C/NOR/9

Submitted by:

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We Shall Overcome (WSO) is a Norwegian NGO/DPO¹, run by and for users and survivors² of psychiatry, established in 1968. WSO advocates for the human rights of users and survivors of psychiatry, the implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD), and bringing forced psychiatric practices and other infringements in the mental health system to an end. 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 DPO - Disabled People's Organisations are representative organizations or groups of persons with disabilities, where persons with disabilities constitute a majority of the overall staff and board, and are well-represented in all levels of the organization.

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

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1. Introduction

We Shall Overcome (WSO) has prepared the following information to give input to the review of Norway's 9th periodic report to the UN Committee against Torture, 18-19 November 2026.

The submission highlights principal areas of concern regarding disability-specific acts of torture and other cruel, inhuman or degrading treatment in Norwegian law and practice. We welcome this opportunity to address these human rights issues and hope the Committee will take up the questions presented with the Norwegian delegation.

We will have representatives from WSO attending the country briefing on 17 November, as well as the examination 18-19 November. Please do not hesitate to contact us for any further information or questions.

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(..) “Our experiences will mark us for the rest of our lives; and yet we are still here, still standing, still fighting for justice, for reparation and for a world where no one else will have to endure what we have suffered.” (...)³

2. Legal definition and recognition of torture - Art 1

A. Legal definition

The UN Committee against Torture has raised concern that the definition of torture in the Norwegian Penal Code is not in full compliance with article 1 of the Convention since it does not include a reference to “discrimination of any kind”, but enumerate acts based on some specific forms of discrimination.⁴

There is a need to amend the current definition of torture in section 174 of Norway’s Penal Code to include a more comprehensive reference to “discrimination of any kind” as one of the purposes of torture. Furthermore, there is a need for a better understanding of the concept of discrimination in relation to torture. Section 174 of the Norwegian Penal Code includes disability as one of the listed grounds of discrimination. However, there are severe shortcomings in correctly applying the definition of torture in this regard and in recognizing acts and practices that constitute disability-specific forms of torture and ill-treatment.

B. Lack of recognition of disability-based torture

The Committee against Torture has emphasized that the discriminatory use of mental or physical violence or abuse is an important factor in determining whether an act constitutes torture⁵, and that protection of certain minority or marginalized populations especially at risk of torture is part of the States obligation to prevent torture or ill-treatment.⁶

In Norway, persons with psychosocial or other disabilities are especially at risk of torture and other ill-treatment through paternalism, deprivation of self-determination, institutionalization, arbitrary

³ From “Charter of Rights of Victims and Survivors of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment”, A/HRC/61/42, UN Special Rapporteur on Torture, January 2026.

⁴ CAT, Concluding Observations, CAT/C/NOR/CO/8, para 7, and CAT LoIPR, CAT/C/NOR/QPR/9, para 2.

⁵ CAT has stated that “in practice, the definitional threshold between ill-treatment and torture is often not clear” and that “experience demonstrates that the conditions that give rise to ill-treatment frequently facilitate torture (...)”, CAT General Comment 2, 2008, para 3.

⁶ CAT, General Comment 2, 2008, para 20 and 21.

detention, coercive regimes, violent medical interventions and discriminatory legislative exceptions infringing on their fundamental human rights (see Article 2 and 16 below).^{7,8}

The UN Committee on the Rights of Persons with Disabilities list regimes of institutionalization, forced treatment and psychiatric violence as forms of disability-based violence and ill-treatment. The Committee recognizes coercion in mental health as a structural form of disability-based violence that may amount to torture or cruel, inhuman or degrading treatment (..).⁹

There is a need to recognize forms of disability-based violence amounting to torture or ill-treatment, including forced psychiatric interventions, and extend the anti-torture framework to them.¹⁰

Norwegian authorities have not yet made such recognition. The Norwegian government deems psychiatric coercion legitimate and upholds exceptions to free and informed consent. Norwegian health legislation authorizes practices like deprivation of liberty, non-consensual medication and electroshock (ECT), restraints and solitary confinement (see further description of the domestic legislation under Art. 2 and 16 below).¹¹ As such, Norway maintain a system of structural and systemic violence where laws, policies, and practices cause harm to persons with disabilities.

C. Psychiatric coercion fulfilling the requirements of torture

Forced psychiatric interventions are discriminatory acts falling under the definition of Art. 1. Obtaining legal recognition of these serious human rights violations is of crucial importance for achieving prohibition, prevention and redress of such acts.

The UN Special Rapporteur on Torture has stated that;

*“Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment. Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged “best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment”.*¹²

⁷ The European Court of Human Rights acknowledged that persons with psychosocial disabilities are “someone belonging to a particularly vulnerable group in society that has suffered considerable discrimination” (Alajos Kiss v Hungary, 38832/06, 2010, para 42 and Cinta v Romania, 3891/19, 2020, para 41).

⁸ The Council of Europe Human Rights Commissioner states that “Persons with psychosocial disabilities routinely suffer some of the most egregious human rights violations on our continent (...) in particular as a direct result of mental health services themselves displaying a tendency towards paternalism, coercion and institutionalization.”, Amicus Brief, Cliepa and Iapara v. Moldova, 39468/17, 2021.

⁹ The CRPD Committee defines psychiatric violence as “a form of disability-based and structural violence driven by the powers conferred on mental health professionals, including psychiatrists to exercise confinement, segregation and non-consensual interventions (...)”, CRPD, Guidelines on identifying and addressing disability-based violence (2026), CRPD/C/8, para 57, see also paras 57-65, and para 1 and 3.

¹⁰ As recommended by the CRPD Committee in Guidelines on disability-based violence (2026), CRPD/C/8, para 83a.

¹¹ State report 2022, CAT/C/NOR/9, para 185-196.

¹² A/HRC/22/53, 2013, para 64, cf. A/63/175, 2008, paras. 38, 40, 41.

i. Inflicting severe physical and mental pain and suffering

Forced psychiatric interventions inflict severe pain or suffering, both physical and mental. The suffering of the victims of forced psychiatry has been recognized by several UN monitoring mechanisms, including by the CRPD committee who in its General Comment 1 makes reference to “people using mental health systems who have experienced deep pain and trauma as a result of forced treatment”.¹³ Various UN experts have expressed that “overwhelming evidence (..) and growing consensus within the United Nations including the World Health Organization, show that forced admission to medical institutions and coercive treatments in institutions will bring harmful effects such as pain, trauma, humiliation, shame, stigmatization and fear to people with psychosocial disabilities”.¹⁴

The Council of Europe Human Rights Commissioner has stated, in regard to the prohibition of torture and other ill-treatment in the European Human Rights Convention (ECHR Art. 3), that “the commissioner considers that the use of coercion in psychiatry, including for example the use of mechanical and chemical restraint, confinement, isolation and forced medication, should always be considered to reach the minimum level of severity to fall within the scope of Article 3, considering the severe fear, anguish, feelings of helplessness, loss of dignity and other mental suffering they invariably cause (..).”¹⁵

Furthermore, psychiatric coercive regimes contain elements of arbitrary detention, intrusive infringements on physical and mental integrity, powerlessness, inability to escape or resist the infliction of pain and suffering, incapacitating medication and electroshock (ECT), deprivation of legal capacity, coercive control, and elements of psychological torture, including fear, phobia, anxiety, domination, oppression, harm to moral integrity, humiliation, breach of privacy, isolation, segregation, social exclusion, stigma, institutional arbitrariness and emotional manipulation. Factors that in combination is creating a torturous environment.¹⁶ At its core, nonconsensual psychiatry is a highly intrusive and discriminatory attempt at modifying and correcting thoughts, feelings, identity, personality and behavior.

In the State reporting so far, there are no signs that the Norwegian government acknowledge the severe pain, suffering, trauma and irreparable damage to life, health and integrity caused by forced psychiatric interventions. There is an urgent need for recognizing the severity of the harm done and the suffering inflicted on the victims, and for this knowledge and awareness to be implemented in national policies, law and practice. A failure to do so hinders the State party in fulfilling its obligations under the Convention (see below for a more detailed description of different forced psychiatric interventions and suffering inflicted on victims of forced psychiatry in Norway).

¹³ CRPD, General Comment 1, 2014, CRPD/C/GC/1, para 42.

¹⁴ UN Rights Experts call on Council of Europe to stop legislation for coercive mental health measures, 2021, UN CRPD Committee, UN Special Rapporteur on the rights of persons with disabilities, UN Special Rapporteur on health, Special Envoy of the Secretary-General on Disability and Accessibility.

¹⁵ Amicus Brief, Clipea and Iapara v. Moldova, 39468/17, 2021.

¹⁶ The report on psychological torture by the UN Special Rapporteur on torture illustrates how various combinations of methods, techniques and circumstances can form “torturous environments” violating the prohibition of torture, A/HRC/43/49, 2020.

ii. **Intentionally inflicted (..) for any reason based on discrimination**

The UN Special Rapporteur on Torture has elaborated on the requirements of intent and purpose in relation to psychiatric coercion in several reports;

*“The requirement of intent in article 1 of the Convention against Torture can be effectively implied where a person has been discriminated against on the basis of disability. This is particularly relevant in the context of medical treatment of persons with disabilities, where serious violations and discrimination against persons with disabilities may be masked as “good intentions” on the part of health professionals”.*¹⁷

*“The discriminatory character of forced psychiatric interventions, when committed against persons with psychosocial disabilities, satisfies both intent and purpose required under the article 1 of the Convention against Torture, notwithstanding claims of “good intentions” by medical professionals.”*¹⁸

Purposefulness is given when pain and suffering is inflicted with a discriminatory nexus, regardless of purportedly benevolent purposes such as “medical necessity”. Alleged “medical necessity” cannot justify coercive and discriminatory practices such as nonconsensual psychiatric interventions, which target people for alteration of consciousness by intrusive bodily interventions without their free and informed consent.

The Special Rapporteur on torture underscores that practices such as involuntary abortion, sterilization, or psychiatric intervention based on “medical necessity” of the “best interests” of the patient, “generally involve highly discriminatory and coercive attempts at controlling or “correcting” the victim’s personality, behavior or choices and almost always inflict severe pain or suffering”. In the view of the Special Rapporteur, therefore, if all other defining elements are given, such practices may well amount to torture.¹⁹

The Norwegian government attempt to justify psychiatric coercion based on standards such as “lack of decision-making capacity” and “best interest”. Such criteria are fundamentally flawed, inherently discriminatory, and run counter to the equal rights of persons with disabilities to legal capacity, respect for physical and mental integrity and to be free from torture and ill-treatment. Regardless of domestic justifications, forced psychiatric interventions are violations under international law and not lawful acts.

The UN Special Rapporteur on the rights of persons with disabilities concluded after her visit to Norway that (..) coercive mental health interventions are contrary to human rights, and that coercion is not a “necessary evil”, but a failure of the State to ensure its human rights obligations towards persons with disabilities (..).²⁰

¹⁷ A/63/175, 2008, para 49.

¹⁸ A/HRC/22/53, 2013, para 32, cf. A/63/175, paras 47 and 48.

¹⁹ A/HRC/43/49, 2020, para 37, see also A/HRC/22/53, paras 20, 32-35; A/63/175, para.49.

²⁰ UN Disability Rapporteur, Visit to Norway, 2020, A/HRC/43/41/Add.3, para 70.

3. Prevention of torture and other ill-treatment - Art. 2 and 16

A. Legal and institutional framework

We welcome the incorporation of the UN CRPD into Norwegian law as an important step in strengthening the rights of persons with disabilities and the prevention of disability-based torture and other ill-treatment.²¹ Unfortunately Norway has not yet ratified the Optional Protocol to the CRPD.

We regret that Norway has still not incorporated the UN Convention Against Torture into Norwegian law²² and that there are no plans to do so in the future.²³ The lack of incorporation hinders full and effective realization of the rights set forth in the Convention, create difficulties in applying and directly invoking the Convention in court and undermines the right to effective remedies and reparations for violations of the Convention (see Art. 14 below).

The Convention needs to be incorporated with the same status as the UN treaties ICCPR, ICESCR, CRC, CEDAW and CRPD (as well as the European Convention on Human Rights), which are all incorporated into the Human Rights Act.²⁴ In case of conflicting legislation, the treaties incorporated in the Human Rights Act takes precedence over provisions in domestic legislation.

B. Lack of prevention of disability-based torture and ill-treatment

Preventing and prohibiting torture and other ill-treatment begins with correctly identifying applicable norms of international law and recognizing acts and practices falling under the scope of international torture standards, including the Convention Against Torture.

The CRPD articulates the latest human rights standards with respect to persons with disabilities. The UN CRPD Committee has spoken clearly; there can be no legitimate detention in any kind of mental health facility, and forced treatment by psychiatric and other medical professionals is a violation of the right to equal recognition before the law, as well as an infringement of the rights to personal integrity (CRPD art. 17); freedom from torture (CRPD art. 15); and freedom from violence, exploitation and abuse (CRPD art. 16).²⁵

The CRPD Committee recognizes no exception from the absolute ban on forced treatment, including on grounds such as “risk of harm to oneself” or “danger to others” and other key actors at the UN level endorse and support the same approach (...).^{26, 27}

²¹ Incorporated into the Norwegian Human Rights Act, incorporation entered into force January 2026.

²² CAT/C/NOR/CO/6-7, para. 6, and CAT/NOR/CO/8, para 9-10.

²³ State report para 10, as reply to the List of Issues Prior to Reporting, para 3.

²⁴ Law on the strengthening of human rights in Norwegian law, 21 May, No. 30, 1999.

²⁵ CRPD General Comment 1, 2014, para 42, Guidelines on CRPD Art. 14, Guidelines on De-Institutionalization, Guidelines on disability-based violence, Biannual reports, as well as consistently through Concluding Observations.

²⁶ CoE Commissioner for Human Rights, amicus brief, 39468/17, 2021, para 10 and 12.

²⁷ UN Special Rapporteurs on the rights of persons with disabilities, Catalina Devandas-Aguilar, and on the right to health, Dainius Pûras; Call on States to eradicate all forms of non-consensual psychiatric treatment. “Dignity must prevail” – An appeal to do away with non-consensual psychiatric treatment, World Mental Health Day, 10 October 2015. <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16583&LangID=E>

The UN Special Rapporteur on torture has urged States to:

*“impose an absolute ban on all forced and nonconsensual medical interventions against persons with disabilities, including the nonconsensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application (...).”*²⁸

Norway has not yet made the necessary recognition of psychiatric coercion as a form of disability-based ill-treatment that should be absolutely prohibited. Despite decades of critique and concerns from national and international human rights monitoring mechanisms²⁹, Norway insist on maintaining laws, policies and practices that institutionalize and forcibly treat people with perceived psychosocial or other disabilities, and thus systematically violate fundamental human rights, including the right to be free from torture and other ill-treatment. Deprivation of legal capacity, a pre-requisite for coercion and a breach of the right to free and informed consent, is authorized through health legislation and other provisions, including;

The Health and Care Services Act that authorizes use of coercion based on intellectual disabilities.³⁰

The Patients’ and Users’ Rights Act chapter 4A that authorizes compulsory somatic treatments based on functional capacity standards (persons perceived not competent to give consent or refuse treatment; “lack of decision-making capacity”), as well as other provisions of the act authorizing nonconsensual treatments.³¹

The Mental Health Act authorizes deprivation of liberty based on psychosocial disabilities, forced treatments and use of coercive means (see below).³²

C. Coercion in the mental health system – Norway’s reply to LoIPR para 22a

In the CAT List of Issues Prior to Reporting (LoIPR), Norway is asked to provide an update on whether the legislation has been amended to;

- (i) abolish the enforced administration of intrusive and irreversible treatments, such as electroconvulsive therapy³³

²⁸ A/HRC/22/53, 2013, para 89b.

²⁹ Recommendations regarding forced psychiatric interventions have been given by; the Council of Europe Human Rights Commissioner, the UN Committee Against Torture, the UN Human Rights Committee, the UN Working Group on Arbitrary Detention, the UN Special Rapporteur on Torture, the UN Special Rapporteur on Health, the UN Special Rapporteur on Violence Against Women, the UN Special Rapporteur on the Rights of Persons with Disabilities, the UN Committee on the Rights of Persons with Disabilities, and through UPR reviews of Norway, to mention some. Several human rights monitoring mechanisms have urged Norway to end the use of coercion in the mental health system.

³⁰ Act relating to Municipal Health and Care Services, etc. (Health and Care Services Act), Lov-2011-06-24-30.

³¹ Act relating to Patients’ and Users’ Rights (Patients’ and Users’ Rights Act), LOV-1999-07-02-63.

³² Act relating to the Provision and Implementation of Mental Health Care (Mental Health Act), LOV-1999-07-02-62.

³³ CAT refers to E/C.12/NOR/CO/6, paras. 40–41; CRPD/C/NOR/CO/1, para. 26 (a); and A/HRC/WG.6/33/NOR/3, para. 41.

Regrettably, the abolition of enforced administration of intrusive and irreversible treatments such as electroconvulsive therapy (ECT) has not been incorporated into law. In fact, Norway has taken regressive steps in this regard, as further described below.

- (ii) ensure that persons with psychosocial or intellectual disabilities are fully informed about the treatment and measures to be applied, (...), and are given the opportunity to refuse them (...)

As already described, both persons with psychosocial disabilities and persons with intellectual disabilities can be subjected to different nonconsensual interventions and measures in Norway, without having an opportunity to refuse them.

- (iii) and prescribe any derogations to the principle of free and informed consent, (...)

Norway has in its health legislation over the last years, increasingly developed the concept of “lack of decision-making capacity” (person perceived not competent to give consent or refuse treatment) as a condition for nonconsensual interventions (capacity-based model). Such model does not bring domestic legislation in compliance with international human rights norms and the principle of non-discrimination.

Legal capacity is an inherent right accorded to all people, including persons with disabilities.³⁴ Every person is therefore *legally* competent to refuse treatment, and mental health and other treatments should only be provided based on the free and informed consent of the person concerned.³⁵ States cannot restrict the legal capacity of persons with disabilities and must rather protect it against any interference in all aspects of life, including decisions related to medical treatment.

The Norwegian government is conflating legal capacity (a person’s ability to hold and exercise 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 to legal capacity).³⁶ 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.³⁷ 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 “best interest”

³⁴ 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.

³⁵ The CRPD Committee underscore the need for an affirmative consent to mental health treatment; “To prevent forced mental health treatment, affirmative, free and informed expression of consent by the person concerned is required”. CRPD, Guidelines on De-Institutionalization, including in emergencies, para 55.

³⁶ 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.

³⁷ Both the CRPD Committee and the UN Working Group on Arbitrary Detention has stated that 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.” CRPD/C/GC/1, 2014, para 13 and A/HRC/30/37, para 106b (UN Basic Principles and Guidelines on remedies and procedures on the right to anyone deprived of their liberty to bring proceedings before a court, adopted by the Working Group on Arbitrary Detention on 29 April 2015).

determinations.³⁸ Norway's derogations from the principle of free and informed consent are contrary to human rights and a core factor in the systematic ill-treatment experienced by people with disabilities in Norway.

D. Legislative developments of concern

In March 2025, at the UN Human Rights Council, We Shall Overcome (WSO) warned against regressive developments during Norway's Universal Periodic Review (UPR);

“Norway is taking regressive steps with a new law proposal currently being reviewed in the Norwegian Parliament; lowering the threshold for and expanding the use of psychiatric coercion and legitimizing non-consensual use of electroshock (ECT). Use of ECT without free and informed consent of the person concerned is a serious violation of human rights; an intrusive and harmful practice inflicting severe pain and suffering, as well as irreparable damage to the victim's life, health and integrity. Such practices amount to torture and other ill-treatment and should be abolished by law and absolutely prohibited.

*We call on Norway to immediately end the grave and systematic human rights violations of forced psychiatry as a matter of urgency. We especially urge Norway to **not** adopt the new law proposal and to immediately secure legal protection against non-consensual electroshock and other ill-treatment in psychiatry. The state must ensure that all mental health services are provided based on the free and informed consent of the person concerned.”³⁹*

In June 2025 the Parliament adopted a number of amendments to the Mental Health Act and to the Patient's and User's Rights Act that are of grave concern; lowering the threshold for declaring a person incompetent to make decisions (“lack of decision-making capacity”), changing the legal definition of coercion in mental health, opening other legal loopholes to nonconsensual treatments, and legalizing the intrusive and mind-altering practice of nonconsensual electroshock (ECT).⁴⁰

i. Lowering the threshold for declaring a person incompetent to make decisions

The legal threshold for declaring a person incompetent to make decisions and thus carry out medical interventions without free and informed consent, has been lowered from “obviously lacking decision-making capacity” to “most likely lacking decision-making capacity” (more than 50 % likely), lowering the bar for health professionals to restrict peoples legal capacity and expanding the avenue to coercion.⁴¹

³⁸ CRPD GC 1 para 21.

³⁹ Statement for the 58th session of the UN Human Rights Council, for Norway's Universal Periodic Review Outcome, March 2025, on behalf of We Shall Overcome (WSO) Norway, and Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP).

⁴⁰ Amendment Law (No 67, Prop. 31 L), adopted 20 June 2025, entered into force 1 June 2026.

⁴¹ Patients' and Users' Rights Act, para 4-3.

ii. Changing the legal definition of coercion

The legal definition of coercion in the Mental Health Act has been changed from “treatment without consent” to “treatment based on the criteria in § 3-3 of the Mental Health Act” (which is invoked when the person is perceived to “resist” the treatment, see below for a further description of the Mental Health Act). Acts that was previously defined as coercion, will with the new amendments fall outside the scope of the legal definition, including certain nonconsensual interventions. For example, when a person is declared to “lack decision-making capacity” and purportedly does not resist, treatments⁴² can be carried out without a formal decision on coercion and without being classified as coercion by Norwegian law.

As such, statistics on formal decisions on psychiatric coercion could improve with lower numbers, without it reflecting an actual decrease in the use of nonconsensual interventions. It could even lead to masking of an actual increase of such cases. It is the de facto situation of the person, and not the formal and de jure status, that is relevant for determining human rights violations, including ill-treatment, based on lack of free and informed consent. All treatment that is not based on the free and informed consent of the person concerned should fall under the scope of coercion.

Furthermore, a development that is basing the definition of coercion on a requirement of active resistance by the person, instead of lack of consent, is a regressive step and contrary to developments in other areas of law protecting bodily integrity. While victims of gender-based violence have experienced a strengthening of the legal definition of rape in the Norwegian Penal Code by grounding it in lack of consent, victims of disability-based violence now experience the opposite; a weakening of the legal definition and a weakening of the protection against bodily infringements.

iii. Opening new legal pathways to nonconsensual treatments

The legislative amendments introduce nonconsensual treatment of “persons with serious mental disorders”, without a formal decision, in cases where the person is declared to “lack decision-making capacity” and is deemed not to resist the treatment.⁴³ This opens a whole new avenue of nonconsensual treatments outside the governments control and oversight.

It lies within the nature of being declared to “lack decision-making capacity” and subjected to a system with extensive power to use coercion, including physical force, that a person experiencing this would feel powerless, and might not express resistance. The fear of formal decisions, physical violence and exaggerating use of coercion could lead to submission or being paralyzed. Perceived lack of resistance cannot be interpreted as confirming anything about the persons will and preferences.

⁴² Electroshock (ECT) is the only exception specifically listed as not permissible under these provisions, but ECT can be administered nonconsensually based on the provisions in the Mental Health Act)

⁴³ Pasients’ and Users’ Rights Act para 4-6 cf. para 4-3

iv. Legalizing the intrusive and mind-altering practice of nonconsensual electroshock (ECT)

Before the new amendments to the Norwegian Mental Health Act, the administration of electroshock (ECT) was not permitted without informed consent. However, ECT without informed consent was still practiced and accepted by the authorities. It was then carried out according to the "principle of necessity" and purportedly justified to prevent (serious) damage to life and health. With the new amendments ECT can legally be carried out without the consent of the person concerned, if the person is declared to "lack decision-making capacity", purportedly does not resist and ECT is deemed necessary based on certain criteria.⁴⁴

Use of ECT without free and informed consent is a serious violation of human rights amounting to torture and other ill-treatment and should be absolutely prohibited. Instead of taking the necessary legislative measures to prevent these acts and abolish nonconsensual ECT by law, Norway has legalized this form of ill-treatment.

E. The Mental Health Act

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

i. Deprivation of liberty in mental health facilities

Persons with perceived psychosocial disabilities in Norway are subjected to imposition of preventive detention for public safety reasons, and paternalistic detention said to be in the person's best interest. Such regimes are not typically imposed on the general population and would rightly be resisted as arbitrary, vague and detrimental to civil liberties if they were.

Thousands are detained in Norwegian mental health facilities each year, locked up for indefinite time and segregated from society.⁴⁵ Involuntary confinement in psychiatric institutions is traumatizing and harmful in itself, and has been recognized as a form of torture and ill-treatment.⁴⁶

Detention based on mental health grounds constitutes adverse treatment targeted at persons with psychosocial disabilities, depriving us of the right to enjoy liberty on an equal basis with others. Involuntary commitment in mental health services is always discriminatory as it is based on actual or perceived impairment ("serious mental disorder"), and it amounts to arbitrary deprivation of liberty.⁴⁷ The UN Convention on the Rights of Persons with Disabilities sets forward an absolute ban on deprivation of liberty based on impairment or health grounds.⁴⁸ This includes where there are

⁴⁴ § 4-4 b; ECT without consent of the person concerned.

⁴⁵ Official statistics indicate around 9400 involuntary admissions in 2022 (these are the most recent statistics made available by the health authorities). However, the quality of national reporting is not satisfactory, and complete data does not exist.

⁴⁶ 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.

⁴⁷ CRPD GC 1, Guidelines art. 14 para 6.

⁴⁸ CRPD Guidelines art. 14, para 6, 8, 10.

additional criteria used to justify the detention, including alleged need for care or treatment or deemed dangerous to self or others.⁴⁹

Contrary to this, the Norwegian mental health legislation authorises administrative deprivation of liberty based on psychosocial disabilities (“serious mental disorder”) combined with the additional alternative requirements “need for care and treatment” or “danger to self or others”.⁵⁰ 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 decision-making capacity, cf. the Patients’ 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.”⁵¹

Deprivation of liberty based on these criteria, irrespective of whether there are due process guarantees and legal safeguards, constitute 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”.

ii. Forced treatments

Involuntary treatments in mental health services violate a number of fundamental human rights, including the right to be free from torture and other ill-treatment. Violent medical practices like forced electroshock, forced drugging, restraint and solitary confinement constitute discriminatory and harmful interventions that can cause severe pain and suffering, as well as deep fear and trauma, in its victims.

⁴⁹ Ibid, para 13.

⁵⁰ Mental Health Act No. 62 of 2 July 1999 section 3-3, see also sections 3-2 and 4-4 on compulsory observation and forced treatment.

⁵¹ These are the central criteria for deprivation of liberty through the Norwegian Mental Health Act, see additional conditions (in Norwegian); https://lovdata.no/dokument/NL/lov/1999-07-02-62/KAPITTEL_4#KAPITTEL_4

The UN Special Rapporteur recognized that non-consensual psychiatric treatment meets the criteria for torture or other ill-treatment,⁵²

*“Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment.”*⁵³

Administration of neuroleptic drugs against a person’s will, the impact on consciousness, physical and mental capabilities, and physical sensations amounts to severe pain and suffering that, given the discriminatory motivation (which is sufficient alone but is nevertheless often combined with purposes relating to coerced change of behavior or punishment) satisfies the criteria for torture.⁵⁴

Forced medication

Forced medication is administered in hospitals and on an out-patient basis. The number of persons subject to a formal decision on forced treatment increased by 90 % between 2018 and 2022. From 2022 there are no data on how many persons that are subject to forced medication in Norway, or how long they are forcibly medicated (see below under Art. 11).

The lack of data on formalized decisions is only part of the problem to record the scope of coerced medication. Formal decisions regarding forced medication do not show the full scope of coerced medication. Research and personal testimonies show that the line between forced medication and voluntary medication is blurred. People report the threat of force, pressure, fear of additional punishment (detention, seclusion and/or physical restraints) and lack of known options as reasons for “complying” with taking medication. Such occurrences would not be registered as forced or non-consensual drugging even before the changes in the legal definition of coercion. All treatment under detention should be deemed nonconsensual as *free* consent could not be determined under such circumstances; deprived of liberty and under the control of the psychiatric institution. In fact, there is no right to free consent at all in a system that is equipped with so much legalized powers of coercion.

“I was pressured to take two injections of ZypAdhera (antipsychotics). I felt that if I didn’t, they would keep me there until I cooperated.”

“I was threatened with forced medication. No formal decision was made since I chose to take the pills myself. I didn’t really have a choice, so in reality, it was forced medication. They didn’t follow up with blood tests, so they failed to detect that I developed diabetes from the medication. The hospital has apologized profusely for this.”

⁵² UN Special Rapporteur on torture, interim report, Protecting Persons with Disabilities from Torture, A/63/175, 2008, paras 38, 40, 41, 47, 61-65; UN Special Rapporteur on torture, Applying the torture and ill-treatment protection framework in health-care settings, A/HRC/22/53, 2013, paras 81 and 89.

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

⁵⁴ Tina Minkowitz, The United Nations Convention on the Rights of Persons with Disabilities and the right to be free from nonconsensual psychiatric interventions, Syracuse Journal of Law and Commerce, Vol. 34, No. 2, 2007.

The pain and suffering inflicted on the persons that are subject to forced medication has been reported through personal testimonies and research. Psychotropic drugs, particularly neuroleptics can cause serious long-term effects, such as drastic weight gains, metabolic syndromes, diabetes, heart disease, neurological damage, akathisia⁵⁵, brain shrinkage, etc.⁵⁶ Common effects reported are that thoughts, feelings, experiences, and the ability to initiate change is affected, neuroleptics act as a “universal brake” on mental function. Many patients describe such medication as a “chemical straitjacket”. The harmful effects include an increase in sudden death and total mortality rate, and shortened lifespan.⁵⁷

In a qualitative survey from 2026, conducted among WSOs members, the experience of being forcibly medicated is consistently described as traumatic, threatening, intrusive, frightening, humiliating, numbing, exacerbating, and life-ruining. Terms such as violence, terror, and torture are used.⁵⁸ Forced medication is often also accompanied by other coercion, such as holding and use of restraints.

“Then the nurse grabbed me and slammed my head against the wall. The next thing I know, I’m being pinned to the floor and my arm is being bent behind my back. I’m screaming, shaking, and trembling, and they take me to a restraint bed, where I’m strapped in. This is especially traumatic since I have claustrophobia.”

“Nothing but pain. I lost myself and the chance to recover. I also experienced many severe side effects. However, they were not life-threatening. The symptoms did not go away. I was not respected even though I argued my case well, using facts and references.”

The findings from the WSO survey corresponds with earlier findings from The National Preventive Mechanism (NPM) who has documented during their visits that patients who were forcibly medicated mostly had negative experiences that were described as “horrible”, “cruel” and “torture”. Several patients showed unpleasant adverse reactions such as headache, apathy and weight gain, as well as increased symptoms of hallucination and confusion. Other findings were loss of trust in the staff after forced medication, pressure to consent to medication to avoid forced medication or other sanctions.⁵⁹

A large part of WSOs members is, or have been, subject to forced medication, and live with

⁵⁵ Akathisia – a combined physical and mental anguish and movement disorder, inability to sit still.

⁵⁶ Food and Drug Administration (FDA). Package inserts and medwatch safety alerts on antipsychotics; <http://www.fda.gov>. Bentall, R, & Morrison, A. (2002). More harm than good: the case against using anti-psychotic drugs to prevent severe mental illness. Journal of Mental Health, Volume 11(4), pp. 351-356; Read, J., Mosher, L.R. og Bentall, R.P. (2004). Models of madness. London: Routledge; Whitaker, R. (2010). Anatomy of an epidemic. Magic bullets, Psychiatric drugs, and the Astonishing Rise of Mental Illness in America; Peter Breggin. (2008). Brain-disabling Treatments in Psychiatry: Drugs, Electroshock, and the Psycho pharmaceutical Complex. Springer Publishing Company, New York.

⁵⁷ Parks J., Svendsen D., Singer P., editors. (2006). Morbidity and mortality in people with serious mental illness. Alexandria: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council; Gale C. R., Batty G.D., Osborn D.P., Tynelius P., Whitley E., Rasmussen F. Association of mental disorders in early adulthood and later psychiatric hospital admissions and mortality in a cohort study of more than 1 million men. Arch Gen Psychiatry. 2012 Aug, 69(8):823-31; Ray, W., and Meador, K.(2002). Antipsychotics and sudden death. British Journal of Psychiatry, Volume 180, pp. 483-484;

⁵⁸ Hjelp og skade i psykisk helsevern - i lys av CRPD (Help and Harm in the mental health system – in light of the CRPD). WSO, 2026. <https://wso.no/wp-content/uploads/2026/08/Elektronisk-WSOs-erfaringsundersokelse-2026-ferdig.pdf>

⁵⁹ NPMs reports after visits to Sørlandet Hospital and Akeshus University Hospital.

the serious consequences. One member described his situation like this⁶⁰:

“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 describes 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.”⁶¹

Medication-free services

Since 2022 there has been a huge reduction in the few medication-free treatment options that exist, allegedly due to reorganization. The government has chosen not to intervene in this process, despite protests from people using the services and research that show the benefits of the medication-free places. The option to choose medication-free treatment is not available for most people in the mental health system.

Electroshock (ECT)

Electroshock is a highly intrusive, controversial and potentially irreversible and harmful procedure. It is a psychiatric method causing a generalized epileptic seizure by passing electrical current through the person's brain. It is carried out under anesthesia.

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

⁶⁰ 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/>

⁶¹ Testimony given at the side-event «Violence against Women and Girls with Disabilities – Intersectional and Double Violence in Medical and Institutional Settings”, 19 August 2015 Palais Wilson.

NPM findings also show that consent not always is free and informed; “There was nevertheless findings from different sources, including interviews with patients, that raised the concern if the consent to ECT was given fully voluntary, and whether consent was collected with too much persuasion. Several of the patients had problems to recollect anything about the circumstances around the ECT treatment.”⁶²

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

“(..), it is of vital importance that ECT be administered only with the free and informed consent of the person concerned, including on the basis of information on the secondary effects and related risks such as heart complications, confusion, loss of memory and even death.”⁶³

There are no official statistics on the extent of the use of forced ECT, nor ECT administered with informed consent. There are, however, clear indications that the use of ECT has increased substantially over the last two decades.⁶⁴

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

«Electroshock is a violent intervention both physical and mental. (..) Loss of memory and cognitive function is common. Our members testifies about personality change, loss of memories, loss of cognitive function and ability to store new memories. We testify of lost lives. For me the most serious effect was loss of vocabulary for speaking and writing, problems with concentration, problems with learning and storing information. (..) For many people the damage is greater than what I experienced; the total loss of memory from your former life; of giving birth to your children, of getting married, of your education and work competencies, of your friends and family. To have 1- 5 - 25 years of your memory erased by electroshock....”⁶⁵

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

“It took many years before I understood the extent of the damage. I lost belonging, identity, I sort of don’t know where I am. It is terribly hard to cope with. I feel like I don’t belong anywhere, because I don’t have any belonging to things, it is a huge void. To create a future you need to know your past.”⁶⁶

⁶² NPM report on visit to Akershus university hospital, 2017.

⁶³ UN Special Rapporteur on torture, A/63/175, 2008, para 61.

⁶⁴ Medicine of today. 18.05.12. <http://www.dagensmedisin.no/nyheter/mener-flere-bor-fa-elektrosjokk/>

⁶⁵ Testimony given by chair of WSO, Mette Ellingsdalen; During the 14th CRPD session, side-event on “Violence against Women and Girls with Disabilities –Intersectional Violence in Medical and Institutional Settings”, 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-networkof-users-survivors/>

⁶⁶ <https://www.vg.no/nyheter/innenriks/psykisk-helse/vg-avsloerer-ga-elektrosjokk-166-ganger-utenpasientenes-godkjenning/a/24150018/>

iii. Coercive means

Physical restraints

The widespread use of mechanical restraints has been well known to the government from before the last reporting cycle, without proper action taken. The national preventive mechanism (NPM) has for many years in their findings documented that the use of physical restraints is widespread, used beyond the criteria of emergency situations, used as a preventative measure and used for prolonged periods.

In 2019, a law committee suggested to phase out the use of mechanical restraints over a period of three years.⁶⁷ This suggestion has not been followed up by the government.

NPM has in 2025-2026 conducted five visits to hospitals with a main focus on mechanical restraints. All the reports have similar findings; widespread and prolonged use of mechanical restraints (from many hours to days and weeks). There are also several examples of the use of spitting masks/towels over the patients face. The Supervisory Commission (kontrollkommisjonen) is failing to exercise sufficient control and has not stopped use of mechanical restraint.⁶⁸

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.⁶⁹

Isolation/Shielding

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

⁶⁷ https://www.regjeringen.no/no/dokumenter/nou-2019-14/id2654803/?_ga=2.203850832.1984254191.1695216060-1761104567.1695216059

⁶⁸ https://www.sivilombudet.no/besoksrapporter/?page=1&sok=&institution_type=psykisk-helsevern&period=

⁶⁹ 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.

The NPM has documented that segregation can in practice be isolation⁷⁰. Our members have for years described their experience with shielding as isolation. They describe the lack of contact with other patients, the experience of punishment, the fear of showing emotions that can lead to more force and the deprivation of stimulance as ill-treatment and torture.

4. Systematic review – Art. 11

A. Lack of data and oversight

In the List of Issues Prior to Reporting the Committee has asked for detailed and disaggregated statistical information on the use of mechanical and chemical restraint, electroshock (ECT), seclusion and shielding, as well as data on the number of persons with psychosocial disabilities confined against their will in psychiatric hospitals.⁷¹

As acknowledged by the state, there has been an increase in the formal decisions on compulsory admissions to mental health facilities and use of coercive measures.⁷² There has also been an increase in formal decisions on forced treatment.

Between 2018 and 2022 there has been a significant increase in formal decisions on compulsory admissions, compulsory out-patient treatment and forced medication.⁷³

In 2022 (data on people 18 years or older):

- 9401 formal decisions on compulsory admission, an increase of 16 % from 2018.
- 3166 formal decisions on compulsory out-patient treatment, 29 % increase from 2018.
- 3768 formal decisions on forced treatment, an increase of 91% from 2018.

There is no available data on the use of coercion from 2023, 2024 and 2025. According to the Norwegian Directorate of Health this is due to changes in the way the data is collected.

However, data from complaints on forced admissions and forced medication indicate that the use of coercion has continued to expand also during those years.

⁷⁰ The Norwegian NPM's submission to the UN Committee against Torture's 63rd session – Information regarding the Norwegian Government's implementation of the Convention.

⁷¹ CAT LoIPR paras 22c and 23.

⁷² State report para 192.

⁷³ Norwegian Directorate of Health, data on compulsory admission and treatment;

<https://www.helsedirektoratet.no/statistikk/samdata-spesialisthelsetjenesten/psykisk-helsevern-behandling-uten-eget-samtykke>

Numbers for the formal use of coercive means can be found here;

<https://www.helsedirektoratet.no/statistikk/kvalitetsindikatorer/psykisk-helse-for-voksne/tvangsmiddelbruk-i-psykisk-helsevern-for-voksne>

In 2022, the number of complaints from people subject to formal decisions on forced treatment was 1659 (44%). In 2024 the number of complaints was 1972.⁷⁴ This could indicate that the number of formal decisions on forced treatment could be above 4400 in 2024.

There is a similar growth in the number of complaints on forced admission, from 2294 in 2018 to 3474 in 2024.⁷⁵

	2018	2019	2020	2021	2022	2023	2024
Number of complaints on forced treatment	1202	1302	1448	1624	1659	1808	1972
Number of complaints on forced admission	2294	2422	2564	2849	3065	3166	3474

It is deeply concerning that the government has stopped monitoring (formal) use of coercion, while the numbers are expanding gravely.

The quality of national statistics reporting is not satisfactory. Complete and reliable data on involuntary admissions, non-consensual treatments and use of coercive means do not exist. The authorities lack complete and reliable data to accurately assess the scale of the problem and to develop effective legal and policy responses, including reparation mechanisms for the many victims.

5. Investigation and the right to complain – Art. 12 and 13

A. Lack of prompt and impartial investigations

People subject to forced admission can make a complaint to the Supervisory Commission (kontrollkommisjonen) and people subject to a formal decision on forced treatment can complain to the State administrator (statsforvalteren). But these mechanisms oversee criteria for use of coercion in the domestic legislation and are not adequate mechanisms for investigating violations of the Convention. In general, there are few signs of any meaningful investigation related to cases concerning psychiatric coercion. Not even when such cases are brought to the attention of the Norwegian government by UN monitoring mechanisms.

On several occasions Norway has 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, the UN Special Rapporteur on Violence against Women and the UN Special Rapporteur on the rights of persons with disabilities.⁷⁶ There are no signs that any of these Urgent Appeals have led to effective investigations or provided the victims with redress.

⁷⁴ <https://www.helsedirektoratet.no/rapporter/kontroll-av-tvangsbruk-i-psykisk-helsevern-2024/statsforvalternes-behandling-av-klager-pa-vedtak-om-behandling-uten-eget-samtykke>

⁷⁵ <https://www.helsedirektoratet.no/rapporter/kontroll-av-tvangsbruk-i-psykisk-helsevern-2024/kontrollkomisjonenes-saksbehandling-i-2024/klager-pa-vedtak-om-tvungen-observasjon-og-tvungen-psykisk-helsevern>

⁷⁶ 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

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

In the last Urgent Appeal, the UN Special Procedures mandate holders states 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 (...) and the provisions of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (..)”.⁷⁷

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

In Norway’s reply to the UN mandate holders, the Government dismiss the case by stating that it “fails to see that this case requires it to take particular measures and that it warrants an urgent appeal to Norway”, without any sign of initiating a prompt and impartial investigation as obligated by CAT articles 12 and 13.⁷⁸

Mr. X remained under forced psychiatric interventions, including nonconsensual neuroleptic medication, for years after the Urgent Appeal.

Meaningful and effective investigation and review of torture and other ill-treatment in relation to use of coercion in the mental health system are persistently jeopardized as long as these practices are accepted by the state authorities and authorized by law.

In a later follow-up letter from the UN Special Rapporteur on the rights of persons with disabilities, the rapporteur underscores that “(..) there is consensus that certain involuntary mental health practices, (...), may amount to cruel, inhuman or degrading treatment or torture (....)” and that “torture, as the most serious violation of the human right to personal integrity and dignity, poses an immediate obligation on States to enforce national laws and frameworks to combat and prevent its occurrence”. The rapporteur urges Norway to “immediately discontinue these coercive practices and replace them with human rights-based responses (..) and states that a “failure to take immediate measures towards such a change is no longer acceptable (.....)”.

B. Lack of effective complaint mechanisms

Victims of psychiatric coercion in Norway experience having few places to turn to for their human rights complaints, including allegations of torture and other ill-treatment. Neither the National Human Rights Institution (NHRI) nor the National Preventive Mechanism (NPM) have within their mandates the ability to support individual survivors of torture. Having to bring the complaint, by yourself, to court for judicial review creates a high barrier for access to justice for survivors of psychiatry alleging ill-treatment (see under Art. 14 for examples from the judicial system).

⁷⁷ Urgent Appeal; <https://spcommreports.ohchr.org/TMResultsBase/DownloadPublicCommunicationFile?gId=22955>

⁷⁸ Norway’s reply; <https://spcommreports.ohchr.org/TMResultsBase/DownloadFile?gId=60255>

6. Right to effective remedies and reparations – Art. 14

People subjected to psychiatric coercion face several barriers to access to justice in Norway and domestic remedies are systematically failing. When ill-treatment is carried out in the name of medical treatment, authorized by domestic legislation and enforced by national law, then there is no real protection or access to effective remedies. There is no redress for victims, no accountability for perpetrators. The ill-treatment goes with impunity. 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.

Though there seem to have been some positive developments, including an increased awareness and use of the CRPD, there is still a long way to go before non-discrimination principles are correctly and fully implemented by the judiciary in forced psychiatry cases and victims are given effective repair.

A. Lack of effective remedies – examples from recent court cases

Two recent court cases illustrate the victim's barriers to justice and the lack of effective reparation;

In September 2021, a woman, IME, brought her case to the Oslo District Court. She had been detained in psychiatric institutions 11 times from 1988 to 2016, forcibly medicated with neuroleptic drugs and subjected to seclusion ("shielding") and isolation. The claim was that the forced treatment and use of coercive means was in violation of CAT, ICCPR, CRPD, the European Human Rights Convention, and the Norwegian Constitution, including the prohibition of torture and other ill-treatment.

In October 2021 another woman, MN, brought a similar case to the same court. MN had been detained in psychiatric institutions 4 times from 1993 to 2015, forcibly medicated with neuroleptic drugs and subjected to seclusion ("shielding") and mechanical restraints. The allegations were violation of the same human rights provisions as in the case of IME. Both women claimed compensation and the cases were later merged by the court for a joint trial.

The claims of violations of CAT (and CRPD, which at the time was not yet incorporated in Norwegian law) were dropped during the proceedings due to procedural barriers and difficulties in directly invoking claims of violations of the Convention in Norwegian courts.

The state further argued that the claim for a declaratory judgment on human rights violations should be dismissed due to lack of legal interest and that the compensation claims should be dismissed based on, among other things, statute of limitations ("obsolete claim"). As a part of the attempt to have the cases completely dismissed, the state argued that the two women had no legal interest in getting a court decision on the human rights violations, that the case was not of principal importance and that a court decision regarding acts that had happened in the past would nevertheless not give guidance on how the treatment would be in the future.

In July 2022, the Oslo District Court ruled in favor of the State, dismissing the claims for a declaratory judgment on human rights and acquitting the State of the compensation claims.⁷⁹

The court concludes that a judgment will not bind future decision-makers (psychiatrists, psychologists) on how future treatment should be carried out.⁸⁰ As such, both the state and the court ignore an important part of reparations; the victims right to non-repetition. For victims of psychiatric ill-treatment it is disheartening to witness the state and the court claiming that not even a judgment declaring that the treatment constituted a violation of the prohibition of torture and other ill-treatment will grant you protection against future recurrence of the same acts.

The two women appealed the decision to the Borgarting Court of Appeal, which, in its ruling of May 2023, rejected the appeal.⁸¹ The cases were brought to the Supreme Court, which, by decision of September 2023, denied leave to appeal on the compensation part. Thus, the decision declaring the rejection of the compensation claims became final and binding (a complaint has been sent to the European Court of Human Rights).

In May 2024, the Supreme Court decided that the claims for a declaratory judgment should be tried but only for the allegations of violations of the European Convention on Human Rights Art. 3 (torture and other ill-treatment) and 8 (right to respect for private life) and the ICCPR Art. 7 and 17, and only for the use of psychiatric coercion from 2013 and later (Norway ratified the UN CRPD in 2013).⁸² The rest of the case is dismissed. The cases are then sent back to the District Court to start over again, this time on the substance of the cases.

In June 2024, woman MN withdraws her case due to the severe strain caused by fighting for access to court for almost 3 years. She never gets to have her case tried in substance and her testimony was never fully heard by the court. We bring her voice forward with a poem she wrote about her experiences with forced psychiatry;

here I am
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

⁷⁹ Oslo District Court 22 July 2022, Case No. 21-123219TVI-TOSL/03 and 21-146772TVI-TOSL/03

⁸⁰ Ibid pages 10 and 22.

⁸¹ Borgarting Court of Appeal 16 May 2023, Case No. 22-146292ASD-BORG/02.

⁸² Supreme Court 3 May 2024, HR-2024-826-A.

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

Poem by woman MN.

Woman IME continues the case and Oslo District Court rules in favor of the State in January 2025 and finds no violations of human rights.⁸³ IME appeals once again to the Borgarting Court of Appeal. Woman IME explains to the court that the forced drugging with neuroleptics caused her severe physical and mental pain and suffering, humiliation, fear and a feeling of inferiority. She describes how she was lifted onto a couch and held down by several men, before they pulled her pants down and injected her. She says that the forced drugging resembled an earlier experience of being raped.

“To me, forced medication is physical violence.
I’m pinned down, four or five people hold me down,
one pulls down my pants and gives me the injections.
It’s also psychological violence because I turn into a zombie,
I lose myself and my own ability to recover when on neuroleptics.
Every injection is like being raped while drugged!”⁸⁴

Woman IME.

From the court summary one can read that in her medical journal it is described a persistent and intense resistance towards neuroleptic drugs, based on the negative effects of the drugs and due to a rape, that was committed against her while she was under the influence of neuroleptics.⁸⁵ This was written in her medical journal in 1994 and despite this she was forcibly drugged with neuroleptics for years to come.

In January 2026 the appeal court finds that the forced medication violated the prohibition of torture and other ill-treatment (ECHR Art 3 and ICCPR Art 7), as well as the right to private life (ECHR Art 8 and ICCPR Art 17). The court also finds violations of the right to non-discrimination (ECHR Art 14 in conjunction with Art. 3 and 8, and ICCPR (Art. 26 in conjunction with Art 7 and 17)). Finally, the court concludes that also use of isolation violated ECHR Art. 3 and 7 and ICCPR Art. 7 and 17.⁸⁶ The decision is final.

These cases demonstrate how difficult it can be just to get such cases tried (in substance) in court. It took almost 3 years to gain access to court. The State battled the victim of ill-treatment all the way to the Supreme Court with the aim of having the case dismissed based on “lack of legal interest” and the

⁸³ Oslo District Court 21 January 2025, Case No. 21-123219TVI-TOSL/03.

⁸⁴ IME, Søkelyset 43, 2021.

⁸⁵ Borgarting Court of Appeal, Case No. 25-042941ASD-BORG/02, page 60.

⁸⁶ Borgarting Court of Appeal, Case No. 2026, 25-042941ASD-BORG/02.

case risked not even being tried in substance before the victim were defeated. One of the women never had her case examined by the court as a cause of this. The other women had to start all over again, back in the District Court, where she lost again and had to appeal again to the Appeal Court for the second time. It took almost 5 years and 5 rounds in court to have the human rights violations acknowledged by the judiciary.

Very few victims of psychiatric coercion would have the opportunity to go through such a process, taking an enormous toll on persons who are already been harmed by the state. Such process also takes a huge amount of resources, in this case of lawyers working pro bono⁸⁷, while the State has all the resources needed at the office of the State Attorney⁸⁸ (inequality of arms). These cases also come with severe economic costs and risk to the victims, in a worst-case scenario they might end up having to compensate the State (the State's case expenses) for the coercion/ill-treatment they endured, if the court does not rule in their favor. These cases are almost impossible to do without pro bono lawyers and external funds that can cover additional expenses.

B. Lack of reparations

In the above cases both women are rendered completely without compensation or any other reparations from the state, which demonstrates lack of redress. For woman IME, it is 38 years since she was first subjected to forced psychiatric coercion and the court has concluded that she was subjected to violations of the prohibition of torture and other ill-treatment, and still these serious human rights violations are not repaired by the State.

Redress should include the five forms of reparation; restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition.⁸⁹ Guarantees of non-repetition should include taking measures to combat impunity, prevent future acts, and reviewing and reforming laws contributing to or allowing these violations. As the cases above demonstrates, none of these reparations have been fulfilled.

In May 2022, a third woman, HW, brings her case to court. She had been deprived of liberty in psychiatric facilities for many years and subjected to extensive neuroleptic medication without free and informed consent. Formal decisions on the use of mechanical restraints were made 67 times and she spent 152 hours and 45 minutes strapped to a bed with belts. She experienced severe harmful effects of neuroleptics, including drooling, shivering, incontinence, cognitive reduction and extensive weight-gain.⁹⁰

As in the case of IME, woman HW had previously been subjected to rape and the psychiatric coercion resembled such assault. She explains in court that being held by staff ("manual control") gave her

⁸⁷ The International Commission of Jurists – Norwegian section (ICJ-Norway), has provided legal aid and third-party interventions in these cases through an established pro bono project litigating human rights cases concerning forced psychiatric interventions.

⁸⁸ These cases are normally handled by the Attorney General for Civil Affairs (Regjeringsadvokaten).

⁸⁹ Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violation of International Human Rights Law adopted by the General Assembly in resolution 60/147 (2005).

⁹⁰ Romerike and Glåmdal District Court 16 July 2026, Case No. 22-065393TVI-TROG/TLST, page 2.

flashbacks of earlier sexual abuse. She explains that she was subjected to mechanical restraints for natural feelings such as being sad, lonely or generally having a difficult time, and that the bed with the belts on several occasions was placed in her room so that it could stand there as a constant threat.⁹¹

“This was not a life, but merely an existence.”

*Woman HW*⁹²

The claim put forward was that the deprivation of liberty, seclusion (“shielding”), use of mechanical restraints and manual control violated the European Human Rights Convention, including the right to liberty (ECHR Art. 5), the right to private life and family life (ECHR Art. 8) and the right to be free from torture and other cruel, inhuman or degrading treatment (ECHR Art. 3). Woman W put forward a claims for a declaratory judgment on the human rights violations, as well as a compensation claim.

Also in this case, the State tries to have the claim for a declaratory judgment on human rights violations dismissed based on “lack of legal interest”. Unfortunately, this has been a typical response from the state in these cases, which makes it more difficult for victims of ill-treatment to get their cases examined by court, and have the human rights violations acknowledged and redressed.⁹³ In the judgment of July 2026, the district court dismiss the claim for a declaratory judgment but rules in favor of HW on the right to compensation and grant her 4.5 million Norwegian kroner (approximately 430 000 Euro) for 7 years and 3 months illegal deprivation of liberty and degrading treatment in the form of mechanical restraints and medication, as well as a breach of right to family life (human rights violations being reviewed prejudicially by the court).

The state has appealed and the case is therefore not binding.

The cases above are examples of serious violations of human rights in the Norwegian mental health system, including violations on the prohibition of torture or other ill-treatment. The lack of reparations from the Norwegian State are unacceptable.

Victims of forced psychiatry experience a systemic lack of redress and structural impunity. Coercive mental health practices represent patterns of violence against persons with psychosocial disabilities and there is a need for reparation on a collective, as well as an individual level. The state should develop procedures for redress covering all victims of forced psychiatric interventions.

⁹¹ Ibid page 24.

⁹² HW, Toppmøtet 2019.

⁹³ Romerike and Glåmdal District Court 16 July 2026, Case No. 22-065393TVI-TROG/TLST, page 8.

7. Violence against Women

A. Intersectional violence based on gender and disability

Various research show that a large number of women and girls in psychiatric units has experienced violence or abuse earlier in their lives. When the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) did a mapping of an acute psychiatric ward they found that more than half of the patients were victims of sexual abuse.⁹⁴

Violence against women, and womens' reactions to such violence, often become an entry point to coercive psychiatric measures. Instead of having the abuse addressed, the women are given a psychiatric diagnosis. Labelling of women's reactions to violence with psychiatric diagnoses mask violence against women and create a basis for mental health detention and forced treatment. This also creates invisibility and denial of injuries, both from the original assault and from the psychiatric coercion. There is a failure in providing appropriate support services for victims of gender-based violence⁹⁵ and a failure in providing protection against psychiatric violence (disability-based violence), as also the court cases above are examples of.

The CRPD committee has expressed concern about the use of non-consensual practices in psychiatric hospitals and institutions such electroconvulsive therapy, straps or belts, solitary confinement and drug treatment and the fact that some of these practices are used more on women.⁹⁶ Some practises can be especially re-traumatizing for women with previous experience of sexual or other violence, like for example to be put in restraints or being held down, while your underwear is pulled away to forcibly inject you with psychotropic drugs.

Forced psychiatric interventions has been recognized as a form of violence against women⁹⁷, and should be addressed as a form of intersectional violence practiced against women and girls with disabilities.

B. Nonconsensual sterilization of women with disabilities

According to Norwegian law, sterilization requires consent from a legal guardian when a person is deemed to have "a serious mental disorder or serious intellectual disability or serious mental impairment", and a legal guardian can apply for sterilization without the person's consent when the person is deemed not able to make a decision about the intervention.⁹⁸

⁹⁴ Study is cited in a white paper to the Parliament; Meld. St. 15 (2012-2013). Forebygging og bekjempelse av vold i nære relasjoner.

⁹⁵ CEDAW General recommendation No. 35 (2017) on gender-based violence against women, para 31b; "Ensure that all (...) support measures and services concerning victims/survivors respect and strengthen their autonomy (...)".

⁹⁶ CRPD Committee, Biannual report, A/70/55.

⁹⁷ 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 with disabilities, A/67/227, para 38.

⁹⁸ 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 apply for persons with psychosocial, mental or intellectual disabilities.

Both the CEDAW and the CRPD Committee have made recommendations calling for the protection of women with disabilities from forced sterilization and for these practices to be abolished in the law.⁹⁹

The UN Special Rapporteur on the rights of persons with disabilities has classified forced sterilization as a pattern of systemic violence being carried out on women and girls with disabilities, causing irreversible harm under the guise of “best interest”, and has called on States to immediately repeal all legislation allowing for the administration of any procedures impacting on the sexual and reproductive health and rights of women and girls without their free and informed consent.¹⁰⁰

Norway has failed to ensure all women and girls with psychosocial and intellectual disabilities the fundamental right to exercise choice and control over their bodies. Discriminatory laws authorizing nonconsensual medical interventions and procedures infringing on their physical, mental, sexual and reproductive integrity, including forced treatment and forced sterilization, must be repealed.

⁹⁹ CEDAW/C/JOR/CO/5, para 46; CRPD/C/PER/CO/1, para 35; CRPD/C/ESP/CO/1, para 38.

¹⁰⁰ 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”.

8. Questions and Recommendations

A. Suggested questions to pose to Norway

- Ask the Norwegian Government what steps are being taken to extend the implementation of the anti-torture framework to include disability-based violence amounting to torture and ill-treatment, including psychiatric detention and nonconsensual treatment (Art. 1, 2 and 16).
- Ask the Government to provide information on what measures have been taken to ensure that all mental health services are based on the free and informed consent of the person concerned and to repeal all legal provisions that authorize any forced or nonconsensual interventions or treatments (Art. 2 and 16).
- Ask the Government to provide information on what steps are undertaken to replace forced treatment and commitment with a wide range of services in the community that respect the person's autonomy, choices and dignity, and meet the needs expressed by persons with disabilities, including peer support, medication-free services and other alternatives to the medical model of mental health (Art 2 and 16).
- Ask the Government to provide data on the use of electroshock (ECT), including ECT administered without free and informed consent. Also provide statistics on the number of people who have applied for compensation for injuries caused by ECT to the Norwegian System of Patient Injury Compensation (NPE), and the number of cases where compensation was awarded. Given that women have a substantially lower seizure threshold than men and might be more exposed to permanent brain injuries of ECT¹⁰¹, please also provide gender-specific data on the use of ECT and of injuries, type of injuries, and how such gender disaggregated data are systematically collected (Art. 2 and 11).
- Ask the Government about any plans to establish an independent mechanism tasked with receiving complaints of torture and other forms of ill-treatment and carrying out prompt, thorough and impartial investigations (Art. 12 and 13).
- Ask the Government how Norway will ensure all victims of psychiatric coercion, and other victims of disability-based violence, effective remedies and reparations for the harm caused, including cession of violations, restitution, satisfaction, rehabilitation, compensation and guarantees of non-repetition (Art. 14).
- Ask the Government for data on how many women with disabilities that have been subjected to sterilization without free and informed consent since the entering into force of the current legislation authorizing these interventions. What steps are taken to repeal all legislation allowing for the administration of sterilization and any other procedures impacting on the sexual and reproductive rights of women and girls without their free and informed consent (Art. 2 and 16).

¹⁰¹ Some research has shown that more women than men experienced long-term injuries (82 % of the women and 18 % of the men); Sackheim, H.A., J. Prudic, R. Fuller, J. Keilp, P.W. Lavori og M. Olfson. The cognitive effects of electroconvulsive therapy in community settings. *Neuropsychopharmacology* 32(1):244-54, jan. 2007. Epub: 23. aug. 2006.

B. Proposed recommendations for the Concluding Observations

- The State party should recognize forms of disability-based violence amounting to torture and ill-treatment and extend the implementation of anti-torture frameworks to them.ⁱ
- The State party should incorporate into the law the prohibition of the use of restraint and the enforced administration of intrusive and irreversible treatments such as neuroleptic drugs and electroconvulsive therapy.ⁱⁱ
- The State party should take all necessary legislative, administrative and judicial measures to ensure that all mental health services are provided on the basis of free and informed consent of the person concerned, including in emergency situations, and to repeal all legal provisions that authorize any forced or non-consensual interventions or treatments in mental health settings.ⁱⁱⁱ
- The State party should abolish legislation placing restrictions on the legal capacity of adult persons with disabilities, develop laws and policies to replace regimes of substitute decision-making by supported decision-making that respects the person's autonomy, will and preferences, and remove functional capacity standards throughout Norwegian law, including criteria that declares a person not competent to give consent or in lack of "decision-making capacity".^{iv}
- The State party should end psychiatric coercion and take effective measures to ensure that no one is detained in any kind of mental health facility or subjected to mental health treatment without the free and informed consent of the person concerned.^v
- The State party should ensure all victims of psychiatric coercion and other disability-based violence effective remedies and reparations for the harm caused, including cessation of violations^{vi}, restitution, satisfaction, rehabilitation, compensation and guarantees of non-repetition.
- The State party should end institutionalization and establish a reparations mechanism and guarantee effective remedies for survivors of institutionalization. Persons leaving institutions should be respected as survivors to whom reparations are due and the State party should provide automatic compensation to survivors of institutionalization at levels that redress the pain, suffering and consequential damages experienced as a result of institutionalization.^{vii}
- The State party should exercise due diligence to prevent, protect, investigate, ensure accountability and effective remedies, including effective reparations for all forms of gender-based violence and disability-based violence against women and girls with disabilities.^{viii}
- The State party should initiate a prompt, independent and thorough investigation into cases of nonconsensual sterilization and provide victims of such human rights violations with an effective remedy for the damage sustained, including fair and adequate compensation.
- The State party should legislate to criminalize disability-based detention, institutionalization and other acts that result in disability-related torture and ill-treatment.^{ix}

“We will continue to tell our stories, to support one another and to transform our suffering into strength. We will honour those who did not survive by ensuring that no one else endures what we have suffered, Our voices will not be taken from us again”.¹⁰²

ⁱ The CRPD Committee recommends States parties to “recognize forms of disability-based violence amounting to torture and/or ill-treatment and extend the implementation of anti-torture frameworks to them”; Guidelines on identifying and addressing disability-based violence, 2026, CRPD/C/8, para 83a.

ⁱⁱ This recommendation was given to Norway in 2020 and 2013 by the CESCR Committee, E/C.12/NOR/CO/6, para 41c, E/C.12/NOR/CO/5, para 19. The CRPD Committee in 2019 recommended Norway to “end the use of coercive methods, such as restraints, isolation, segregation, involuntary treatment and other intrusive methods” as well as to “prohibit the use of forced administration of intrusive and irreversible treatments such as electroconvulsive therapy” (CRPD/C/NOR/CO/1, para 24b, 26a). The CAT Committee has recommended Norway to “consider incorporating into law the abolition of the enforced administration of intrusive and irreversible treatments, such as electroconvulsive therapy” (CAT/C/NOR/CO/8, para 22i).

ⁱⁱⁱ In its Concluding Observations on Norway from 2019, the CRPD Committee recommends Norway to “repeal all legal provisions allowing for involuntary deprivation of liberty based on perceived or actual impairment and the forced treatment of persons with psychosocial or intellectual disabilities (...)” (CRPD/C/NOR/CO/1, para 24a). In 2020 the UN Special Rapporteur on the Rights of Persons with Disabilities recommended the Norwegian Government to “guarantee that all mental health services are provided based on free and informed consent” and to “end the use of coercive interventions for persons with psychosocial disabilities, including involuntary admissions, shielding and isolation, restraints, forced medication and outpatient commitment”, UN Disability Rapporteur, Visit to Norway, A/HRC/43/41/Add.3, para 90a-b.

^{iv} Legislation placing restrictions on the legal capacity of adult persons with disabilities includes; Patients’ and Users’ Rights Act, Mental Health Act, Health and Care Services Act, Sterilization Act.

^v The UN Human Rights Committee has recommended to UK to “repeal legislation, (...), and practices that authorize non-consensual, involuntary, compulsory treatment and detention of persons with disabilities based on actual or perceived impairment.” (Concluding Observations on UK and Northern Ireland, CCPR/C/GBR/CO/8, adopted 26 March 2024, para 37). See also CRPD Committee Guidelines on article 14 on the right to liberty and security of persons with disabilities, 2015, and Guidelines on deinstitutionalization, including in emergencies, 2022, CRPD/C/5.

^{vi} The UN Working Group on Arbitrary Detention states that “individuals who are currently detained in a psychiatric hospital or similar institution and/or subjected to forced treatment, or who may be so detained or forcibly treated in the future, must be informed about ways in which they can effectively and promptly secure their release including injunctive relief; such relief should consist of an order requiring the facility to release the person immediately and/or to immediately cease any forced treatment, as well as systemic measures such as requiring mental health facilities to unlock their doors and inform persons of their right to leave; WGAD, United Nations Basic Principles and Guidelines on remedies and procedures on the right of anyone deprived of their liberty to bring proceedings before a court, 2015, guideline 20.

^{vii} As recommended by the CRPD Committee in Guidelines on deinstitutionalization, including in emergencies, 2022, CRPD/C/5, chapter II, and paras 53, 95d, 119.

^{viii} As recommended by the CRPD Committee in Guidelines on identifying and addressing disability-based violence, 2026, CRPD/C/8, para 150d.

^{ix} As recommended by the CRPD Committee in Guidelines on identifying and addressing disability-based violence, 2026, CRPD/C/8, para 120.

¹⁰² “Charter of Rights of Victims and Survivors of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment”, A/HRC/61/42, UN Special Rapporteur on Torture, January 2026”