**Subpoena**

**to**

**Oslo District Court**

Oslo, 3rd of September 2021

**Plaintiff:** Inger-Mari Eidsvik

Roald Amundsens veg 11B

6007 Ålesund

**Legal representative:**  Lawyer Stine Moen

Føniks Advokater AS

Waldemar Thranes gt. 1B

0171 Oslo

**Sued/prosecuted:** The State of Norway

Ministry of Health and Care Services

Postboks 8011 Dep

0030 Oslo

**The case concerns:** Demands for sentencing for human rights violations, as well as

claims for compensation/redress

**\*\*\***

**1. Introduction**

The case has its origins in the fact that the plaintiff has been illegally forcibly medicated several times and isolated or de facto isolated by shielding during hospitalization at Hjelset psychiatric hospital.

The plaintiff demands that it be confirmed that the authorities' actions were violations of hers

rights under the Norwegian Constitution (The Constitution) and several human rights conventions Norway is bound by. She

requires further redress for these breaches.

A summons has been issued before the Oslo District Court, as the defendant's ordinary venue is Oslo, see the Norwegian Dispute Act article 4-4.

**2. The factual side of the case**

The plaintiff, Inger-Mari Eidsvik, is 57 years old and trained as a child welfare educator at Volda University College.

First admission: Hjelset 09.12.88- 16.12.88

Eidsvik was admitted for the first time to the psychiatric ward at the County Hospital in Molde department Hjelset in December 1988. She is diagnosed with reactive psychosis. At this first admission she gives a clear message that she does not want to be treated with medication. She is, against her will, yet forcibly medicated with neuroleptics. On one occasion she is being forcibly medicated in her own bed while she is being held by up to 4-5 nurses. On several occasions she is asked to stay alone in the room.

**Appendix 1: Journal printout Hjelset, 09.12.88- 11.05.89 pp. 1-4**

Second admission: Hjelset 02.01.89 - 15.03.89

The plaintiff returned to the hospital in early January 1989. On income she

expresses that she is anxious to be forcibly medicated, but stays in spite of this

compulsorily medicated with Haldol and Largactil.

The same medication takes place on 17.02.89. She then gets speech difficulties, which is one

sign of extrapyramidal side effects due to the neuroleptics given. She is given

Discipal, which is a medicine that is supposed to prevent the side effects of neuroleptics, but this does not seem to have any effect on the speech difficulties. During the same admission, it appears that the plaintiff shows total refusal of medication. During this admission, she is forcibly medicated in the room in the bed, on the sofa in the office, on the sofa in the smoking room where there are other patients. Eventually the hospital respects her desire not to be medicated and ends the medication. It appears from the medical record that the plaintiff gets better without the use of medication. During the stay she also experiences being kept sheltered / isolated alone in a separate room for extended periods. She becomes further deprived of access to fresh air for 5-6 weeks. **See Appendix 1, pp. 4- 12**

Third admission: Hjelset 21.03.89 - 25.05.89

The plaintiff was admitted again on 21.03.89. During her stay she is coercively medicated a number of times with Haldol and Largactil, even though she opposed it. She says that she has side effects, which is interpreted as "acting/playing games" by the officer (15.04.89). She is also screened in a separate room during this stay. At this admission the patient is being transferred to a heavier ward: C4. This is a separate shielding department called “Lilleskjermingen” (“The Small Shielding”). She is being exposed to massive medication. In ward C4 in the ordinary room, she becomes physically confined in the room by the caregiver. She is also exposed to violence in the bed against her neck by the caregiver . Plaintiff will explain about this in more detail. It appears from the medical record that she has been improving for the last four weeks of her stay without medication. **See Appendix 1 pp. 13 -17**

Fourth admission: Hjelset 29.01.91-16.04.91

The plaintiff was admitted on 29.01.91. She is immediately transferred to C4. She then expresses anxiety about being forcibly medicated and states that previous compulsory medication was traumatic for her. Despite this she is still being forcibly medicated with Halodol, Stesolid, Cisodrdinol acutard. It appears from the journal (11.02.01) that she gets side effects such as drooling and stiff jaw / neck and looks medicated. She is given antiparkinsonian medicine for this (Disipal). Later, the side effects are interpreted as “playing games”/”acting”, and she is forcibly medicated with Cisodrdinol accutard depo. The last injection was set 20.02.91. Towards the end of her stay, she recovers without the use of drugs. She again experiences shielding / isolating in rooms. During this stay at C4 she was admitted to what was called “Storeskjermingen” (The Grand Shielding”). She got a room with only a mattress and linens, no other furniture or pictures. In this room she was physically trapped at night by nurses sitting with their feet against the door leaf through the nights. During the day she was allowed to get out in an intermediate passage. She was alone in the shielding ward. She was eventually transferred to “Lilleskjermingen”. Here she is subjected to a sexual violation by a nurse. Here, too, she stays alone in her room at night. The plaintiff will explain this in more detail in his explanation. **See Appendix 1 pp. 17- 22**

Fifth admission: Hjelset 05.06.91-25.07.91

The plaintiff was re-admitted in the period 05.06.91- 25.07.91. A decision of compulsory medication is being made also during this stay, but the execution is postponed when she complains the decision to the County Medical Officer. It appears that the plaintiff gets better without the use of medication. Under conversational therapy she tells that she relives a previous rape when the hospital exercises coercion against her. During this stay, the plaintiff is also screened in a room and is being refused to leave the room. This happens especially at night. **See Appendix 1 p.22-26**

Sixth admission: Åsgård, in Tromsø 11.08.94-29.08.94.

In 1994 the plaintiff was admitted for two weeks at the psychiatric ward, Åsgård, in Tromsø. She was offered relationship therapy / open dialogue, for which she was delighted.

After this she was healthy for 11 years without the use of neuroleptics.

Seventh admission: Hjelset 29.01.05-23.02.05

In 2005, she had a psychotic breakthrough after strong pressure at work, and was admitted 28.01.05 at Molde hospital, ward Hjelset. Here she was offered Zyprexa, but she refused to take it. She was then forcibly medicated with Zyprexa and Cisordinold on 07.02.05. During this stay she was sheltered in the shielding department dept. North. Medication was carried out by several nurses who held her fastened to the bed in her room. (At this point, she wanted to be allowed to rest in the shielding department). At night, she was physically locked inside a room alone, if the night watchman meant it was too much unrest.

**Appendix 2: Journal Hjelset, 29.01.05 - 08.06.2016 pp. 1-11**

**Appendix 3: Shielding decision dated 30.01.05**

Eighth admission: Hjelset 20.03.07 to 10.04.07

The plaintiff was re-admitted in the period 20.03.07 to 10.04.07 and diagnosed with psychosis breakthroughs (acute polyform psychosis / reactive psychosis). She was picked up at home by uniformed police when her 11 year old daughter was present. It appears from the medical record that she had not used neuroleptics in the two years that had passed since the last admission. In this admission she is also forced into neuroleptics. Her reaction was anger and rejection. After the injection she has difficulty speaking (Tardiative dyskinesia). After this she receives Akineton, (medicine for side effects of medicine), also against her will. During this stay, she was sheltered for 14 days in the shielding department. The plaintiff graduated in “management and administration” at the University College in Ålesund during the stay. She was locked up in a room alone at night if the nurse experienced unrest. She was, among other things, allowed to invite her daughter and sister to a barbecue on the beachthat she herself organized, to show the child where she was and reassure her that she was fine after the police picked her up at home. The decision was turned into a voluntary stay after she contacted a lawyer, and she signed out from Hjelstet. **See Appendix 2 pp. 11-18**

**Appendix 4: Shielding decision dated 21.03.07**

Ninth admission Hjelset 22.02.2014 - 19.03.14

On 23 February 2014 a decision on compulsory medication was made. The hospital derogates from the requirement of three 24-hour observations since she is *“well known from the past”*. Again she is completely dismissive against medication, but she is forcibly re-medicated repeatedly with Zyprexa, Stesolid, Cisordinol and Akineton. It appears from the medical record that the medication does not have a good effect. A decision on shielding for the entire period was made, as well as a decision on shielding on two occasions in rooms with a closed door. The latter is without the staff being present following a decision according to the Norwegian Mental Health Care Act article 4-8. In reality this happened on several following occasions where the night watchman would lock the door by sitting in the hallway with the footrest on/against the door leaf, or in stressless with the back against the door. Also during the day, the nurse often sat in the hallway with her foot on the door and refused the plaintiff to get out from the shielding unit. Occasionally she was allowed to come out to a line on the linoleum floor, about 1.5 meters outside the door, though she was not allowed to move across it. She was physically led / pushed in by the head of the department, and barred inside on one occasion. The plaintiff will explain herself in more detail about this. **See Appendix 2 p. 18-26**

**Appendix 5: Compulsory medication decision (examination time deviated from) dated 23.02.14**

**Appendix 6: Decision on the use of coercive measures (isolation) dated 22.02.14**

**Appendix 7: Decision on the use of coercive measures (isolation) dated 04.03.14**

Tenth admission Hjelset 21.10.14-25.11.14.

According to the medical record, the plaintiff does not use any medication between the psychotic episodes. On admission, the daughter informs that the plaintiff is terrified of being medicated. Yet, during her stay she was repeatedly being forcibly medicated with Zyprexa, Cisordinol, Zypadhera, Xepilon, Akineton and Risperdal. The latter is not written on the compulsory medication form. Possible side effects registered in the form are slurred speech and tongue hanging partially out of the mouth. This time, too, a decision on isolation in a room without the staff is being made, see the Mental Health Care Act article 4-8. The plaintiff complains about the medicine decision, but does not get the appeal upheld. It is the department as earlier in 2014. The experiences of shielding are repeated, but the different night shifts have different practices. A night watchman tends to sit in a stressless inside her room – which calms the plaintiff. Others close the door from the outside, which makes her uneasy, frustrated, angry and offended. **See Appendix 2, pp. 26-33.**

**Appendix 8: Shielding decision dated 22.10.14**

**Appendix 9: Shielding decision dated 07.11.14**

**Appendix 10: Decision on the use of coercive measures (isolation) dated 10.11.14**

Eleventh admission Hjelset 07.03.16 - 08.06.16.

The plaintiff was admitted to the Emergency Department at Ålesund Hospital Psychiatric ward on 07.03.16 and transferred to Hjelset on 08.03.16. The hospital made a decision of Xepilon depot injection, as well Temesta injection the following day, thus the requirement for a three-day observation period is deviated and the appeal period with suspensive effect is set aside. Eventually she is given Zyprexa, Temesta, Risperdal, Xepilon and Orfiril. These are given by injection, despite the fact that the plaintiff wants tablets. Orfiril is given orally, with the threat of injection of Zyprexa if she does not take it. It appears from the medical journal that the hospital is well acquainted with the plaintiff's attitude and commitment against compulsory medication with neuroleptics. The plaintiff is provoked when the hospital wants to forcibly medicate her. She is afraid of the syringes that are inserted. The plaintiff complains against the compulsory medication decision, but is not upheld.

Shielding / isolation as in 2014, the same department. The plaintiff works with substance abuse care / psychiatry in 100 % position in Helseforetaket. Therefore she wants to be in the shielding unit to avoid meeting people whom she has a professional relationship with in this situation. She did not want to be physically confined in a room or in a shielding unit.

On one occasion, the nurse stands outside her door and yells at her. The window cannot be opened, except ajar in a smoking room.

The last shielding period without expiration is from 13.05.16 to 19.05.16. Then she was ordered to take leave from the hospital where she worked against her will 20.05.16 to 22.05.16. She checked into a hotel in Mold to avoid being a burden for her daughter in Ålesund. After this, the psychologist in the department chose to advocate that the stay should be changed to be a voluntary stay. He asked her to leave before the next injection 06.13.16 **See Appendix 2 pp. 33- 56**

**Appendix 11: Shielding decision dated 22.03.16**

**Appendix 12: Shielding decision dated 05.04.16**

**Appendix 13: Shielding decision dated 19.04.16**

In 2015, the plaintiff was diagnosed with post-traumatic stress disorder (PTSD) (among other things) due to trauma after experiences with coercion during their stays at Hjelset by private practitioners psychologist Brita Hunskaar. She has, since the first admission, chosen a follow-up by a psychologist from another place than the institution. (Bjarte Rekdal from MRDH in Volda (1988 to 1992), Årstein Skiftun (2005 to 2008) and Brita Hunskaar (2014 until Hunskaar moved in 2017). In addition, she herself has taken an education as a trauma therapis, where she has processed/found strength to bear her own traumas during this process.

**Appendix 14: Doctor's statement dated 25.08.2015 from doctor Anne-Marte Bye Flem**

The plaintiff reacts, as mentioned, to the treatment she has received from the first admission. She has not used any kind of neuroleptics between the admissions, and has strongly committed to change the current coercive treatment regime, including work in user organizations. She has given a number of lectures at various conferences, written a debate post in the magazine “Dagens Medisin” (Today’s medicine”) , and is also the user organizations' representative in The Norwegian Directorate of Health working group set up to update the psychosis guidelines. She wants to explain in more detail about this in her statement.

**3. The Legal Side of the Case**

**3.1 Introduction**

The protection of the citizens' physical and mental integrity is a fundamental value in a democratic society. Whether it is protection from interference from other citizens or from the state. The integrity is protected through the rule of law, as well as through the rights in the Constitution and international conventions which protects the people from torture, inhuman and other degrading treatment and encroachment on their privacy.

Being forcibly medicated is one of the most intrusive measures a state can take against its citizens. An enroachment is not only an enroachment on a person’s physical integrity itself -- often in combination with use of force -- it is also a violation of the mental inegrity by the use of medicines which influence one’s thought and emotional life. Uncertainty related to the positive effect of the medications, and the harmful side effects of the medication, makes it severe.

The plaintiff claims that the compulsory medication with neuroleptics, which she has been exposed to at Hjelset psychiatric hospitals, have been an unlawful interference with her integrity, in violation of the rule of law and her fundamental human rights.

The plaintiff further claims that the isolation and parts of the shielding she has been subjected to at Hjelset psychiatric hospital has been an unlawful interference with her integrity, in violation of the rule of law and her fundamental human rights.

It is certain law that a determination action can be brought in for the courts with a claim for a judgment that there exists a violation of an incorporated human rights convention, as well as violation of the Constitution, see Rt. 2003 p. 301 section 39 and Rt. 2016 p. 2178.

The violations of the constitutional and human rights obligations are further grounds for

liability for redress, according to ECHR art. 13 cf. art. 41 and ICCPR art. 2 no. 3, cf. the Human Rights Act article 2 and article 3.

**3.2 The compulsory medication of the plaintiff which took place in the periods 09.12.88- 16.12.88, 02.01.89 - 15.03.89, 21.03.89-25.05.89, 29.01.91-16.04.91 and 05.06.91-25.07.91, 29.01.05- 23.02.05, 20.03.07-10.04.07, 21.10.14-25.11.14, 22.02.14-19.03.14, 21.10.14-25.11.14 and 07.03.16-08.06.16 was a violation of her rights under ECHR Article 3, The Constitution article 93, ICCPR Article 7, UNCAT Article 1 cf. 16 and CRPD Article 15**

Freedom from torture, other inhuman or degrading treatment is a fundamental

personal right, which the state must respect and secure, cf. the Constitution article 92. The right is absolute and may be limited only for the sake of other fundamental rights.

The right was enshrined in the Constitution in its current form in 2014 in article 93 of the Constitution, but it was earlier partly covered by article 96 and existed as non-statutory law.

The prohibition of torture, other inhuman and degrading treatment is further enshrined in the The European Convention on Human Rights (ECHR) art. 3, The International Convention

on civil and political rights (ICCPR) art. 7, the Convention against Torture and Other Cruel, inhuman or degrading treatment or punishment (UNCAT) art. 1 cf. art. 16 and CRPD art. 15. The ECHR and the ICCPR were incorporated into Norwegian law with priority in 1999, cf. the Norwegian Human Rights Act articles 2 and 3. The presumption principle meant that it was also previously assumed that Norway was bound by the treaties. See the Norwegian Supreme Court's statement in Rt. 1984 p. 1175:

*"The decision must be made on the basis of the legal considerations that apply here, including the consideration that Norwegian law must as far as possible be presumed to be in accordance with treaties to which Norway is bound, in this case the European Convention on Human Rights of 4 November 1950."*

*[“Avgjørelsen må treffes ut fra de reelle hensyn som her gjør seg gjeldende, herunder*

*det hensyn at norsk lov så vidt mulig må forutsettes åpresumpsjonsprinsippet være i samsvar med traktater som Norge er bundet av, i dette tilfellet Den europeiske menneskerettighetskonvensjonen av 4. november 1950.”]*

The second section of article 93 of the Constitution is modeled after Article 3 of the ECHR, and it is assumed that the provision is fully covered by ECHR art. 3 cf. the Norwegian Parliament (Stortinget)’s Human Rights Committee chapter 20.6. In the following, the starting point is ECHR art. 3 and practice from the European Human Rights Court (HUDOC) to clarify the content of the right.

**Appendix 15: The Norwegian Parliament’s Human Rights Committee, Document 16, 2011-2012, chapter 20.6**

**3.2.1 The content of the right to freedom from torture and other inhuman or degrading treatment or punishment degrading treatment**

In order to be considered a violation of Article 3, the acts that violate the integrity must be of a certain seriousness. Practice from the HUDOC shows that this assessment is relative, including the vulnerability of the victim;

*“The Court reiterates that ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum level is, in the nature of things, relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim” (see Kudła v. Poland 30210/96 - section 91, Peers v. Greece 28524/95 section 67).*

According to court practice, inhuman treatment or punishment involves that the person

is subject to measures that lead to an unjust and strong physical or mental disorder. There is a derogatory treatment, among other things, when the person in question is exposed to

measures that humiliate him or her and that are suitable for creating a feeling of fear and

inferiority (Kudła v. Poland 30210/96 section 92).

People with mental health problems are particularly vulnerable, which shall be emphasized in the assessment of the threshold under Article 3 (see Keenan v. The United Kingdom 27229/95 - section 111, Rohde v. Denmark 69332/01 - section 99, Renolde v. France 5608/05 - section 120, M.S v. Croatia Nr. 2 - section 96).

The HUDOC emphasizes that coercive measures will be a further restriction of an already limited personal autonomy for persons who’ve already been deprived of their liberty (Munjaz v. The United Kingdom 2913/06 - section 80).

The purpose of the action may be of importance. When the purpose is medical treatment, the Court have developed a practice where a crucial assessment theme is whether the encroachment must be considered to be a medical necessity:

*“The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3 (art. 3), whose requirements permit of no derogation.*

*The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist». Herczegfalvy v. Austria 10533/83 section 82-84.”*

The clear requirement of the medical necessity of treatment from Herczegfalvy, is repeated in later practices of the HUDOC, including Nevmerzhitsky v. Ukraine 54825/00 - section 94 and M.S. v Croatia (No 2). This is in accordance with the absolute character of art. 3. Interventions can only be defended if it is necessary on the basis of the state's positive obligations under other convention rights, especially the right to life by species. 2.

The manner in which the procedure is performed will also be important. It appears in Nevmerzhitsky that it must also be considered whether the manner in which the medical procedure was performed, in itself, exceeds the treshold of inhuman or degrading treatment, see Nevmerzhitsky v. Ukraine 54825/00 - section 94.

The legal assessment theme in Article 3 is therefore a) whether the seriousness of the encroachment reaches the threshold for Article 3, b) whether it has been proven that the compulsory medication of the plaintiff was a mandatory medical necessity, and c) whether the implementation of the procedure in itself violates Article 3.

**3.2.2. Subsumption: inhuman and degrading treatment**

**3.2.2 a) Severity of the enroachment**

It is stated that the compulsory medication of the plaintiff that occurred at Hjelset psychiatric hospital, was an encroachment on her integrity that clearly exceeds the lower limit of inhuman and degrading treatment in ECHR art 3, cf. Kudla v Poland, section 92.

According to HUDOC’s practice, she must have been considered to have been particularly vulnerable, due to her mental health problems and who was forcibly admitted with restrictions on her communication and freedom of movement, being totally dependent on the hospital's decisions.

Furthermore, it is documented that she experienced serious side effects from the treatment, both physical and mental. See Appendices 1 and 2, where it is stated that the plaintiff experienced extrapyramidal side effects, speech difficulties and Tardative dyskinesia. These are known, predictable and serious side effects from the medication the plaintiff was forced to take.

In 2015, the plaintiff was diagnosed with post-traumatic stress disorder, PTSD, due to his traumas related to coercion in psychiatry, cf. Appendix 14.

**3.2.2 b) Medically necessary**

It is stated that the compulsory medication of the plaintiff that took place at Hjelset psychiatric hospital, was not medically necessary. Neither the individual circumstances of the plaintiff, nor the general knowledge one has about the effect of drug treatment with neuroleptics, indicates that the coercive treatment was a medical one

necessity.

**The plaintiff's individual circumstances**

The plaintiff has been affected by acute polymorphic (reactive) psychosis. Such psychoses usually go away on their own without drug treatment, see Appendix 16. This will be elaborated in more detail by our witnesses, Dr. Joanna Moncrieff, Magnus Hall and Jaakko Seikkula.

**Appendix 16: Acute polymorphic psychosis by Ulrik Malt, Store norske leksikon [The Large Norwegian Encyclopedia], updated 09.10.2019**

The plaintiff has, on several occasions, recovered without the use of neuroleptics or after

the medication is discontinued. Furthermore, it appears from the journal that neuroleptics did not have a positive effect on her. This is shown in Appendices 1 and 2.

Based on the plaintiff's diagnosis and course of the disease, she must obviously be considered among the large group of patients who do not have a positive effect of neuroleptics. The treatment cannot have been medically necessary.

**The general knowledge base for neuroleptics**

In NOU [Norwegian Official Report] 2011: 9 “Økt selvbestemmelse og rettsikkerhet” [“Increased self-determination and the rule of law”], there is a summary of research on the effect of neuroleptics which was performed by the Knowledge Center [Kunnskapssenteret] in 2009. The conclusion is that one must medicate five to ten patients with mani as part of a bipolar disorder or acute psychosis, to achieve that one additional patient improves.

**Appendix 17: NOU 2011: 9 Chapter 9, p. 109-113**

Furthermore, it follows from the Compulsory Limitation Act Committee's [tvangsbegrensningslovsutvalget] review of research on the treatment effect of neuroleptics in acute psychosis, that one must medicate between five and ten patients for an additional patient to experience improvement. Reference is made to a meta-analysis which found that one must treat more than ten patients with neuroleptics in order for an additional patient to experience a good effect (Leucht in 2017).

**Appendix 18: NOU 2019: 14 Chapter 10, p. 241**

In her doctoral degree from 2021 at the Faculty of Medicine and Health Sciences at NTNU, Annbjørg Haram refers to a number of studies and writes that these show that neuroleptics at a group level only have a moderate treatment effect on positive symptoms of psychotic disorders, while the effect on the negative symptoms cannot be documented. (Fusar-Poli et al., 2015; Gleeson, Killackey, & Krstev, 2008; Lemos-Giraldez et al., 2015; Leucht, Helfer, Gartlehner, & Davis, 2015; 2014). Furthermore, she writes that the database is too limited to be able to predict the effect of treatment with neuroleptics at the individual level in early episodes of psychosis of schizophrenia types.

**Appendix 19: Dialogue Therapy and Standard Psychiatric Treatment in Psychosis –**

**Psychological Aspects, Treatment and Outcome», (NTNU, 2021)**

There is also research that shows an equally good effect of treatment without medication, see Appendix 20, as well as research which shows significantly better results for those patients who are not being treated with medication. Reference is made, in particular, to the results from Open Dialogue [Åpen dialog] in Finland, where 86 % of the patients return to work or education after five years. As many as 71 % of the patients were not treated with antipsychotics, and only 20 % used them regularly. Furthermore, reference is made to research from the Soteria House in San Francisco which showed 85-90 % recovery without the use of neuroleptics. See also esults from Martin Harrow and Thomas Jobs' long-term study from Chicago which shows between a 6-8 times higher chance of complete recovery without the use of medication. The recovery rate, when using medication, is only 5-6%, see appendices 24 and 25. A new research study from the research institute Norce in Bergen, Norway, shows that being subjected to forced admission to mental health care, reduces the probability of getting a job by 77 %, see Appendix 27. The treatment in the closed emergency departments is, with a few exceptions, unilaterally medicinal. For psychosis patients, this means detention in an institution, where the only offered treatment is neuroleptics given with or without coercion. The plaintiff and our other Norwegian witnesses will elaborate on this.

**Appendix 20: Psychosocial Intervention With or Without Antipsychotic Medication for First- Episode Psychosis: A Randomized Noninferiority Clinical Trial, Francey, 20.03.2020**

**Appendix 21: Psychotherapy Research, March 2006; 16(2): 214-228, Five- year experience of first- episode nonaffective psychosis in open- dialogue approach: Treatment principles, follow-up outcomes, and two case studies**

**Appendix 22: Soteria 6 weeks and 2 years results**

**Appendix 23: Mad in Norway, Harrow 08.02.2021**

**Appendix 24: Harrow and Jobs, twenty-year effects of antipsychotics in schizophrenia and affective psychotic disorders 08.02.2021**

**Appendix 25: A systematic review and meta-analysis of recovery in**

**Schizophrenia, Jååskelåinen and others 2013**

**Appendix 26: “Ny studie: Tvangsutsatte har lavere sjanse til å få jobb”, NRK 14.04.2021**

**Appendix 27: OECD tall om dødelighet og uførerater, Norge på topp [OECD figures on mortality and disability rates, Norway at the top]**

The plaintiff claims that a treatment where the treatment effect is so low and uncertain can never be claimed to be a medical necessity, within the meaning of the convention.

This view is supported by the fact that the requirement that the medication must have a "high probability" [“stor sannsynlighet”] of "cure or significant improvement of the patient's condition" [“helbredelse eller vesentlig bedring av pasientens tilstand”] in the Norwegian Mental Health Care Act article 4-4, is included to ensure that Article 3 of the ECHR is fulfilled (Ot.prp.nr. 11 (1998-1999) pp. 112).

Furthermore, it must be clear that compulsory medication with neuroleptics cannot be considered a medical necessity as long as the research indicates that the chance of recovery is greater without the use of neuroleptics in the treatment.

**3.2.2 c) The implementation**

The compulsory medication was carried out in a brutal way, on several occasions. On multiple occasions, the plaintiff was held down by several male employees and the trousers were pulled down for injection. This happened both in bed in her own room, in the office and on the sofa in the common areas by the ward. It appears from the records that the plaintiff told treatment personnel that this made her re-experiencing a rape she had previously been subjected to, see Appendix 2. The plaintiff will explain this to the court.

**3.2.3 International criticism:**

The plaintiff notes that international human rights bodies and the WHO repeatedly have criticized the use of coercion, including coercive medication, in mental health care and pointed out that the principle of necessity is not followed. Criticism has also been directed directly at Norwegian practice. Reference is made to the report of the European Committee for the Prevention of Torture, the UN Committee against Torture and the UN's previous special reports against torture, Juan Mendez.

**Appendix 28: Den europeiske torturforebyggings- komité – besøk til Norge i 2005, CPT/Inf (2006) 14, avsnitt 107 [European Committee for the Prevention of Torture - Visit to Norway in 2005, CPT / Inf (2006) 14, article 107]**

**Bilag 29: UN Torture Report 2018**

**Appendix 30: UN Special Rapporteur on Torture Juan Mendez’s report to the UN Human Rights Council 1 February 2013**

**Appendix 31: WHO, Guidance on community mental health services 10.06.2021**

**Appendix 32: UN Rights experts call on Council of Europe to stop legislation for coercive mental health measures, 28.05.2021**

**3.2.4 Conclusion**

The plaintiff's coercive medication with neuroleptics was an encroachment on her integrity that clearly exceeds the lower limit of inhuman and degrading treatment and was further carried out in a brutal and degrading manner. Compulsory medication was not medically necessary.

The compulsory medication of the plaintiff constitutes a violation of Article 3 of the ECHR, article 93 of the Constitution, ICCPR art. 7, UNCAT art. 1 cf. art. 16 and CRPD art. 15.

**3.3 The compulsory medication of the plaintiff which took place in the periods 09.12.88- 16.12.88, 02.01.89 - 15.03.89, 21.03.89-25.05.89, 29.01.91-16.04.91 and 05.06.91-25.07.91, 29.01.05-23.02.05, 20.03.07-10.04.07, 21.10. 14-25.11.14, 22.02.14-19.03.14, 21.10.14-25.11.14 and 07.03.16-08.06.16 were violations of the Constitution articles 113 and 102, ECHR art 8, ICCPR art. 17 and CRPD art. 22 No. 1.**

Compulsory medication is a violation of the core area of ​​the rule of law, and shall not occur without a clear legal basis.

The statutory requirement/the rule of law was enshrined in the Constitution in 2014 in article 113 of the Constitution. It previously existed as non-statutory law with constitutional rank/constitutional customary law.

The statutory requirement is further laid down in ECHR art. 8 No. 2, ICCPR art. 17 and CRPD art. 22 no. 1, and interpreted in the Constitution in article 102. The provisions protect the right to privacy, including a person's physical and mental integrity. It is clear that medication with neuroleptics against the patient's will is an encroachment on the right to privacy. A clear legal basis in national law is required in order for intervention in the court to be permitted. The authorities could document that the law's requirements are met for intervention to be permitted.

The ECHR and the ICCPR were incorporated into Norwegian law of precedence in 1999, cf. the Human Rights Act articles 2 and 3. The presumption principle meant that it was also previously assumed that Norway was bound by the treaties. Reference is made to the Norwegian Supreme Court's statement in Rt. 1984 p. 1175.

**3.3.1 The conditions for compulsory medication according to the Mental Health Care Act are not met.**

Compulsory medication for treatment purposes can only take place if the conditions in the Mental Health Care Act article 4-4 are met. The plaintiff states that three of the conditions of the law were not met when the compulsory medication was carried out:

**a) The condition for treatment, according to the Mental Health Care Act article 4-4, fourth section, second sentence, and previous regulations on limited access to compulsory treatment in the mental health care article 3-2 litra a and b**

**b) The condition of a beneficial effect that clearly outweighs the disadvantages of any side effects, see the Mental Health Care Act article 4-4, second section litra a, and previous regulations on limited access to compulsory treatment in the mental health care article 3-4, second section**

**c) By far the best solution for the person in question, after an overall assessment, see the Mental Health Care Act article 3-3, first section, and previous case law**

In the following, each of the conditions will be reviewed.

**3.3.1 a) The treatment condition**

Treatment with drugs without consent "can only be initiated and carried out when they can in all probability lead to a cure or significant improvement in the patient's condition, or that the patient avoids a significant aggravation of the disease", cf. the Mental Health Care Act article 4-4 fourth section 2. p.

Prior to the introduction of the current Mental Health Care Act, almost identical conditions were laid down in the Regulations on restricted access to compulsory treatment in mental health care 3-2 a) and b), laid down by Royal Decree no. of 21 September 1984 pursuant to Act of 28 April 1961 No. 2 on mental health care article 2 fifth section. The condition thus applied on all occasions when the plaintiff experienced being forcibly medicated, and the discussion takes place here together. In the preparatory work for the Act, the threshold is commented on as follows: "A high degree of probability is thus required with regard to the expected effect, and the effect must be of a qualified nature" (Ot.prp.nr. 11 (1998-1999) p 80). Furthermore, it appears “that there must be a high probability of this, i.e. more than the usual predominance of probabilities” (Ot.prp.nr. 11 (1998-1999) p 155).

The Civil Ombudsman [Sivilombudsmannen] comments on the provision in the decision dated 18.12.2018 (SOM- 2017-543) Here it appears that:

“A requirement for a general probability of an effect would, after incorporated language use - not least in litigation - mean that the effect had to be more probable than the alternatives. In other words, a requirement of general probability would have entailed a requirement of more than 50 per cent probability. When the requirement in the law is "highly probable", it entails a stricter requirement. "High probability" is something else and more than ordinary probability predominance.”

[“Et krav om alminnelig sannsynlighet for en effekt ville etter innarbeidet språkbruk— ikke minst innen tvistemål- innebære at effekten måtte være mer sannsynlig enn alternativene. Sagt på en annen måte ville et krav om alminnelig sannsynlighet ha innebåret et krav om mer enn 50 prosents sannsynlighet. Når kravet i loven er «stor sannsynlighet» medfører det et strengere krav. «Stor sannsynlighet» er noe annet og mer enn alminnelig sannsynlighetsovervekt.”]

The requirement of probability relates to the patient in question in the specific case. The assessment must be knowledge-based and based on recognized research that provides a basis for relatively certain conclusions. The knowledge base for neuroleptics is set against the requirements of the law.

The treatment effect and accuracy of using neuroleptics are uncertain and low. One must

medicate between five and ten patients for an additional patient to experience qualified improvement. Reference is made to the summary of the knowledge base in the Paulsrud Committee and the Compulsory Law Committee, cf. Appendices 17 and 18. Furthermore, it must be assumed that when the medication takes place by force, the treatment effect will be further reduced, due to the effect of lack of placebo effect as well as an independent and negative effect of the coercion called nocebo effect, cf. Appendix 18.

The knowledge base about the treatment effect and the accuracy of the treatment will be further elucidated by witnesses Joanna Moncrieff, Magnus Hald and Robert Whitaker.

The research thus does not provide a basis for believing that in the treatment of individuals there is a high probability of a qualified positive effect, as required by law. At the group level, a qualified positive effect is seen only in a few of the cases and there are no known biomarkers or other markers that can say in advance whether a person will have a good or bad treatment response.

In NOU 2011: 9, cf. Appendix 17, the Paulsruds Committee states that the practice has been in violation of the law:

*“(...) the requirement of "high probability" appears unrealistic, especially when faced with new patients. The committee also has the impression that the current evidentiary requirements have to a small extent functioned as an effective barrier to practice, which may be partly due to the fact that it has been perceived as unrealistically strict. A somewhat weaker, but more realistic evidentiary requirement combined with the committee's various measures for increased legal certainty, is then considered to form a better basis for a practice that is in accordance with the wording and intention of the law. In the committee's opinion, the main problem under current law is that the law's strict material requirements have not been followed in practice."[[1]](#footnote-1)*

In 2019, the Compulsory Restrictions Act Committee [Tvangsbegrensingslovsutvalget] also states, cf. indireclty in Appendix 18, that practice is contrary to the law, when they write that *“On the basis of this meta-analysis (refers here to Zhu et al. 2017), which have more optimistic conclusions than those otherwise discussed in Chapter 10, a requirement for a more than normal overriding probability of effect may be tantamount to a ban on compulsory medication - at least for persons who have not tried such drugs before”.*[[2]](#footnote-2)Furthermore, the majority write that they have *"a great understanding of a desire for a ban based on the knowledge base that currently exists about effects on effects and side effects"*.[[3]](#footnote-3) Failure to comply with the treatment condition has also been pointed out by leading lawyers.

**Appendix 33: “Tvangsmedisinering må forbys” [“Compulsory medication must be prohibited”], Ketil Lund, Tidsskrift for norsk legeforening [Journal of the Norwegian Medical Association], 2016**

**Appendix 34: Falkanger, Aage Thor, “Psykisk helsevern og tvangsmedisinering” [“Mental health care and compulsive medication”], Lov og rett 05/2017 (Volum 56)**

**Appendix 35: “Kritiserer tvangsmedisinering” [“Criticizes compulsive medication”], Tidsskrift for Norsk psykologforening [Journal of the Norwegian Psychological Association], Vol. 56, number 2, 2019.**

**Individual factors**

Reference is made to what is stated about the plaintiff's individual circumstances in section 3.2.2 b.). The plaintiff has been affected by acute polymorphic psychosis. Such psychoses usually go away on their own without drug treatment. Reference is made to the attached Appendix 16, and will be elaborated by our witnesses Dr. Joanna Moncrieff, Magnus Hald and Jakku Seikkula.

The plaintiff has on several occasions experienced that she recovered without the use of neuroleptics. See Appendix 1 and 2.

Based on the plaintiff's medical history, where she has several times experienced recovery without the use of neuroleptics and had treatments without effect, see Appendix 2, there has never been any basis for claiming that the treatment *with great probability can lead to a cure or significant improvement of the patient's condition.*

**Conclusion of the treatment condition:**

Neither the general knowledge base on antipsychotics from recognized research, nor the individual circumstances of the complainant, have provided grounds for stating that coercive drug treatment would, in all probability, lead to a cure or significant improvement of the plaintiff’s health.

The conditions of the law have not been met. The breach of integrity has thus taken place without legal authority and has been illegal.

**3.3.1 b) The condition that a beneficial effect must clearly outweigh the disadvantages of any side effects**

The Mental Health Act article 4-4, second section, litra a, sets conditions tha*t “Drug treatment can only be carried out with drugs that have a beneficial effect that clearly outweighs the disadvantages of any side effects”.[[4]](#footnote-4)*

Prior to the introduction of the current Mental Health Care Act, almost identical conditions were laid down in the *Regulations on limited access to compulsory treatment in mental health care [Forskrift om begrenset adgang til tvangsbehandling i det psykiske helsevern]*, laid down by Royal Decree no. of September 21st 1984 pursuant to the Act of 28 April 1961 no. 2 on mental health care article 2, fifth section, article 3-4 second section.

The condition is applied on all occasions when the plaintiff experienced being forcibly medicated, therefore this is an overall discussion below.

It appears from the preparatory work that the provision was included on the basis of the recognition that treatment with drugs without the patient's consent must, in itself, be regarded as a serious intervention against the patient. Given the knowledge that neuroleptics do not infrequently cause side effects to the patient, strict requirements of the quality of the assessment, forming the basis for such a decision, must be set (Ot.prp.nr. 11 (1998-1999) p 161). Emphasis shall be placed on *"whether there is a risk that the treatment will have side effects, and how strongly and how the medicine affects the patient's physical and mental condition"[[5]](#footnote-5)* (Ot.prp.nr. 11 (1998-1999) p. 111).

The condition is that the beneficial effects clearly outweigh the disadvantages of any side effects. There must therefore be a clear positive effect that undoubtedly outweighs the side effects.

**Generally about side effects of neuroleptics**

Antipsychotic medication brings with it serious side effects. These are divided into psychological, metabolic and motor (neurological).

A very common psychological side effect is that the patient becomes lethargic, unobtrusive and apathetic. Motivational emotions such as joy, enthusiasm, empathy and sexual desire can be subdued. It has been found that regular use of first-generation neuroleptics is associated with a higher incidence of depressive episodes than placebo.

All neuroleptics are also associated with metabolic side effects, such as the risk of weight gain, high blood sugar and elevated cholesterol levels. This, in turn, increases the risk of developing diabetes and heart disease.

Among the neurological side effects are acute dystonia, the patient may develop uncontrolled muscle twists, especially in the face or neck. Furthermore, the drugs can cause parkinsonism, symptoms reminiscent of Parkinson's disease. Patients may have stiff muscles and joints, tremors, little facial expressions, drooling. The side effects will go away when you step down, or when the patient stops taking, the medicine. Tardive dyskinesias are permanent neurological changes that cause uncontrolled movements such as smacking, reaching heavy or powerful chewing movements. Akathisia is another extrapyramidal side effect that causes tingling in the legs, restless restlessness and mental symptoms, severe discomfort, intense depression and sometimes aggression and suicidality. Furthermore, malignant neuroleptic syndrome is mentioned, which in rare cases can occur when starting neuroleptics. It causes fever and stiffness in the body and can be fatal.

Reference is made to the reports of the Paulsrud Committee and the Compulsory Limitation Law Committee, cf. Appendix 17 chapter 9.3 and Appendix 18 pp. 247-248. The Coercive Law Committee says that it is an open question whether the effect of neuroleptics is so great that it outweighs the side effects and violations associated with coercive intervention. The side effects of neuroleptics will also be highlighted by witnesses Joanna Moncrieff, Magnus Hald and Robert Whitaker.

**Individual conditions**

The plaintiff experienced strong side effects. Reference is made to Appendices 1 and 2. She will also talk about the side effects in her diploma.

**Weighing and conclusion**

The complainants have experienced strong and serious physical and mental side effects.

However, the treatment effect has been small, cf. above.

The drugs with which the plaintiff has been forcibly treated have not on any occasion had a favorable one

effect that has clearly outweighed the side effects she has experienced.

The conditions of the law have not been met. The breach of integrity has thus taken place without legal authority and has been illegal.

**3.3.1 c) Clearly the best solution for the person in question after an overall assessment**

Article 3-3, first section, no. 6 of the Mental Health Care Act states that:

“Compulsory mental health care can only take place where, after an overall assessment, this appears to be the clearly best solution for the person in question, unless he or she constitutes an imminent and serious danger to the life or health of others. In the assessment, special emphasis shall be placed on how great a burden the coercive intervention will entail for the person in question.”[[6]](#footnote-6)

The condition of overall assessment was first enacted in the current Act from 1999, but has its origins in case law related to the Mental Health Care Act of 1961, cf. Rt 1981 p 770 and Rt 1988 p 634, where coercive decisions were revoked after an overall assessment even though the other laws the conditions were first found to be met (Syse p. 146). Even if the conditions of the law were otherwise met, an overall assessment should be made of whether the establishment of coercion was "necessary and reasonable". (see Appendix 17, p. 148).

The condition thus applied on all occasions when the plaintiff experienced being forcibly medicated, and the further discussion takes place together. The condition of overall assessment is in reality an expression of the fact that coercive intervention must be subjected to a proportionality check. The general genetic dimension of coercion is expressed through the principle of proportionality. This is a basic principle of legal certainty that contributes to creating a counterweight to the professional judgment that otherwise has a dominant role in compulsory mental health care (NOU 1988: 8. P. 181). Proportionality is also an integral part of the human rights protection of a person's integrity, cf. ECHR Article 8, ICCPR art. 17 and CRPD art. 22 no. 1. It is thus clear that even though the provision in the Act is placed in article 3-3 on the establishment of compulsory protection, the condition will also apply to decisions on compulsory medication pursuant to article 4-4, cf. also article 4-4-1. section 1. p.

It follows from the provision's first sentence that compulsory mental health care can only be adopted when this is the "clearly best solution" for those who are subject to coercion, which expresses a high threshold for how reasonable and proportionate the intervention must be. In the second sentence it is said that the burden on the individual by being subjected to coercion shall be given "special weight" in the assessment to be made. The patient's interests and perceptions must therefore be taken into account proportionately greater weight than the health professional and social considerations that speak for compulsory mental health care (cf. Appendix 17 pp. 183-184)

**Research on the experience of compulsive medication with neuroleptics**

Research shows that a large proportion of patients during compulsory treatment with neuroleptics experience the treatment situation as unacceptable and humiliating. Despair, fear, powerlessness and helplessness are common feelings, cf. Appendix 18 p. 251-253. Naturally, this is especially true for patients who do not experience a treatment response to the medications they are forced to take. This will be elaborated by witness Olav Nyttingnes, postdoctoral fellow at the Department of Health Services Research and the R&D department of mental health care at Akershus University Hospital.

**Appendix 36: “'It's unbelievably humiliating'-Patients' expressions of negative effects of**

**coercion in mental health care” Nyttingnes, Ruud, Rudkåsa**

**Appendix 37: “Loven om begrensning av tvang har et hovedproblem” ["The law on the restriction of coercion has a main problem"], Nyttingnes, Dagens**

**Medisin [Today’s Medicine], 12.05.2019**

**Individual conditions**

The plaintiff has horrbile experiences of being forced to take drug treatment neuroleptics. She has experienced strong side effects from the medicine and experienced the implementation

as excruciating.

These experiences are the origin of her strong and consistent commitment against neuroleptics and the use of compulsive medication in psychiatry. Reference is made to what is stated above about the side effects the plaintiff has experienced and her long and public commitment to coercive medication with neuroleptics and coercive drug use in psychiatry.

Moreover, there must be placed emphasis on the great extra mental strain, and feeling of violation, that coercive medication has entailed for the plaintiff -- as an active and pronounced opponent of neuroleptics. Her attitudes and commitment have been known in the treatment apparatus and among those responsible for decisions, without it being taken into account.

The complainant's experiences of coercion in the psychiatry have contributed to her being diagnosed with PTSD, see Appendix 14.

**Weighing and conclusion - overall assessment according to article 3-3, first section, no. 6**

The plaintiff has experienced strong and serious physical and mental side effects from the medication. Besides, the coercion she has been subjected to has been offensive and psychologically stressful. This is reinforced by the fact that her well-known and strong commitment to compulsory medication with neuroleptics has been disrespected. She has been diagnosed with PTSD.

Compulsory treatment with neuroleptics has not been medically necessary and has had little treatment effect. Compulsory medication has on no occasion emerged as the clearly best solution for the plaintiff.

The law's conditions for compulsory medication have not been met. The breach of integrity has thus taken place without legal authority and has been illegal.

**3.3.2 Compulsory medication was not necessary or proportionate**

Even if it was assumed that the conditions for the compulsory medication of the plaintiff under the Mental Health Care Act were met, the compulsory medication was not necessary and proportionate. The state must prove that the coercive use is necessary.

A requirement of necessity and proportionality in the event of an enroachment of the rights enshrined in numerous human rights conventions. In HUDOC’s practice, proportionality is interpreted in the wording “necessary in a democratic society”, cf. Article 8 (2).

On the concept of "necessary in a democratic society", the HUDOC has stated (Buck v. Germany, (HUDOC-1998-41604) section 44):

*“Under the Court's settled case-law, the notion of “necessity” implies that the interference corresponds to a pressing social need and, in particular, that it is proportionate to the legitimate aim pursued (see, among many other authorities, Camenzind v. Switzerland, judgment of 16 December 1997, Reports of Judgments and Decisions 1997-VIII, p. 2893, article 44). In determining whether an interference is “necessary in a democratic society”, the Court will take into account that a certain margin of appreciation is left to the Contracting States. However, the exceptions provided for in section 2 of Article 8 are to be interpreted narrowly, and the need for them in a given case must be convincingly established (see, inter alia, Funke, cited above, p. 24, article 55).”*

Article 102 of the Constitution does not contain such a legal basis for intervention, but it is clear that restrictions and encroachments on the right are regulated according to patterns by the HUDOC. HR-2018-104-A specifies the content of the proportionality requirement according to the Constitution article 102 and ECHR art. 8. It was stated here that interventions can only be made *“to the extent that this is necessary in a democratic society: The measure must in the specific case be sufficient, necessary and proportionate. It refers to the HUDOC's judgment of 28 April 2005 Buck v. Germany, sections 44-45 [HUDOC-1998-41604] 1 and the judgment of 2 April 2015 Vinci Construction and GTM Génie Civil et Services v. France, section 79 [HUDOC-2010-63629]”*[[7]](#footnote-7)

The intervention in the form of the compulsory medication was neither suitable nor necessary for the plaintiff to recover. Reference is made to the assessment of medical necessity in section 3.2.1 b). Less intrusive measures were available, such as talk therapy or open dialogue, or simply let the plaintiff have time and care at the treatment institution so that the psychosis could go away on its own.

We are facing a central right: the protection of a plaintiff's privacy, including her physical and mental integrity. This must be taken into account in the proportionality assessment. She has been hurt by the enroachement - it is referred to the serious side effects she experienced, as well as the psychological trauma the coercion and the coercive medication have given her. Reference is also made to the assessment in section 3.3.1.

**Conclusion compulsory medication**

The compulsory medication had no legal basis, nor was it necessary or proportionate. The compulsory medication was therefore in violation of the Constitution article 102, ECHR art 8, ICCPR art. 17 and CRPD art. 22 no.

**3.4. Isolation and shielding**

On several occations the plaintiff has experienced being kept isolated or shielded.

Isolation as a coercive measure was regulated from 1977 in *“Regulations on limited access to the use of coercive measures and a ban on corporal punishment in mental health care, health care for the mentally handicapped and health care for epileptics”*.[[8]](#footnote-8) It is stated about insolation in article 3, first section 1).

*“Som tvangsmiddel regnes isolasjon og mekaniske tvangsmidler.*

*1) Isolering*

*Som isolering regnes anbringelse bak avlåst dør i godkjent isolat, enerom e.l.*

*Ved isolering av pasienter under 14 år eller av særlig umodne personer over 14 år, skal en av personalet alltid være tilstede i rommet eller i naborommet med ulåst dør til isolatet.*

*Isolering er bare tillatt i rom hvor gulvflaten er minst 8 m2 og hvor lysflaten ikke er mindre enn 1/10 av gulvflaten.*

*Nattopphold i avlåst rom anses ikke som tvangsmiddel mår det dreier seg om forvirrede og desorienterte pasienter.”*

*[“Isolation and mechanical coercive measures are considered coercive measures.*

*1) Isolation*

*Isolation is considered to be placement behind a locked door in an approved isolation, solitary confinement or the like.*

*In the case of isolation of patients under 14 years of age or of particularly immature persons over 14 years of age, one of the staff must always be present in the room or in the next room with an unlocked door to the isolate.*

*Isolation is only permitted in rooms where the floor area is at least 8 m2 and where the light surface is not less than 1/10 of the floor area.*

*Night stays in locked rooms are not considered a coercive measure when it is regarding confused and disoriented patients”]*

With the adoption of the Norwegian Mental Health Care Act in 1999, the main provision on isolation as a coercive measure was included in the legislation. The provision in article 4-8 has been unchanged until today and the first and second sections letter b) reads:

*“Tvangsmidler skal bare brukes overfor pasienten når dette er uomgjengelig nødvendig for å hindre ham i å skade seg selv eller andre, eller for å avverge betydelig skade på bygninger, klær, inventar eller andre ting. Tvangsmidler skal bare brukes når lempeligere midler har vist seg å være åpenbart forgjeves eller utilstrekkelige*

*Som tvangsmiddel kan anvendes:*

*b) kortvarig anbringelse bak låst eller stengt dør uten personale til stede”*

The use of shielding increased beyond the 1980s, but was not regulated by law until the Mental Health Care Act of 1999 was passed.

Article 4-3 first section then read as follows:

*“Dersom pasienten under opphold i en enhet lider av sterk uro eller har utagerende atferd, kan den faglig ansvarlige bestemme at pasienten av behandlingsmessige grunner eller av hensyn til andre pasienter skal holdes helt eller delvis atskilt fra medpasienter og fra personell som ikke deltar i undersøkelse og behandling av og omsorg for pasienten. Når skjerming opprettholdes over 48 timer, skal det treffes vedtak i saken. Vedtaket om skjerming skal nedtegnes uten ugrunnet opphold. Vedtak kan bare treffes for inntil tre uker om gangen.”*

*[If the patient during a stay in a unit suffers from severe anxiety or has extravagant behavior, the responsible professional may decide that the patient for treatment reasons, or for the sake of other patients, should be kept completely or partially separate from fellow patients, and from staff who do not participate in examination and treatment of and care for the patient. When shielding is maintained for more than 48 hours, a decision in the case must be made. The decision on shielding shall be recorded without undue delay. Decisions can only be made for up to three weeks at a time.”]*

In 2007 article 4-3 is altered so that the first and second section reads as follows:

*“Dersom en pasients psykiske tilstand eller utagerende adferd under oppholdet gjør skjerming nødvendig, kan den faglig ansvarlige bestemme at pasienten av behandlingsmessige grunner eller av hensyn til andre pasienter skal holdes helt eller delvis atskilt fra medpasienter og fra personell som ikke deltar i undersøkelse og behandling av og omsorg for pasienten*

*Det treffes vedtak dersom skjerming opprettholdes ut over 24 timer. Dersom pasienten overføres til skjermet enhet eller liknende som innebærer en betydelig endring av vedkommendes omgivelser eller bevegelsesfrihet, skal det treffes vedtak dersom skjerming opprettholdes ut over 12 timer. Vedtak om skjerming skal nedtegnes uten ugrunnet opphold. Vedtak kan bare treffes for inntil to uker om gangen”*

*[“If a patient's mental state or extravagant behavior during the stay makes shielding neccesary, the responsible professional may decide that the patient, for treatment reasons or for the sake of other patients, shall be kept completely or partially separate from fellow patients and from personnel who do not participate in examination and treatment and caring for the patient*

*A decision is made if shielding is maintained for more than 24 hours. If the patient is transferred to a sheltered unit or similar that involves a significant change in the person's surroundings or freedom of movement, a decision must be made if shielding is maintained for more than 12 hours. Decisions on shielding shall be recorded without undue delay. Decisions can only be made for up to two weeks at a time”]*

Shielding can thus be used both as a coercive measure and treatment. Shielding as a treatment is a particularly Norwegian phenomenon without research evidence of a treatment effect. Recent research does not support assumptions that sheltered rooms stripped for interiors can result in a reduction in mental symptoms or violent behavior. Our expert witnesses will explain this in more detail.

Shielding measures are often implemented in separate shielding units. In its annual report from 2017, the Civil Ombudsman had shielding as its theme. In the chapter *“Isolasjonspreget skjerming i psykisk helsevern” [“Isolation-oriented shielding in mental health care”]* it is described that these units generally have a sterile character, and that in several places they are described as prison-like by both employees and patients. The patient rooms are typically painted white without any decoration or pictures on the walls and lack furniture except for a bed and sometimes a table and a chair. Many of the shielding rooms lacked direct access to open air areas and in practice many patients are not allowed to get outside every day. The patients also otherwise had limited freedom of movement as several shielding units lack access to the common room.

Moreover, the Civil Ombudsman writes:

*“Et sentralt funn var at skjermingstiltak ble gjennomført på måter som gjorde at inngrepet hadde klart preg av isolasjon eller måtte betraktes som isolering.*

*Noen steder ble det funnet skriftlige rutiner eller uformelle praksiser som tydet på at få minutters kortvarig blokkering av pasienters dør ble ansett som “en del av skjermingsvedtaket”. Slike tvangstiltak utgjør isolering etter psykisk helsevernloven article 4-8 og kan bare iverksettes i nødrettsliknende situasjoner.*

*Pasienter som var plassert i skjermingsenhet tilbrakte store deler av tiden alene på sitt eget rom uten særlig kontakt med personalet. Skjermingstiltaket ble ofte praktisert ved at pasientene fikk beskjed om å holde seg på rommet, men uten at døren ble stengt. Flere pasienter opplevde slike muntlige beskjeder som ydmykende og formidlet ensomhet og behov for å ha noen å snakke med. Det varierte hvor personalet oppholdt seg under gjennomføringen av skjerming. Det var utbredt at personalet satt utenfor døren til pasientens rom, som oftest med døren på gløtt eller igjen. Noen steder ble skjerming praktisert ved at pasientene var alene i enheten med døren ut til fellesarealet åpen. Pasientene ble så bedt om å holde seg mest mulig på eget rom, mens personalet satt ute i fellesområdet på et sted de kunne se inn i skjermingsenheten. Det fremkom sjeldent at personalet oppholdt seg sammen med pasienten, selv om lovverket om skjerming forutsetter tett oppfølging og kontakt fra helsepersonell.*

*(...)*

*Forskning om isolasjon i fengsel har vist at kombinasjonen av begrensninger i menneskelig kontakt, sanseinntrykk og selvbestemmelse kan være helseskadelig (For oppsummering av forskningsfunnene, se Sharon Shalev, A Sourcebook on Solitary Confinement, LSE/Mannheim Centre for Criminology 2008). Skjerming, særlig der det skjer over lengre tid, utgjør en risiko for umenneskelig eller nedverdigende behandling. Steder i psykisk helsevern bør på denne bakgrunn ta særlig hensyn til risikoen for isolasjonsskader i sin praksis.”*

*["A key finding was that shielding measures were implemented in ways that meant that the enroachement had elements of isolation or had to be regarded as isolation.*

*In some places, written routines or informal practices were found that indicated that a few minutes of short-term blocking of patients' doors was considered a "part of the shielding decision". Such coercive measures constitute isolation according to the Mental Health Care Act article 4-8 and can only be implemented in emergency law-like situations.*

*Patients who were placed in a shielding unit spent much of the time alone in their own room without much contact with the staff. The shielding measure was often practiced by the patients being told to stay in the room, but without the door being closed. Several patients experienced such verbal messages as humiliating and conveyed loneliness and the need to have someone to talk to. It varied where the staff stayed during the implementation of shielding. It was common for staff to sit outside the door of the patient's room, usually with the door ajar or closed. In some places, shielding was practiced by the patients being alone in the unit with the door to the common area open. The patients were then asked to stay as much as possible in their own room, while the staff sat outside in the common area in a place they could see into the shielding unit. It rarely occurred that the staff stayed with the patient, even though the legislation on shielding presupposes close follow-up and contact from health personnel.*

*(...)*

*Research on isolation in prison has shown that the combination of limitations in human contact, sensory impressions and self-determination can be harmful to health (For a summary of the research findings, see Sharon Shalev, A Sourcebook on Solitary Confinement, LSE / Mannheim Center for Criminology 2008). Shielding, especially where it occurs over a long period of time, poses a risk of inhuman or degrading treatment. With this in mind, places in mental health care should pay special attention to the risk of isolation injuries in their practice ».*

**Appendix 38: “Isolasjonspreget skjerming i psykisk helsevern”, chapter in the Civil Ombudsman’s annual report 2017.**

The same description is repeated in the Civil Ombudsman’s thematic report the following year.

**Appendix 39: Shielding in mental health care risk for inhuman treatment, Theme Report 2018**

NOU 2011: 9 also describes a gradual transition between shielding and isolation. An example is described of the patient having to be alone in the room, but the door is open for ten minutes within an hour. There are also examples of the door not being locked, but secured physically with a wooden block, chair or by the health personnel's foot. Verbal guidance from health professionals can also be seen as synonymous with a locked door.

**Appendix 40: NOU 2011: 9 Chapter 15.3 Tvangsmidler and Chapter 15.4 Skjerming**

The plaintiff has on three occasions been isolated according to article 4-8, see appendices 6, 7 and 10. She has on repeated occasions been kept shielded alone in a room with a staff sitting outside the door, where the staff physically prevented her from leaving the room, in other words what the Civil Ombudsman says must be regarded as isolation. This is not documented through decisions, either because shielding was not regulated by law at the time of the incident or because the legal basis for shileding after 1999 is so broad that it is impossible to read from the decisions whether the shielding has been carried out with isolation or not, see among others Appendix 2. The events will be elucidated through plaintiff's explanation and testimony from Jarle Røstberg.

**3.4.1 The use of isolation and de facto isolation in the periods 09.12.88-16.12.88, 02.01.89 -15.03.89, 21.03.89-25.05.89, 29.01.91-16.04.91 and 05.06.91-25.07.91, 29.01.05-23.02.05,**

**20.03.07-10.04.07, 21.10.14-25.11.14, 22.02.14-19.03.14, 21.10.14-25.11.14 and 07.03.16-**

**08.06.16 violated her rights according to ECHR article 3, the Constitution article 93, ICCPR article 7, UNCAT Article 1 cf. 16 and CRPD Article 15**

Reference is made to section 3.2 for the content of the provisions and the scope of Norway's obligations. The further starting point is ECHR Article 3, which fully covers the other provisions.

**The severity of the enroachement.**

During the stays at Hjelset, the plaintiff was kept completely isolated, placed in solitary confinement and she was cut off from contact with other patients.

There is no doubt that isolation and the shielding in a closed solitary confinement (de facto isolation) by the plaintiff were measures that were suitable for creating a feeling of humiliation, fear and inferiority. The measure thus exceeded the limit for degrading treatment pursuant to Article 3 of the ECHR (Kudła v. Poland 30210/96 section 92).

This in particular with regard to her vulnerable situation as mentally ill and deprived of liberty, cf. Kudła v. Poland 30210/96 - section 91, Peers v. Greece 28524/95 section 67, Keenan v. United Kingdom 27229/95 - section 111, Rohde v. Denmark 69332/01 - Section 99, Renolde v. France 5608/05 - Section 120, M.S v. Croatia No. 2 - Section 96, Munjaz v. United Kingdom 2913/06 - Section 80.

**Purpose of the procedure: coercive measures or treatment.**

The purpose of the measure was either coercive measures or treatment. Isolation according to article 4-8 is used as a coercive measure. The shielding on closed solitary confinement (de facto isolation) has been used both as a coercive measure and as a treatment. It is not possible to determine what the purpose of the shielding has been in the individual case due to lack of legal regulation at the time and thus no decisions or very little specified decisions after 2001.

**Coercive measures.**

According to the ECHR practice, isolation and shielding (de facto isolation) as a coercive measure is considered a severe intervention against the individual. It can only be used when strictly necessary.

In the decision M.S. v. Croatia (No. 2) section 104, the HUDOC stated that:

*“....the developments in contemporary legal standards on seclusion and other forms of*

*non-consensual measures against persons with psychological or intellectual disabilities in hospitals and all other places of deprivation of liberty require that such measures be employed as a matter of last resort and when their application is the only means available to prevent immediate or imminent harm to the patient or others…”*

The court thus established a legal rule that such coercive measures can only be justified if they are implemented as a last resort, and it is the only measure to prevent immediate or imminent harm to the patient or others.

Furthermore, the use of such coercive measures must be:

*“...commensurate with adequate safeguards from any abuse, providing sufficient procedural protection, and capable of demonstrating sufficient justification that the requirements of ultimate necessity and proportionality have been complied with and that all other reasonable options failed to satisfactorily contain the risk of harm to the patient or others. It must also be shown that the coercive measure at issue was not prolonged beyond the period which was strictly necessary for that purpose…”*

The necessity assessment used in determining the threshold for what is inhuman and degrading treatment has thus been sharpened in relation to the necessity assessment for encroachment on relative rights, compare M.S. v. Croatia (No. 2) 75450/12, sections 104-105 and Silver and others v. The United Kingdom (5947/72; 6205/73; 7052/75; 7061/75; 7107/75; 7113/75; 7136/75) section 97.

In this case, we cannot see that the isolation and shielding in the solitary confinement of the defendant was the last resort, and the only measure to prevent immediate or imminent damage to the plaintiff or others. The plaintiff is also of the opinion that the use of isolation and shielding lasted longer than necessary.

Furthermore, it is clear that the lack of regulation of shielding before the Mental Health Care Act of 1999 meant that there were no procedural guarantees of legal certainty. The legal regulation after 1999 is also lacking in this respect, see section 3.5.1 below.

**Treatment**

The ECHR demands that the treatment measure must be in accordance with “recognized rules of medical science”, s*ee Herczegfalvy v. Austria, complaint no. 13699/06.* In light of the weak knowledge base for isolation as a treatment measure, this requirement cannot be said to have been met in this case.

The use of shielding and de facto isolation for treatment measures is a particularly Norwegian phenomenon. The idea is that reducing sensory impressions should have a healing effect. There is very little research on the measure, hardly any randomized studies and effect studies. It is impossible to conclude with a positive treatment effect based on these.

**Appendix 41: “Shielding in acute psychiatry”, Journal of the Norwegian Medical Association no. 1, 2015; 135. pp. 35-39. [“Skjerming i akuttpsykiatrien”, Tidsskrift for Norske Legeforening]**

In NOU 2019: 14 it appears that the committee, through its extensive literature searches, has not succeeded in finding any confirmations of the positive treatment effect of shielding, beyond a short-term reduction of acting out. On the other hand, the committee found articles which claim that it has not succeeded in confirming the positive treatment effect of shielding, cf. Appendix 18, Chapter 10.1.2.

However, there is a lot of research that shows that isolation (and de facto isolation) is harmful. The research is mainly done among inmates in prisons, but there is no indication that it will not be transferable to patients. Reference is made to the Civil Ombudsman's report, Appendix 47. Our witnesses Nora Sveeas and Tonje Lossius Husum will also explain in more detail about the harmful effects of such isolation.

In this case, the isolation and shielding has been going on for a long time, with little meaning

human contact and with a low degree of self-determination and freedom of movement. The plaintiff believes that the extensive isolation she has been subjected to has harmed her mentally. She believes she has developed PTSD after the isolation use and the de facto isolation she has been exposed to, see Appendix 14.

**International criticism**

We would also like to point out that international human rights bodies have repeatedly raised serious criticisms of the use of isolation and shielding in Norwegian psychiatric hospitals. Reference is made to the report of the European Committee for the Prevention of Torture, the UN Committee against Torture and the UN's previous special reports against torture, Juan Mendez, cf. Appendices 29, 30 and 31.

The CRPD Committee has also stated that the Convention prohibits "seclusion and various methods of restraint in medical facilities", and that such practices are not in accordance with Article 15 of the UNCAT.

**Appendix 42: CRPD Committee Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities, adopted during the Committee's 14th session, September 2015.**

**Conclusion:**

The isolation and isolation-like shielding the plaintiff was subjected to is an encroachment on her integrity which clearly exceeds the lower limit of inhuman and degrading treatment. The isolation was not absolutely necessary to avoid injury to the plaintiff or others. Furthermore, the shielding was not in line with recognized medical methods or medically necessary.

The isolation and de facto isolation of the plaintiff through shielding constitutes a violation of Article 3 of the ECHR, the Constitution article 93, ICCPR art. 7, UNCAT art. 1 cf. art. 16 and CRPD art. 15.

**3.5 The use of isolation in the periods 09.12.88- 16.12.88, 02.01.89 - 15.03.89, 21.03.89- 25.05.89, 29.01.91-16.04.91 and 05.06.91-25.07.91, 29.01.05- 23.02.05, 20.03.07-10.04.07, 21.10.14-25.11.14, 22.02.14-19.03.14, 21.10.14-25.11.14 and 07.03.16-08.06.16 constituted violations of the plaintiff's rights under the Constitution articles 113 and 102, ECHR art 8, ICCPR art. 17 and CRPD art. 22 No. 1.**

Reference is made to section 3.2 for the content of the provisions and the scope of Norway's obligations. In the following the starting point is Article 8 of the ECHR, which fully covers the other provisions.

Article 8 of the ECHR may be applied when Article 3 does not apply. There is no doubt that isolation and isolation-like shielding constitute an encroachment on a person's private life, and may constitute a breach of the ECHR.

In Munjaz v. The United Kingdom, the HUDOC concludes that the scope of Article 8 also covers the situation where a prisoner is isolated. Munjaz became increasingly psychotic, aggressive and violent while serving a prison sentence. He was transferred to hospital and at times isolated in his room for the safety of the other patients. The HUDOC stated after referring to the statements of Hirst v. UK and Gülmez v. Turkey (HUDOC-2002-16330) (section 80):

*“In applying those principles to the present case, the Court agrees that the compulsory seclusion of the applicant interfered with his physical and psychological integrity and even a minor such interference must be regarded as an interference with the right to respect for private life under Article 8 if it is carried out against the individual's will (Storck, article 143, cited above). Moreover, the importance of the notion of personal autonomy to Article 8 and the need for a practical and effective interpretation of private life demand that, when a person's personal autonomy is already restricted, greater scrutiny be given to measures which remove the little personal autonomy that is left.”*

Reference is made to the Oslo District Court's thorough judgment of 02.06.14, the "smooth cell" case.

Such an intervention may only be defended if it has sufficient authority in national law, and if the state proves that the use of shielding / isolation – in each individual case – has been "necessary in a democratic society". If the state cannot prove that these conditions have been met, there is a violation of Article 8 of the ECHR.

**3.5.1 The legal requirement**

The statutory requirement/the rule of law was enshrined in the Constitution in 2014 in article 113 of the Constitution, but previously existed as a non-statutory law

with constitutional rank/constitutional customary law.

The legal requirement is further stated in ECHR art. 8 No. 2, ICCPR art. 17 and CRPD art. 22 no. 1, and interpreted in the Constitution article 102. The ECHR and the ICCPR were incorporated into Norwegian law with priority in 1999, cf. the Human Rights Act articles 2 and 3. The presumption principle meant that it was also previously assumed that Norway was bound by the treaties. Reference is made to the Supreme Court's statement in Rt. 1984 page 1175.

The term "in accordance with the law" in ECHR art. 8 no. 2, covers both written and unwritten rules, but the intervention must have a basis in national law. In addition, there are two requirements which are above national law. The rule must be "adequately accessible" and it must be formulated "with sufficient precision" for the citizens to be able to direct their behavior according to it, cf. Sunday Times v. The United Kingdom (No1) (HUDOC-1974-6538) section 49:

*“In the Court's opinion, the following are two of the requirements that flow from the expression “prescribed by law”. Firstly, the law must be adequately accessible: the citizen must be able to have an indication that is adequate in the circumstances of the legal rules applicable to a given case. Secondly, a norm cannot be regarded as a “law” unless it is formulated with sufficient precision to enable the citizen to regulate his conduct.”*

The decision concerned freedom of expression (ECHR Article 10), but the conditions for encroachment on freedom of expression are the same as for encroachment on the right to privacy. The term "in accordance with the law" refers not only to national legislation, but also to"the quality of the law". The rule must be in accordance with the requirement of legal certainty ("the rule of law"). National law must provide legal protection against the authorities' arbitrary interference with their rights.

This is both for the sake of the citizen to be able to predict his or her legal position and for the sake of the possibility of control over the exercise of authority. It is especially the latter consideration that is important when it comes to coercion against the mentally ill, who are already in a vulnerable position and where it is the authorities' special responsibility to ensure that their fundamental rights are fulfilled, cf. HUDOC judgment Herczegfalvy v. Austria 10533/83 .

**De facto isolation without legal authority**

The isolation-like shielding the plaintiff experienced in the period 1988 to 2001 took place without legal authority. It must be clear that any treatment practices or local routines cannot replace legislation for measures of such an intrusive nature.

The shielding thus constituted a violation of the Constitution articles 113 and 102, ECHR art 8, ICCPR art. 17 and CRPD art. 22 No. 1.

**The wording of article 4-3 in the Mental Health Care Act does not meet the requirement for clarity and quality.**

The isolation-like shielding the plaintiff experienced in the period 2001 to 2016 took place on the basis of the Mental Health Care Act of 1999 article 4-3.

The plaintiff claims that article 4-3 is contrary to the legal requirement in that the provision gives the authorities too much and vague discretion with regard to whether the patient is to be shielding or not, how the shielding is to be carried out, the time within which the shielding can take place. Furthermore, the discretionary authority is not accompanied by basic guarantees of legal certainty.

Reference is made to article 4-3 which provides authority for the measure both as a coercive measure and treatment, that the shielding may involve both complete or partial separation from fellow patients and other than primarily treatment personnel and that the measure can be adopted over a 14-day period. During this period, it will not be possible for the patient to predict what degree of shielding or de facto isolation the person will be exposed to, nor the length and frequency of this. Furthermore, there is also no requirement for a decision if the shielding does not last longer than 12 hours (24 hours until 2007). It will neither be possible in retrospect to follow up the justification, execution and necessity of the measure.

The provision does not provide patients with legal protection against arbitrary interference with their right to privacy, and thus does not meet the ECHR's requirements for the quality of the law.

It must thus be concluded that the isolation-like shielding the plaintiff was subjected to in the period 2001 to 2016 did not occur in accordance with the requirement of authority in clear legislation, and thus constituted a violation of the Constitution article 113 and 102, ECHR art 8, ICCPR art. 17 and CRPD art. 22 no. 1.

**3.5.2 The isolation and the isolation-like shielding were neither necessary nor proportionate**

Even if it were to be assumed that the conditions for isolation according to the Mental Health Care Act article 4-8 and shielding according to article 4-3 by the plaintiff were met, it is disputed that the measures were necessary and proportionate.

A requirement of necessity and proportionality in the event of an infringement of rights follows from all human rights conventions. In the HUDOC’s practice, proportionality is interpreted in the wording “necessary in a democratic society”, cf. Article 8 no. 2 on the content of the term, see section 3.3.2 above.

There were no circumstances in the plaintiff's individual case that indicated that there were sufficient compelling and concrete reasons to keep precisely her isolated or de facto isolated through shielding. It was therefore not "necessary in a democratic society". It must also be emphasized that there is no research that shows that shielding has a therapeutic effect, on the contrary a lot of research shows that isolation, sensory deprivation and little human contact are harmful.

It must be assumed that the plaintiff was in an extra vulnerable situation due to her mental illness/illness. This fact must be emphasized in the proportionality assessment. The purpose of the shielding does not imply that there was a need for isolation. It is not stated that the plaintiff was in such a situation that it was necessary to isolate her for reasons of e.g. her own safety.

As a result of the stays in the shielded ward, the plaintiff has suffered an injury in the form of strong mental reactions. She has developed PTSD according to the extensive use of isolation, cf. Appendix 14. The plaintiff's trauma therapist, Mette Kristine Mehus, will also explain this in more detail.

**3.6 Cumulation**

In assessing whether there is degrading/inhuman treatment, the various conditions must be cumulated. If the coercive medication or isolation alone does not reach the threshold for degrading/inhuman treatment, they can do so overall. The HUDOC has stated in Stanev v. Bulgaria (36760/06, 2006) that cumulation can be made in all cases involving deprivation of liberty, see section 205 of the judgment: “When assessing the conditions of a deprivation of liberty under Article 3 of the Convention, account has to be taken of their cumulative effects”.

**3.7 Compensation**

The violations of the constitutional and human rights obligations shown above are the basis for redress liability.

ECHR art. 13 cf. art. 41 and ICCPR art. 2 no. 3, cf. The Human Rights Act article 2 and article 3, provides independent authority for redress. Article 13 stipulates that anyone who believes that his rights under the Convention have been violated shall have an effective right of review before a national authority. If it is necessary for the test to be considered effective, the person in question is entitled to compensation and/or redress, cf. Rt. 2000 p. 428.

Compensation for non-pecuniary damage is actualized in the case of serious breaches of integrity close to Article 3, where the injured party has “suffered obvious trauma, whether physical or psychological, pain and suffering, distress, anxiety, frustration, feelings of injustice or humiliation, prolonged uncertainty, disruption to life, or real loss of opportunity”. Elsholz v. Germany [GC], no. 25735/94, article 70, HUDOC 2000-VIII; Selmouni v. France [GC], no. 25803/94.

The liability for redress shall help to compensate for the violation of personal integrity and has a special function as it can be difficult to prove financial loss in this type.

violations.

It is also clear from the preparatory work for the catalog of human rights incorporated in Part E of the Constitution that in the event of a serious violation of central rights, the authorities are required to restore the situation or compensate for the violation through redress. The Constitution's human rights catalog shall have real significance for those who believe they have been violated, cf. the report from the Human Rights Committee, cf. Appendix 15.

We also refer to Rt. 2013 p. 588, Rt. 2004 p. 1868 and Rt. 2010 p. 291. Rt. 2001 p. 428 (p. 445), as well as LB-2016-8370 and TOSLO-2013- 103468, LG-2003-391.

In the alternative, it is stated that the plaintiff is entitled to redress from the State after the “body responsibility” [“organansvaret”].

The claim for compensation can also be a result of the employer's liability, cf. the Norwegian Damages Act [skadeerstatningsloven] article 2-1.

Again in the alternative, it is stated that the plaintiff is entitled to compensation according to section 3-5 of the Damages Act.

It is required that the tortfeasor has exercised gross negligence if he is to be held liable for redress according to the Damages Act article 3-5. This is met in this case.

The Constitution, ECHR, ICCPR (and CRPD) have been violated because compulsory medication with neuroleptics routinely has been carried out without legal authority. This is and has been known to the authorities, and nothing has been done to stop the illegal practice.

The state has continued the practice of compulsory medication, despite repeated warnings from a competent professional environment and international criticism. Furthermore, it was already clear at the Paulsrud Committee report in 2011 that the compulsory medication practice is illegal, and in violation of central human rights provisions, since the conditions set by law are not respected at treatment institutions. As the presentation of evidence will show, the State has also been made aware of this through the Compulsory Law Committee and from the Civil Ombudsman. Furthermore, several user organizations repeatedly have pointed this out to the Norwegian Directorate of Health. The head of the WSO and a member of the Joint Action for drug-free offers, Mette Ellingsdalen, will explain in more detail. Norway has also repeatedly been criticized by international human rights bodies for both the illegal coercive medication practice and the isolation / shielding practice. Despite this, nothing has been done to stop this illegal practice and the hospital at Hjelset has also after 2011 forcibly medicated the plaintiff repeatedly.

It is further pointed out that the State has continued the practice of shielding and isolating psychiatric patients, despite repeated warnings from a competent professional environment and international criticism over many years.

Finally, the claim for compensation follows from the Damages Act article 3-6

**3.7.1 The measurement**

The redress shall mark the suffered injustice and compensate for the violation that has been done. It is the violation of the law and the breaches of the convention that are the key factors in determining compensation.

In the assessment, it must be placed emphasis on the seriousness of the violations of key human rights that protect the citizen's physical and mental integrity. The plaintiff was subjected to repeated illegal violations since the State did not take into account its known constitutional and international law obligations.

The long time the violation has been going on - over three decades - speaks for a significant amount of compensation. The strain has been considerable. The plaintiff has been forcibly medicated up to several times during 11 involuntary admissions. She has also been subjected to extensive isolation during all hospitalizations. The burden imposed on the plaintiff is thus extensive, extends over a long period of time and has in itself given her mental distress. She is anxious to be forcibly medicated and isolated again if she needs help from the health service and is thus also hindered in her exercise of the right to health. She has also suffered from PTSD after the treatment she underwent at Hjelset.

**4. OPEN DOORS**

The plaintiff wishes that the case will go before open doors and that it is facilitated for the press to have the opportunity to cover the case, cf. the Norwegian Courts of Justice Act article 124. Already now it is announced that movie director Ellen Ugelstad is going to film the court proceedings in their entirety in conjunction with her new movie about coercion in psychiatry.

**5. OTHER EVIDENCE, WITNESSES, AND SO ON**

In addition to the above-mentioned documentary evidence, the plaintiff will also bring the following witnesses:

**Dr. Joanna Moncrieff,** psychiatrist and professor at University College London. Among other things, she will explain about psychoses, neuroleptics, and what these drugs do to the brain and body. We point out that the witness speaks English and that she will testify via video or telephone.

**Robert Whitaker,** science journalist and author. Among other things, he will explain the effects of neuroleptics, the pharmaceutical industry's influence on research into the use of neuroleptics, alternatives to the use of neuroleptics in treatment, etc. We point out that the witness speaks English and that he will testify via video or telephone.

**Magnus Hald,** chief physician and psychiatrist at the drug-free unit in Tromsø. Among other things, he will explain the harmful effects of neuroleptics, the myth of the chemical imbalance, etc.

**Ragnfrid Kogstad**, professor at Innlandet University College. Among other things, she will explain about the use of neuroleptics in Norway, forced user experiences, violations of human rights in Norwegian psychiatry, etc.

**Jaakko Seikkula,** clinical psychologist and researcher. He will explain about Open Dialogue in Finland and how they treat acutely psychotic patients without medication. We point out that the witness speaks Swedish and that he will testify via video or telephone.

**Olav Nyttingnes,** postdoctoral fellow at the Department of Health Services Research and the R&D department of mental health care at Akershus University Hospital. Among other things, he will explain about patients' experience of coercion, etc.

**Tonje Lossius Husum,** professor of mental health work at Oslo Metropolitan University. She will explain about the harmful effects of shielding and isolation etc.

**Nora Sveaas,** professor emeritus and psychologist at the University of Oslo. She will explain about the harmful effects of isolation etc.

**Mette Ellingsdalen,** leader of WSO and member of the Joint Action for drug-free offers. She will explain about the user organizations and the Joint Action's work to introduce drug-free services, including the dialogue with the Norwegian Directorate of Health where the authorities have repeatedly been made aware of illegal coercive medication, shielding and isolation, etc.

**Jarle Røstberg**, nurse/environmental staff at Hjelset from 1988 to 2016. He will explain how the plaintiff has been treated at Hjelset.

**Mette Kristine Mehus,** plaintiff's supervisor and trauma therapist. She will explain about the plaintiff's PTSD and trauma after the admissions at Hjelset.

It is also announced that there will be witnesses from the World Health Organization (WHO) and from the UN. We will return to the names and information about who is applying from these organizations, as soon as it has been clarified who this will be.

The witnesses meet voluntarily and on request from here.

**6. CLAIM**

On behalf of Inger-Mari Eidsvik, the following **claim** is filed:

1) Compulsory medication of the plaintiff which took place in the periods 09.12.88-16.12.88, 02.01.89-15.03.89, 21.03.89-25.05.89, 29.01.91-16.04.91 and 05.06.91-25.07.91, 29.01.05- 23.02.05, 20.03.07-10.04.07, 21.10.14-25.11.14, 22.02.14-19.03.14, 21.10.14- 25.11.14 and 07.03.16-08.06.16 violated her rights according to Article 3 of the ECHR, article 93 of the Constitution, ICCPR art. 7, UNCAT art. 1 cf. art. 16 and CRPD art. 15.

2) The compulsory medication of the plaintiff which took place in the periods 09.12.88-16.12.88, 02.01.89-15.03.89, 21.03.89-25.05.89, 29.01.91-16.04.91 and 05.06.91-25.07.91, 29.01.05- 23.02.05, 20.03.07-10.04.07, 21.10.14-25.11.14, 22.02.14-19.03.14, 21.10.14- 25.11.14 and 07.03.16-08.06.16 violated her rights according to Article 8 of the ECHR and articles 102 and 113 of the Constitution, ICCPR art. 17 and CRPD art. 22 No. 1.

3) The use of isolation and de facto isolation in the period 09.12.88- 16.12.88, 02.01.89-15.03.89, 21.03.89-25.05.89, 29.01.91-16.04.91 and 05.06.91-25.07.91, 29.01.05-23.02.05, 20.03.07-10.04.07, 21.10.14-25.11.14, 22.02.14-19.03.14, 21.10.14- 25.11.14 and 07.03.16-08.06.16 violated her rights according to ECHR Article 3 and the Constitution article 93, ICCPR art. 7, UNCAT art. 1 cf. art. 16 and CRPD art. 15.

4) The use of isolation in the period 09.12.88-16.12.88, 02.01.89 - 15.03.89, 21.03.89- 25.05.89, 29.01.91-16.04.91 and 05.06.91-25.07.91, 29.01.05 -23.02.05, 20.03.07- 10.04.07, 21.10.14-25.11.14, 22.02.14-19.03.14, 21.10.14-25.11.14 and 07.03.16- 08.06.16 violated her rights according to ECHR article 8 and the Constitution article 102 and 113, ICCPR art. 17 and CRPD art. 22 No. 1.

5) The State by the Ministry of Health and Care Services is sentenced to pay Inger-Mari Eidsvik compensation and/or redress nominal NOK 3,000,000 more, with the addition of the default interest rate in force at any given time, calculated from two weeks after the judgment is served until payment is made.

6) The State by the Ministry of Health and Care Services is ordered to reimburse Inger-Mari Eidsvik's legal costs.

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This summons has been uploaded to the player portal.

Oslo, 03.09.2021

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Stine Moen

lawyer

1. “(...) kravet om "stor sannsynlighet» framstår som urealistisk, særlig der man står overfor nye pasienter. Utvalget har videre inntrykk av at dagens beviskrav i liten grad har fungert som en effektiv skranke for praksis, noe som blant annet kan skyldes at det har blitt oppfattet urealistisk strengt. Et noe svakere, men mer realistisk beviskrav kombinert med utvalgets ulike tiltak for økt rettssikkerhet, blir da vurdert å danne et bedre grunnlag for en praksis som er i samsvar med lovens ordlyd og intensjon. Etter utvalgets oppfatning er hovedproblemet etter gjeldende rett at lovens strenge materielle krav ikke har blitt fulgt i praksis.” [↑](#footnote-ref-1)
2. “På bakgrunn av denne metaanalysen (viser her til Zhu et alt. 2017), som har mer optimistiske konklusjoner enn de som ellers er omtalt i kapittel 10, kan et krav om mer enn alminnelig sannsynlighetsovervekt for effekt være ensbetydende med et forbud mot tvangsmedisinering – i alle fall for personer som ikke har prøvd slike midler før” [↑](#footnote-ref-2)
3. “stor forståelse for et ønske om forbud ut fra det kunnskapsgrunnlaget som i dag foreligger om virkninger om virkninger og bivirkninger” [↑](#footnote-ref-3)
4. “Legemiddelbehandling kan bare gjennomføres med legemidler som har en gunstig virkning som klart oppveier ulempene ved eventuelle bivirkninger” [↑](#footnote-ref-4)
5. “hvorvidt det er fare for at behandlingen vil ha bivirkninger, og på hvor sterkt og hvordan medisinen påvirker pasientens fysiske og psykiske tilstand” [↑](#footnote-ref-5)
6. “tvungent psykisk helsevern bare kan finne sted hvor dette etter en helhetsvurdering framtrer som den klart beste løsning for vedkommende, med mindre han eller hun utgjør en nærliggende og alvorlig fare for andres liv eller heles. Ved vurderingen skal det legges særlig vekt på hvor stor belastning det tvangsmessige inngrepet vil medføre for vedkommende.” [↑](#footnote-ref-6)
7. “i den grad dette er nødvendig i et demokratisk samfunn: Tiltaket må i det konkrete tilfellet være egnet, nødvendig og forholdsmessig. Det vises til EMDs dom 28. april 2005 Buck mot Tyskland avsnitt 44-45 [EMD-1998-41604]1 og dom 2.april 2015 Vinci Construction og GTM Génie Civil et Services mot Frankrike avsnitt 79 [EMD-2010-63629].” [↑](#footnote-ref-7)
8. «Forskrifter om begrenset adgang til bruk av tvangsmidler og forbud mot korporlig refselse innen psykisk helsevern, helsevernet for psykisk utviklingshemmede og helsevernet for epileptikere». [↑](#footnote-ref-8)