BORGARTING COURT OF APPEAL

Automatically translated into English by MS Word from the original.

VERDICT

Delivered: 30.01.2026

Case no.: 25-042941ASD-BORG/02

Referees:

Judge of Appeal	Lisa Vogt-Lorentzen
Judge of Appeal	Guro Hansson Bull
Extraordinary Judge of Appeal	Karen Wendel Sandaa

Appellant	Inger-Mari Eidsvik	Attorney Gro Hofseth Hermansen Attorney Mads Andenæs Lawyer Stine Moen
Respondent	The State v/Ministry of Health and Care Services	Lawyer Bjarne Snipsøyr Associate Vilde Frigstad Aggvin

The case concerns a claim for a declaratory judgment for violation of Articles 3 and 8 of the European Convention on Human Rights (ECHR), cf. Article 14, and Articles 7 and 17 of the UN Covenant on Civil and Political Rights (ICCPR), cf. Article 26. It is stated that the aforementioned articles should be interpreted in the light of the UN Convention on the Rights of Persons with Disabilities (CRPD).

Interventions are stated to exist in the case of forced medication, isolation and isolation-like shielding, cf. Sections 4-4, 4-8 and 4-3 of the Mental Health Care Act. Such measures are often referred to as
«coercion in the coercion» and is not covered by the judicial review pursuant to Chapter 36 of the Dispute Act.

Background to the case

The account of the case background in the district court's appealed judgment is undisputed, and is reproduced here:

> The plaintiff, Inger-Mari Eidsvik, was subject to compulsory mental health care eleven times in the period 1988–2016. At ten of these admissions, she was medicated with various neuroleptics (also called antipsychotics or psychotropic drugs) and subjected to shielding and isolation. At one of the admissions, she was treated without medication.
>
> Eidsvik has not disputed that the conditions for compulsory mental health care were met. She therefore never brought a case for termination of health care under Chapter 36 of the Dispute Act or the corresponding rules in the former Civil Procedure Act. Her view is that the above-mentioned coercive measures – the coercion in the coercion – were illegal and subject to compensation. She has on some occasions complained about the forced medication to the county governor, but has not been successful.
>
> Eidsvik filed a lawsuit against the state by summons on 3 September 2021. The case originally concerned several claims, including claims that the treatment was in violation of CAT (UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) and CRPD (UN Convention on the Rights of Persons with Disabilities), as well as the Constitution. These claims, with the exception of the requirement for a declaratory judgment for violations of the Constitution after 2014, (when the Constitution's Part E on human rights was adopted), have been waived during the course of the case.
>
> Furthermore, she submitted a claim for compensation for the alleged violations of human rights and the Constitution.
>
> In its response to the District Court, the State submitted a claim that the claims for a declaratory judgment should be rejected due to a lack of legal interest. The state also submitted a claim for acquittal of the claims for damages, based on, among other things, claims of limitation.

On 27 January 2022, the District Court decided that a separate hearing should be held on the issues relating to legal interest and limitation, cf. Section 16-1 of the Dispute Act. The case was also joined with a parallel case from another plaintiff, Merete Nesset. She has later withdrawn the lawsuit by a procedural claim of 13 June 2024.

The start of the case was that in the summer of 2016, Eidsvik and Nesset came into contact with the International Commission of Jurists – Norwegian Section ("ICJ"), which is also

party assistant in the case. The ICJ is a human rights organization that in 2016 had established a pro-bono project for the reprimand of cases of compulsory mental health care. Eidsvik and Nesset's cases were selected as relevant to have tried in the court system. The ICJ declared assistance to the parties pursuant to Section 15-7 of the Dispute Act on 5 February 2022.

On 22 July 2022, Oslo District Court issued a ruling in which the claims for a declaratory judgment were rejected, and a judgment in which the State v/ the Ministry of Health and Care Services was acquitted of the claims for damages.

The plaintiffs appealed the decision to the Borgarting Court of Appeal, which in its judgment and ruling
16 May 2023 rejected the appeal. The plaintiffs then appealed to the Supreme Court, which by decision of 25 September 2023 denied the appeal against the judgment submitted. The Court of Appeal's decision that the compensation claims are time-barred is thus legally binding.

With regard to the question of whether the claims for a declaratory judgment should be dismissed, the Supreme Court ruled on this in a ruling of 3 May 2024 [HR-2024-826-A], where the conclusion reads as follows:

> "1. The actions are brought insofar as they relate to allegations of violation of Articles 3 and 8 of the European Convention on Human Rights and Articles 7 and 17 of the International Covenant on Civil and Political Rights, but only for coercive measures implemented in 2013 and later.
>
> 2. Otherwise, the appeals are dismissed.
>
> 3. In costs before the District Court and the Court of Appeal, the State, represented by the Ministry of Health and Care Services, jointly pays Inger-Mari Eidsvik and Merete Augusta Nesset NOK 550,000 – five hundred and fifty thousand – within 2 – two – weeks after the service of the ruling."

The points of dispute that remain in the case, following the Supreme Court's decision, are whether medication, isolation and shielding, in the form of alleged de facto solitary confinement, under compulsory mental health care violate the rules of ECHR Articles 3 and 8 and Articles 7 and 17 of the ECHR, for coercive decisions implemented after 2013 and later.

As mentioned above, Nesset dropped the lawsuit by procedural claim of 13 June 2024, so that the case now only concerns Eidsvik.

On 21 January 2025, Oslo District Court delivered its judgment with the following conclusion:

> 1. The State v/Ministry of Health and Care Services is dismissed.
>
> 2. No costs are awarded.

Inger-Mari Eidsvik has appealed the verdict to the Borgarting Court of Appeal. The state, represented by the Ministry of Health and Care Services, has countered in its response to the appeal. Gender equality and

The Anti-Discrimination Ombud and ICJ Norway have submitted submissions to shed light on public interests, which are included in the basis for the decision, cf. Section 15-8 of the Dispute Act.

An appeal hearing was held on 26–28 November 2025 in the Borgarting Court of Appeal.

The parties' views on the case

The appellant, **Inger-Mari Eidsvik**, has essentially claimed:

The coercive interventions in Eidsvik's bodily and mental integrity constituted a violation of ECHR Articles 3 and 8, as well as violations of ECHR Articles 3 and 8 in conjunction with Article 14.
The SP applies correspondingly to Articles 7 and 17, cf. Article 26.

In principle , it is stated that all coercive psychiatric interventions are in violation of the ECHR and the ECHR, interpreted in the light of the CRPD.

The CRPD prohibits any psychiatric treatment without free and informed consent, cf. Articles 5, 12, 14, 15, 17 and 25d, cf. Articles 1, 2 and 3 and the preamble (k). In order to avoid conflict between regional and international human rights instruments, the ECHR and the ECHR must be interpreted in accordance with the CRPD, cf. also the Vienna Convention on the Law of Treaties Articles 31 –
33. The CRPD is lex specialis and lex posterior, in particular in the case of coercive interventions against persons with disabilities. A paradigm shift has taken place. The CRPD is the final step in the development of procedural safeguards for persons with disabilities. There is no conflict between the human rights and the medical profession. The World Health Organization (WHO) is the authoritative body for medicine and does not recommend the use of force. The CRPD Committee has determined that forced medication is illegal under the CRPD.

In the alternative, it is argued that the specific interventions in Eidsvik's physical and mental integrity in 2014 and 2016 constituted a violation of the ECHR and the ECHR.

The court will carry out a human rights review. The provisions do not allow for administrative discretion. They require an assessment of necessity and proportionality, not expediency. The court has full power of review, even where the assessment of evidence or the application of the law contains discretionary elements. The questions raised by the case lie at the core of the principle of legality. The national review must be at least as thorough as the review carried out by the ECHR, which in the application of Article 3 of the ECHR conducts "a particularly thorough scrutiny", particularly in cases involving psychiatric patients. The CRPD further sharpens the intensity of testing.

The standard of proof is a general preponderance of probabilities.

The burden of proof shall be reversed in all cases concerning violations of conventions committed against persons in the custody of the authorities, and thus also in this case. The journal cannot be used as a neutral document. For example, it cannot be assumed that it would have been recorded that the night watchman kept one foot against Eidsvik's door when she was subject to shielding.

The coercive measures were in violation of *Article 3 of the ECHR*.

The forced medication with antipsychotics and its implementation was likely to give Eidsvik severe physical and/or mental suffering, humiliation and a sense of fear and inferiority. Eidsvik was, among other things, lifted onto the sofa and held by several men, before they pulled down her pants and injected with antipsychotics. Such use of coercion requires a separate decision, and in any case entailed that the coercive medication was particularly invasive. Eidsvik's clear and long-standing stand against taking antipsychotics, both as a professional and as a patient, meant that she experienced the forced medication as a further humiliation. Antipsychotics can have serious side effects, and they did for Eidsvik as well. Her previous experiences, both with serious side effects of the medication and a previous rape, which she informed the therapist about, also made the forced medication particularly invasive.

The forced medication was not medically necessary. The research-based knowledge about drug treatment of Eidsvik's disorder is very inadequate. Research on voluntary drug treatment is not transferred directly to coercive medication.
Forced medication escalates the situation, creates stress in the patient and destroys the relationship between therapist and patient, and can therefore hinder recovery. Eidsvik wanted to live through the psychosis without medication and let it "burn out" by itself. Eidsvik's one experience without medication showed that at the time this only took one month. The only thing the forced medication could possibly do was to shorten the period this would take.

Less invasive treatment was possible to achieve recovery. She could have been given sedatives, combined with shielding and conversations. No measures other than medication with antipsychotics have been considered in the medical records. Nor does it appear that her known trauma has been taken into account in the assessment of what treatment should be offered.

Sufficiently effective procedural mechanisms were not available. The Control Commission does not take a position on drugs. The courts do not take a position on the durability of coercive medication in cases under Chapter 36 of the Dispute Act. Such a trial was in any case unavailable to Eidsvik as she did not oppose the actual compulsory hospitalization. Judicial review of the validity of the decisions would have taken place in accordance with the rules of general procedure.

The rules on free legal aid would not have applied. The fact that there are no examples of such a review illustrates how difficult this remedy is to access.

The legal protection mechanisms that existed were not complied with. The County Governor failed to process several complaints from Eidsvik and her relatives. The decision was inadequately reasoned, and there is a high probability that the County Governor did not understand the law correctly.

The isolation Eidsvik was subjected to was not a last resort. She posed no imminent danger to herself or others.

The shielding pursuant to Section 4-3 of the Mental Health Care Act was carried out in such a way that it was in violation of Article 3 of the ECHR. It happened several times that the staff closed the door to Eidsvik's room by holding one foot against the door or by sitting on an armchair with their back to the door.
She was also accidentally "backed up" into the room by the head of department. The shielding went beyond the framework of the law and the regulations and was characterized by isolation. Eidsvik has no opportunity to document this himself, but has given specific descriptions of the place, people and situations. Combined with reports from the Parliamentary Ombud, and information about the specific hospital, this is sufficient to reverse the burden of proof for the question of whether this happened.

Confinement in the room was likely to cause Eidsvik severe physical and/or mental suffering, humiliation and a feeling of fear and inferiority. This was a very invasive measure, which was likely to humiliate, create fear and cause possible harm. It was not treatment and must be equated with solitary confinement, for which the conditions of the law were not met.

Nor were sufficient procedural mechanisms available for shielding and isolation. The decisions can be appealed to the Control Commission, but the procedural rules in Section 6-4 of the Mental Health Care Act do not apply. It is only where these procedural safeguards apply, in connection with discharge, that the Commission can be considered a court-like body. Lack of documentation requirements makes control impossible.

The interventions were in violation of *Article 8 of the ECHR*.

The coercive medication is not authorised by law and has been carried out in violation of the law's conditions that there must be a "high probability" that the treatment can lead to "cure or significant improvement of the patient's condition", and a requirement for a beneficial effect that "clearly" outweighs the disadvantages of side effects. More than the usual preponderance of probabilities is required, both for prognosis requirements and qualification requirements. The lack of effective procedural safeguards in itself constitutes a violation.

The forced medication was not necessary and proportionate. Reference is made to side

effects and that any effect of the medicine is poorly documented.

The legal basis for solitary confinement in Section 4-8, second paragraph, of the Mental Health Care Act is too broad according to the ECHR's practice. It does not provide adequate regulatory protection and does not prevent arbitrariness.

The shielding as it was carried out was in reality isolation and unauthorized. The legal basis in Section 4-3 of the Mental Health Care Act is too broad; it provides a large and vague margin of discretion. There are no sufficient documentation requirements to enable verifiability.

Neither the shielding nor the isolation was necessary or proportionate. The

same arguments apply to the corresponding provisions of the SP.

The state has been properly sued for a declaratory judgment for all the human rights violations, and cannot be acquitted on the grounds that the health trusts are independent legal entities.

The following claim has been made:

1) The forced medication of the plaintiff that took place in the periods 22.02.14-19.03.14, 21.10.14-25.11.14 and 07.03.16-08.06.16 violated her rights under ECHR Article 3 and SP Article 7.

2) The forced medication of the plaintiff that took place in the periods 22.02.14-19.03.14, 21.10.14-25.11.14 and 07.03.16-08.06.16 violated her rights pursuant to Article 14 of the ECHR and Article 26 of the ECHR; cf. Article 3 of the ECHR and Article 7 of the ECHR.

3) The forced medication of the plaintiff that took place in the periods 22.02.14-19.03.14, 21.10.14 - 25.11.14 and 07.03.16-08.06.16 violated her rights under ECHR Article 8 and SP Article 17.

4) The forced medication of the plaintiff that took place in the periods 22.02.14-19.03.14, 21.10.14-25.11.14 and 07.03.16-08.06.16 violated her rights under ECHR Article 14 and SP 26, cf. ECHR Article 8 and SP Article 17.

5) The use of shielding with an insulation-like character in the period 22.02.14-19.03.14, 21.10.14- 25.11.14 and 07.03.16-08.06.16 violated her rights under cf. Article 3 of the ECHR and Article 7 of the ECHR.

6) The use of shielding with an insulation-like character in the period 22.02.14-19.03.14, 21.10.14-25.11.14 and 07.03.16-08.06.16 violated her rights under cf. Article 8 of the ECHR and Article 17 of the ECHR.

7) The use of solitary confinement in the period 22.02.14-19.03.14 and 21.10.14-25.11.14 violated her rights under ECHR Article 3 and SP Article 7.

8) The use of solitary confinement in the period 22.02.14-19.03.14 and 21.10.14-25.11.14 violated her rights under ECHR Article 8 and SP Article 17.

9) Orders Inger-Mari Eidsvik to pay the costs.

The respondent, **the state represented by the Ministry of Health and Care Services**, has essentially claimed:

Eidsvik is not a victim of human rights violations.

The court should decide on Eidsvik's claim in two parts. First, the court must assess whether the Mental Health Care Act in itself is in conflict with the invoked provisions of the Convention. If it is not, the only question is whether the processing has been in accordance with the law.

The Mental Health Care Act is not in conflict with human rights. The processing has been in accordance with the law, and it has therefore also been in accordance with human rights.

The assessment shall be made on the basis of the facts at the time of the decision, including with regard to the underlying knowledge base. The medical records must, as evidence close to the time, be given great weight. There is less reason to attach importance to explanations from parties. When assessing the probative value of Eidsvik's explanation, it must be taken into account that both the illness and the coercive regime may have affected her memories.

The burden of proof rests with Eidsvik. No concrete evidence of human rights violations has been adduced, which is a prerequisite for the burden of proof to be reversed.

It is unclear whether the ECHR's application of a qualified standard of proof provides a basis for departing from the starting point in Norwegian law regarding a general preponderance of probabilities.

There are good control mechanisms in the Mental Health Care Act. The basic conditions for compulsory mental health care in section 3-3 and the conditions for specific coercive measures must be seen in context.

Sections 4-3 and 4-4 of the Mental Health Care Act provide instructions in their entirety on administrative discretion, the appropriateness of which the courts cannot review. Sections 4-8, on the other hand, do not provide guidance on any administrative discretion.

The forced medication took place in accordance with Section 4-4 of the Mental Health Care Act, cf. Section 4-2. Although medication was the first choice as a form of treatment, forced medication was not.

Mania/psychosis in isolation will go away on its own, and the state largely agrees that forced medication should be the last resort. The fact that Eidsvik was a strong opponent of medication is a weighty element against forced medication. This has been weighed against

the factors that indicated medication. Eidsvik was very ill and needed treatment.
Forced medication was necessary to prevent her from perishing, to limit intolerable suffering and to get into a position for conversations and other treatment. The therapist had good

experience with medication of her in the past. The medication had few very serious side effects. The case does not concern either first-time medication or long-term treatment.

General knowledge supports that the conditions were met. The treatment was in line with the guidelines¸which expressed the best knowledge during the period in question, even though they do not apply to forced medication. The witnesses and documents Eidsvik has referred to related to the treatment have not been successful, neither medically nor legally.

The forced medication was carried out in accordance with the decisions and the law. Section 4-4 of the Mental Health Care Act authorised the use of force in 2014 and 2016. Section 4-8 second paragraph (d) of the Act does not apply to treatment, cf. Section 25 of the Mental Health Care Regulations. However, following instructions from the Directorate of Health and the Ministry, the practice since 2020 has been to make decisions pursuant to Section 4-8 of the Act in relation to the use of force during forced medication, including to ensure the right to appeal and registration of the use of force. From 2020, section 4-8 decisions were therefore necessary and correct, while it was not required in 2014 and 2016. If such a decision was nevertheless necessary, the conditions were met, so that the error only consisted of a lack of a formal decision.

The isolation took place in accordance with Section 4-8 of the Mental Health Care Act, cf. Section 4-2. Eidsvik was very outgoing and aggressive. There were emergencies and it was necessary to take intrusive measures. The isolation was carried out in accordance with the decisions and the law.

The shielding took place in accordance with Section 4-3 of the Mental Health Care Act, cf. Section 4-2 and Section 18 of the Mental Health Care Regulations. Eidsvik has not provided sufficient evidence that the shielding took place in the way she claims. The general description of the facts in the reports from the Parliamentary Ombud is not disputed, but there is not a sufficient basis for reversing the burden of proof.

Shielding is not necessarily sharply delimited against insulation, cf. cf. Section 4-8 second paragraph (c) of the Mental Health Care Act. The patient may, under certain conditions, be "detained" during shielding, cf. Section 18, second paragraph, of the Mental Health Care Regulations.

To (attempt to) "close" a door by having staff sit in a chair with their backs to the door is outside the scope of the rules on shielding, cf. Section 18, first paragraph, second sentence of the Regulations. Putting a foot against the door, on the other hand, is inside; one foot will not be sufficient to
"shut" a door, just to hold it in place. "Reversing" the patient into the room is within the shielding rules, cf. Section 18, first paragraph, last sentence of the Regulations.

If, instead of deciding on Eidsvik's claim in two paragraphs, the court makes a direct assessment of whether the coercive measures entailed violations of the Convention, it will reach the same conclusion.

The CRPD does not prohibit coercive treatment in psychiatry. The CRPD Committee's practice is not binding under international law, only recommendations and proposals, cf. CRPD Articles 36 and 39;

cf. Article 5 of the Optional Additional Protocol to the CRPD. The practice of the UN Human Rights Committees is not among the interpretative factors mentioned in Article 31 of the Vienna Convention. It is most obvious to consider the UN committees' statements in line with the supplementary instruments referred to in Article 32 of the Vienna Convention. When the Committee's statements conflict with the result of interpretation in accordance with the rules for treaty interpretation in Article 31 of the Vienna Convention, they cannot be given weight.

Neither the ECHR nor the SP prohibits forced treatment in psychiatry.

The ECHR gives nation states a considerable margin of discretion in medical assessments.

Article 3 of the ECHR and Article 7 of the ECHR have not been violated. In contrast to Article 8 of the ECHR, Article 3 does not have an independent condition regarding legal authority. The treatment has been medically necessary and proportionate. Articles 2 and 3 of the ECHR require the state to protect patients from itself, and Article 8 to protect institutional staff and other patients. There are good legal protection mechanisms. Any deviation is just above the limits of the law.

Article 8 of the ECHR and Article 17 of the ECHR have not been violated. Coercive treatment constitutes intervention, but there are "proper safeguards against arbitrariness".

The legal requirement has been met. Norwegian courts shall assess the application of the law of the administration in the same way as the ECHR assesses the application of the law of national authorities. The legal requirement is only violated if the application of the law is arbitrary or manifestly unreasonable. Any error in the application of the law is at most just above the limits of the law.

A decision that does not have a legal basis as a result of an error in the application of the law will not automatically violate the legal requirement under Article 8 of the ECHR. Internal law invalidity does not in itself mean that the ECHR has been violated. The principle of subsidiarity means that it is up to national authorities to interpret national law. The interference in Article 8(1) of the ECHR does not have to be within the legal basis. Statements in legal theory about violation by non-compliance with national law are linked to ECHR Article 5 and deprivation of liberty, where the ECHR goes further in reviewing legality. The ECHR only normally overrides the view of national courts on this issue by means of "evident arbitrariness".

The focus of the ECHR's review concerns whether the result of the application of national law is in accordance with the Convention, not whether there is a legal basis that allows for this precise result. The ECHR's review of the legal requirement means that it does not in itself protect against decisions that may be materially incorrect under domestic law.

Another understanding means that national rules that affect the area of the right to privacy are raised to the "human rights level".

Supreme Court case law related to Article 5 of the ECHR, cf. HR-2023-604-A, paragraph 70 and HR-2024-

2167-A, paragraph 51, is in a special position. LB-2023-120551 and LB-2023-177557 are based on an incorrect understanding of the legal requirement.

The interventions were proportionate. The same factors that imply that the processing was in accordance with the law also indicate that the processing did not violate the rights of the Convention.

Article 14 of the ECHR and Article 26 of the ECHR have not been violated. Disability in the form of long-term and serious mental illness may, depending on the circumstances, be grounds for discrimination. However, there are significant differences between people who are involuntarily hospitalised and those who are not. A permanent and serious mental illness is in any case not sufficient for compulsory treatment. The states have a certain margin of discretion.

There is no discrimination against Eidsvik. The situations are not comparable. Any differential treatment has a factual and reasonable purpose. The factors that show that the processing has been in accordance with the law also indicate that it has been factual, reasonable, legitimately justified, necessary and proportionate.

Any violation of convention rights is not due to errors for which the state is responsible. Even though the state is an obligated party under international law, internal law rules must be decisive for the division of responsibilities under internal law. The coercion itself is carried out by a health trust, which is a separate legal entity, cf. Section 6 of the Health Enterprises Act. The state is not responsible for any errors related to the health trust, including specific interventions against Eidsvik and assessments made in this connection. The state is only responsible for legislation, general guidelines and state control functions, and there are no errors in these.

The following claim has been made:

1. The appeal is dismissed.
2. The State, represented by the Ministry of Health and Care Services, is awarded costs before the Court of Appeal.

The Court of Appeal's assessment

1. Introduction

1.1 Conclusion

The Court of Appeal has come to the conclusion that the appeal is partly successful.

As the Court of Appeal interprets the Mental Health Care Act, the legal framework for coercive medication, solitary confinement and shielding, hereinafter also referred to

collectively as coercive measures, in Norway is neither in conflict with ECHR Articles 3, 8 and 14 nor SPR Articles 7, 17 and 26. This also applies when the conventions are interpreted in the light of the CRPD. The Court of Appeal cannot see that the

invoked convention rights prohibit all coercive treatment and all coercive measures in psychiatry, nor coercive medication with antipsychotics.

The conditions for forced medication in Section 4-4 first paragraph, second paragraph (a), third paragraph and fourth paragraph of the Mental Health Care Act provide instructions on the application of the law, which the court can review in full. The circumstances of the individual case may nevertheless give reason to be reluctant to try those of the conditions of the Act that require special medical expertise. When the conditions of the Act are met, it is left to the discretion of the public administration whether it uses the competence to make decisions on forced medication. This administrative discretion can only be reviewed by the courts within the general framework for this.

The conditions for solitary confinement in Section 4-8 of the Mental Health Care Act and for shielding in Section 4-3 also provide instructions on the application of the law, which the court can review in full. However, depending on the circumstances, there may be reason to be reluctant to try those parts of the conditions for risk-free return that require special medical expertise.

The Court of Appeal has concluded that the specific forced medication of Eidsvik violated her convention rights in that the procedural safeguards stipulated in the Act and the Regulations were not met. One case of solitary confinement also violated her convention rights. Under some doubt, the shielding is not considered to constitute an offence.

1.2 Overview of issues and structure

Eidsvik has submitted a claim for a declaratory judgment for violation of Articles 3 and 8 of the ECHR, cf. Article 14, and Articles 7 and 17 of the ECHR, cf. Article 26. In *HR-2024-826-A* , the Supreme Court ruled that the claims are legal claims pursuant to Section 1-3 of the Dispute Act and are submitted for coercive measures in 2013 and later.

The right to request a declaratory judgment for violations of the ECHR and the ECHR is based on the right to an effective remedy and the principle of subsidiarity. *HR-2024-826-A* , paragraph 32 states:

> The right to an effective remedy in Article 13 of the ECHR and Article 2(3) of the ECHR has two aspects: One is that the person who makes a procedural claim of a breach of the Convention must be given access to a national authority that can examine the claim. The second is that this authority must be able to provide effective repair in the event of breakage, see HR-2022-401-A two brothers paragraphs 30 and 31 with references. In other words, arrangements must be made for an effective national examination of allegations of breach of convention and reparation before they are subject to international review. This is often referred to as the "principle of subsidiarity", which is now stated in the preamble to the ECHR.

The relationship to human rights obligations is the application of law and is fully reviewed by the courts. This also applies when the Norwegian provision provides instructions for so-called "free discretion", cf. the plenary judgment *Rt-2012-1985 (Long-term child I),* paragraph 142. It is a

«safe starting point» that «the courts can also examine the specific subsumption where there is a question of the relationship to our *human rights obligations*», cf. the plenary judgment *Rt-2015-1388 (Internal Flight)* paragraph 226, see also paragraph 118 on behalf of the minority. The fact that there are obligations under international law in an area is also an argument in favour of the courts having full jurisdiction to review; *Rt-2015-1388 (Internal displacement),* paragraph 216.

Article 3 of the ECHR and Article 7 of the ECHR prohibit torture and inhuman/degrading treatment. Article 8 of the ECHR and Article 17 of the ECHR protect the right to privacy, including personal integrity. Article 14 of the ECHR and Article 26 of the ECHR prohibit discrimination. Eidsvik has argued that the above-mentioned articles in the ECHR and SP should be interpreted in the light of the CRPD.

Human rights norms will "have to govern the interpretation and application" of the Mental Health Care Act; *HR-2016-1286-A* paragraph 31 and *HR-2023-2018-A* paragraph 119. The legal basis for competence in the Mental Health Care Act must therefore be interpreted in light of the relevant articles in the ECHR and the ECHR, cf. Sections 2 and 3 of the Human Rights Act. It is only when the result of such an interpretation is in conflict with articles in the ECHR and the SPC that the legal framework for the coercive measures in question in itself entails a violation of the Convention.

The Court of Appeal explains the scope of the convention protection in section 2. Sections 3–6 discuss the legal framework for forced medication, solitary confinement and shielding. The specific treatment of Eidsvik is assessed in item 7. In paragraph 8, the Court of Appeal considers the state's argument that it has not been properly sued with regard to a declaratory judgment that the coercion against Eidsvik constitutes a breach of the Convention, and in paragraph 9, the claims for costs are decided.

2. Convention protection

2.1 Introduction

Norway is legally obliged to comply with international law agreements that Norway has ratified. The national legislation may not conflict with, and must be practiced in accordance with, the minimum requirements arising from the provisions of such conventions. If the states do not implement the rights, there is a violation of international law. Individual provisions in the ECHR, SP and CRPD thus represent important framework conditions for the legislation on the use of coercion in mental health care.

The ECHR and the ECHR apply as Norwegian law with precedence over other Norwegian legal rules in the event of conflict, cf. Sections 2 and 3 of the Human Rights Act. Norway ratified the CRPD in 2013. At the time of the circumstances at issue in this case, the Convention had not been incorporated into Norwegian law. On 9 December 2025, the

Storting decided to incorporate the CRPD through a new no. 6 in Section 2 of the Human Rights Act, so that the CRPD will also apply as Norwegian law in the future and take precedence over other legislation in the event of any conflict.

2.2 The framework for convention interpretation

Norwegian courts shall determine the content of the protection afforded by means of an independent interpretation of the relevant conventions. The general rules for treaty interpretation in international law are codified in the Vienna Convention on the Law of Treaties of 23 May 1969, Articles 31–33. The key interpretative factor is the actual wording of the treaty or convention in question.
The text of the Convention shall be interpreted in good faith in accordance with the general meaning of the terms used, cf. Article 31. The Vienna Convention does not mention the significance of statements from UN monitoring committees. Such statements are not binding under international law, but may carry considerable weight as a source of law, cf. HR-2016-2591-A, Section 57. Subsequent state practice is also relevant, cf. Article 31 third paragraph (b). Consideration shall also be given to "relevant rules of international law applicable in the relations between the parties", cf. Article 31 third paragraph (c). As a general rule, the preparatory works of the Convention can only serve as an interpretative factor to confirm a result of interpretation that follows from the main rule in Article 31, cf. Article 32. The exception is if the interpretation according to the main rule gives an "ambiguous or obscure", "manifestly absurd or unreasonable" interpretation result.
The Court of Appeal assumes that the use of preparatory works to establish what the states meant when the treaty was negotiated is even less relevant in the case of dynamic interpretation than in the case of general treaty interpretation.

The parties agree that the SP does not provide further protection than the ECHR for the circumstances to which this case relates. The Court of Appeal agrees with this, and will further concentrate its discussion on the ECHR.

The Supreme Court has stated that the interpretation of the ECHR shall be based on the method used by the ECHR. Norwegian courts must relate to the text of the Convention, considerations of purpose and the ECHR's decisions. It is primarily the ECHR that will develop the ECHR, and Norwegian courts should normally not add safety margins against Norway being convicted of a violation of the Convention. If there is doubt about the interpretation of a provision of the Convention, Norwegian courts may draw on value priorities that form the basis of Norwegian legislation and legal opinion when weighing up different interests or values. In such cases, it may be of importance in such cases whether the legislator itself has made such trade-offs when formulating the regulations, and as part of this assessed the relationship with the ECHR. In the event of doubt as to the significance of the ECHR's decisions, it will be of importance whether the facts of the case can be compared with what is available for a decision in Norwegian law. Reference is made, inter alia, to *HR-2022-2329-A*, paragraph 70, *HR-2019-1206-A* (ground lease), paragraph 104, the plenary decision *Rt-2005-833*, paragraphs 45–47 and *Rt-2000-996*.

When the ECHR decides whether a Member State has violated the ECHR, the ECHR's intensity of the review varies; The ECHR gives states a margin of appreciation to varying degrees. The margin of the nation states depends, among other things, on the rights and interests affected, how intrusive the measure is, and what justification has been given for the measure.

The doctrine of discretion has no place in the interpretation of the absolute protection in Article 3 of the ECHR, but is relevant in the case of interference with Article 8 of the ECHR.

The doctrine of discretion applies to the relationship between the ECHR and the States Parties. It is traditionally justified by democratic legitimacy, proximity to the facts and the degree of European consensus; *Hatton et al. v. United Kingdom* (36022/97, Grand Chamber judgment of 8 July 2003) paragraph 97. The margin of discretion also operationalises the principle of subsidiarity, which means that it is primarily the task of the national authorities to safeguard the rights of the Convention, while the ECHR shall have a supervisory function, cf. the ECHR's preamble pursuant to Protocol 15. In recent times, the ECHR has developed what is often referred to as a process-oriented review, where the ECHR places increasing emphasis on whether the national authorities have carried out a thorough propagandistic
Assessment of visibility; *M.A. v. Denmark* (6697/18, Grand Chamber 9 July 2021) paragraph 149 and *The Karibu Foundation v. Norway* (2317/20, 10 November 2022) paragraphs 79 and 92.

The doctrine of discretion cannot be directly applied to the intensity of review by national courts, cf. *A et al. v. Great Britain* (3455/05, EMDN-2005-3455, Grand Chamber of 19 February 2009) paragraph 184.

In four recent decisions, the Supreme Court has taken this as a basis. *HR-2022-718-A (cabin quarantine)* section 89 reads as follows:

> The margin of discretion that follows from the ECtHR's case-law applies to the states, and will therefore not be transferable to national courts' review of measures implemented in a state, see, inter alia, ECtHR's judgment of 19 February 2009 A and Others v. the United Kingdom [EMDN-2005-3455]1 paragraph 184 and the decision of 23 June 2015 Nicklinson and Lamb v. the United Kingdom [ECHR-2015-2478] paragraph 84. However, on the basis of Norwegian law, the Supreme Court will be cautious about reviewing assessments that are largely professional or based on complex social considerations.

See also *HR-2022-2171-A (Oslo Regulations)* section 75, *HR-2022-2329-A (age limit)* cf. section 73 and *HR-2024-1107-A (quarantine hotel)* paragraph 94.

However, as stated in the Cabin Quarantine judgment, the Supreme Court will "on the basis of Norwegian law" be cautious about reviewing assessments that are "largely professional or based on complex social considerations". *HR-2022-2329-A (age limit)*, paragraph 73, states that there is particular reason to be cautious about reviewing "trade-offs of legitimate considerations made by political authorities, cf. HR-2018-1958-A, paragraph 86". In *HR-2024-1107-A (quarantine hotel)*, the following was stated in

paragraph 94:

> In an area such as the present case, it is therefore of little practical significance whether the margin of discretion formally applies only to the states. In any case, the executive authorities must be granted a space to make medical and broad societal assessments without the courts intervening.

What these statements refer to and imply has been discussed in legal literature, see e.g. Henrik Jorem, *On the Role of the Margin of Discretion in Norwegian Law in Light of Legal Developments in Strasbourg*, Jussens Venner col. 59 pages 35–54 and Theodor Karlsen, *The State's Margin of Discretion at National Court Review of Interventions in the ECHR – A Change of Course from the Supreme Court*, Law and Justice, vol. 62, 2023, pages 551–567.

The Court of Appeal assumes that the Supreme Court's statements that Norwegian law instructs caution refer to the caution exercised by the courts in reviewing the legislator's deliberate assessments, and in certain cases in the administration's specific assessments.

The Court of Appeal assumes that the caution provided for by Norwegian domestic law may in some cases lead to the Norwegian courts' intensity of review being equivalent to that exercised by the ECHR with reference to the margin of discretion; *HR-2024-1107-A (Quarantine Hotel)* Section 94. However, the two forms of caution have partly different justifications and partly take care of different considerations. The fact that the principle of subsidiarity is a fundamental element of the ECHR system, including the doctrine of discretion, indicates that national courts must ensure effective protection of human rights. This may require a more intensive review than the ECHR would have done, especially where considerations such as democratic legitimacy and professional assessments do not apply. The courts must therefore make a specific assessment of whether there is a basis for exercising caution in the review, and highlight the grounds for any caution.

In summary, Norwegian courts must determine the content of the ECHR according to the ECHR's method. In the application of the convention rights, no margin of discretion shall be included in accordance with the ECHR's doctrine of discretion. Norwegian law may nevertheless give reason for caution when reviewing.

In sections 3.4, 4.3.1, 5 and 6, the Court of Appeal returns to the extent to which Norwegian domestic law provides instructions for caution when reviewing the assessments of the legislator and the administration. However, the Court of Appeal already notes here that when the court is to assess the degree of intensity with which it is to review, it must ensure that the overall national processing satisfies the requirements of the ECHR and the ECHR, cf. Section 3 of the Human Rights Act.

In the following, the Court of Appeal will explain its understanding of the invoked provisions of the Convention.

Because it has been stated that the ECHR and the ECHR are to be interpreted in the light of the CRPD, the Court of Appeal has found it appropriate to first look at the CRPD, before discussing the ECHR and the SP in the light of the CRPD.

2.3 CRPD

The appellant has argued that the CRPD prohibits coercive psychiatric measures, and has received support for this view from ICJ Norway in submissions pursuant to Section 15-8 of the Dispute Act.

The CRPD establishes comprehensive protection against discrimination and a rights-based approach to interventions that affect persons with disabilities.

When interpreting the CRPD, *the wording is* crucial, cf. Article 31 of the Vienna Convention. In Article 2 of the CRPD, discrimination on the basis of disability is defined as follows:

> «Discrimination on the basis of disability» means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.

In Norwegian translation, the provision reads:

> "Discrimination on the grounds of disability" means any discrimination, exclusion or restriction on the grounds of disability which has the object or effect of restricting or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other sphere. It includes all forms of discrimination, including being denied reasonable accommodation.

General principles of the Convention include, inter alia, respect for the inherent dignity of human beings, individual autonomy including the freedom to make one's own choices, and acceptance of persons with disabilities as part of human diversity. cf. Article 3.

Article 5 "Equality and non-discrimination" requires states to ensure equality, prohibit all forms of discrimination on the grounds of disability, and ensure that persons with disabilities have equal and effective legal protection against discrimination.

Article 12 "Equal recognition before the law" requires states to recognise that persons with disabilities have legal capacity on an equal basis with others, and to make arrangements for them to exercise this capacity. The expression "on an equal basis with others" in Article 12(2) requires that persons with disabilities shall not be discriminated against – directly or indirectly – in matters of legal capacity. Article 12(3) states that the state shall provide decision-making support to a person if he or she needs it to exercise his or her legal capacity («shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity»). Decision support is

measures that make it possible for people with disabilities to make, express and implement their own decisions.

Article 12(4) requires that all measures related to the exercise of legal capacity shall have appropriate and effective safeguards to prevent abuse. The measures must ensure respect for the rights, will and wishes of the person. They must also be proportionate and individualised, apply for the shortest possible period of time and be regularly reviewed by a competent, independent and impartial authority or judicial body.

Read as a whole, the Court of Appeal finds that the wording of Article 12 allows for limitations on a person's legal capacity when decision support is not sufficient, if the limitations are based on a mapping of the person's will, framed by procedural safeguards, proportionate and lasting for the shortest possible time.

Article 14 "Liberty and security of the person" requires states to ensure, among other things, that persons with disabilities have the right to liberty and personal security on an equal basis with others, with guarantees in accordance with international human rights provisions.

Article 15 "Freedom from torture or cruel, inhuman or degrading treatment or punishment" prohibits torture and degrading treatment and reads:

1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhumane or degrading treatment or punishment.

Article 17 "Protecting the integrity of the person" states that persons with disabilities have the right to respect for their physical and mental integrity on an equal basis with others.

The wording must be interpreted in the light of its *context*, what the provision objectively refers to, and what *purpose* it is intended to serve, cf. Article 31(1) of the Vienna Convention.

The purpose of the CRPD is to ensure that persons with disabilities, including mental disabilities, have an equal right to enjoy human rights and fundamental freedoms, and to promote respect for their inherent dignity, cf. Article 1. The purpose suggests that the right to self-determination should be respected, but that in certain situations it is possible

to limit a person's legal capacity to act in order to provide effective human rights protection, as the state is also obliged to do under the Convention. In order to determine whether someone is discriminated against, general discrimination law takes into account whether the differential treatment is justified. The requirement of objectivity means that the differential treatment is not discriminatory if the justification for the differential treatment is relevant and objective, and the purpose of the differential treatment is to achieve an objective that is legitimate under the Convention. There must also be proportionality between the goal you are trying to achieve and the measure. Measures must protect the person's life, health or integrity, among other things. Such protection and safeguarding constitute a factual purpose in light of the purpose and context of the Convention.

As a context, it is also relevant to look at other provisions of the CRPD, in our case in particular CRPD Article 25 "Health". The provision states that people with disabilities have the right to the highest attainable standard of health without discrimination on the basis of disability. This means that the state's duty to ensure the person's health may in some cases be at the expense of the person's self-determination.

Article 34 of the CRPD establishes the CRPD Committee, which will monitor compliance with the Convention. Articles 35–36 set out the system of state reporting. Article 36, first paragraph, gives the Committee the power to assess the States' periodic reports and to make such proposals and general recommendations for the report as it deems appropriate. Article 34, tenth paragraph, gives the Committee the power to draw up its own rules of procedure. By virtue of this, the Committee has given itself the competence in Rule 47, first paragraph, to make general comments that are not addressed to individual states, but which are interpretative statements.

As mentioned, statements from the UN Monitoring Committees are not binding under international law, but can carry considerable weight as a source of law. The Court of Appeal assumes that the specific weight of the committee opinions may vary depending on how well they are anchored in the text of the Convention; International Court of Justice in The Hague, *Ahmadou Sadio Diallo* (Republic of Guinea v. Democratic Republic of the Congo, ICJ-2010-0103j,
November 30, 2010) section 66. It may also be of importance whether the statement must be seen as an interpretation or a recommendation for optimal practice, cf. HR-2018-2096-A, Section 14.

The UN Committee on the Rights of Persons with Disabilities (CRPD Committee) has stated in General Comment No. 1 (2014) on Article 12 in paragraph 15:

> In most of the State party reports that the Committee has examined so far, the concepts of mental and legal capacity have been conflated so that where a person is

considered to have impaired decision-making skills, often because of a cognitive or psychosocial disability, his or her legal capacity to make a particular decision is consequently removed. […] In all of those approaches, a person's disability and/or decisionmaking skills are taken as legitimate grounds for denying his or her legal capacity and lowering his or her status as a person before the law. Article 12 does not

> permit such discriminatory denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity.

In the same place, the following is stated about the relationship between Article 12 and Articles 15, 16 and 17, cf. paragraph 42:

> As has been stated by the Committee in several concluding observations, forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16). This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention. States parties must, instead, respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations; […] Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities. States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment [...] The Committee recommends that States parties ensure that decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the person concerned.

The CRPD Committee reiterated this in guidelines to Article 14 (2015) paragraph 11.

In its periodic report on Norway, CRPD/C/NOR/CO/1 (2019), the CRPD Committee has made the following recommendation in item 24 b:

> End the use of coercive methods, such as restraints, isolation, segregation, involuntary treatment and other intrusive methods, for persons with intellectual or psychosocial disabilities, particularly those in detention and older persons, especially those with dementia and in nursing homes, by, inter alia, training staff, prioritizing community-based and peer-led support initiatives, and strengthening procedural guarantees and control

When interpreting the CRPD, "relevant rules of international law applicable in the relations between the parties" must also be taken into account; cf. Article 31 third paragraph (c) of the Vienna Convention. How other international human rights conventions and their monitoring bodies relate to the legal issue is therefore also relevant.

The report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/22/53 (2013) states:

> Both this mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health care facilities are forms of torture and ill-treatment. Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged 'best interest' of the person

> On the other hand, the T Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41).

Reference is also made to the report of the UN Special Rapporteur on the rights of persons with disabilities following a visit to Norway, A/HRC/43/41/Add.3 (2020), paragraphs 70 and 90 a and b, as well as the WHO and the UN High Commissioner for Human Rights' publication *Mental health, human rights and legislation: guidance and practice* (2023) point 4. The Court of Appeal has also taken into account, among other things:

- Recommendation 2158 of the Parliamentary Assembly of the Council of Europe, *'Ending coercion in mental health: the need for a human rights-based approach*', (2019) paragraph 2;
- UN Human Rights Council Resolution (HRC 52/12) of 3 April 2023,
- written statement by the Commissioner for Human Rights of the Council of Europe to the ECHR in *Clipea and Others v. Moldova* (39468/17), paragraph 16,
- The UN Human Rights Committee's statements on detention in *General Comment no.*
  35 (CCPR/C/GC/35, 2014) on Article 9 of the SP, paragraph 19, and
- Report of the UN Working Group on Arbitrary Detention (WGAD) *(*A/HRC/30/37, 2015), Annex *Basic Principles and Guidelines on Remedies and Procedures on the Right of Persons Deprived of Their Liberty to Bring Proceedings Before a Court*, «Specific measures for persons with disabilities» item 106 b.

As the Court of Appeal will return to in section 2.8, the Court of Appeal cannot see that the ECHR has found that ECHR Articles 3, 8 and 14, interpreted in the light of the CRPD, entail an absolute prohibition against coercive treatment and coercive measures in psychiatry.

In *HR-2016-1286-A* , the first respondent stated in paragraph 30 that there is "no basis for concluding in general that the Convention prohibits compulsory hospitalisation and compulsory treatment of the mentally ill, when this takes place in accordance with the criteria set out in the Mental Health Care Act". The first respondent considered the material presented to the Supreme Court "with regard to the guidelines and limitations provided by the Convention on Persons with Disabilities for compulsory hospitalisation and compulsory treatment of the mentally ill", as
«fragmentary, ambiguous and to some extent also contradictory», cf. paragraph 29.

The Court of Appeal notes that there is a fairly extensive number of legally relevant recommendations and statements that indicate that compulsory treatment of mentally ill persons is not in accordance with the CRPD. The Court of Appeal has nevertheless come to the conclusion that there is no reason to conclude differently than the Supreme Court

did in 2016.

The Court of Appeal agrees with the State that certain parts of the statements from the CRPD Committee go further than is covered by the wording of the Convention. Compulsory treatment of persons with disabilities does not necessarily take place because of the reduced functional capacity in itself. Nor does it necessarily restrict their exercise of human rights

compared to other persons, cf. cf. CRPD Article 2. Article 15(1), which requires free consent for medical experiments, cannot be said to cover all coercive treatment. Nor can the Court of Appeal see that the use of the term «free and informed consent» in Article 25 (d) implies an absolute requirement for consent in connection with processing.

In connection with the ratification of the CRPD, it was assumed that the Mental Health Care Act was not in conflict with the CPRD; Prop. 106 S (2011–2012) pp. 16–17. Although Norwegian law was considered to be in accordance with the provisions of the Convention, the following declarations were made to Articles 12, 14 and 25 in ratification in order to clarify Norway's understanding. Norway declared, among other things, that it understands the Convention to mean that it "permits compulsory care and treatment of people, including measures taken to treat mental disorders, when circumstances make such treatment necessary as a last resort, and the treatment is subject to procedural safeguards".

The interpretative declarations in isolation have no significance for Norway's obligations under international law under the CRPD. Seen together with similar declarations from other states, they may nevertheless have some significance for the interpretation of the provisions under international law in that they express state practice, which is a relevant interpretative factor; cf. Article 31 third paragraph (b) of the Vienna Convention. The weight of such practice in terms of sources of law increases if it establishes a clear consensus on the content of the Convention and is well anchored in the wording.

Other States Parties have also issued interpretative declarations in connection with Article 12 similar to the one Norway submitted, including Australia, Canada, Ireland, the Netherlands, Poland and Estonia. The Court of Appeal further refers to the fact that according to the Norwegian Institution for Human Rights' (NIM's) report of 21 March 2022, *Incorporation of the CRPD into Norwegian law, Particularly on CRPD Articles 12 and 14,* item 3.4, all of the 96 state parties that had been examined by the CRPD Committee as of 20 February 2022 received recommendations from the Committee to move away from a "substituted decision-making system". This indicates that the parties do not consider that Article 12 excludes limitations on legal capacity. The same is stated about Article 14, see section 4.4 of the report.

Accordingly, it is the Court of Appeal's conclusion that the CRPD does not prohibit all forms of coercive treatment and coercive measures when a person is subject to compulsory mental health care, nor any form of coercive medication.

Reference is also made to *HR-2016-2591-A*, where the Supreme Court found that the Norwegian interpretative declaration on CRPD Article 12, which was submitted by ratification, was in clear contradiction to the CRPD Committee's interpretation. There was no doubt about what had been the legislator's prerequisites when the Guardianship Act was adopted and when Norway ratified the Convention.

On the basis of case law on the presumption principle, Norwegian courts would then have to base their decision on the Act's solution, even if it were contrary to international law, cf. paragraphs 58–63.

However, the CRPD expresses an international development with an increased focus on self-determination and non-discrimination. This was part of the reason why the Mental Health Care Act was amended in 2017; Prop. 147 L (2015–2016) item 6.2.4.1 page 24.

2.4 Article 3 of the ECHR and Article 7 of the ECHR: The prohibition of torture and inhuman or degrading treatment

2.4.1 General

Article 3 of the ECHR "Prohibition of torture" reads:

> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

The provision sets out an absolute prohibition against torture and inhuman or degrading treatment. It is a fundamental value in a democratic society, closely linked to respect for human dignity. The prohibition applies without exception, also in situations of serious threats to society or to persons who have committed serious offences; *Bouyid v. Belgium* (23380/09, Grand Chamber of 28 September 2015, EMDN-2009-23380), paragraph 81. In interpreting the provision, the provision shall be given a practical and effective scope; *Soering v. United Kingdom* (14038/88, 7 July 1989) paragraph 87.

In order for the treatment to be covered by Article 3 of the ECHR, it must have a minimum degree of seriousness. The assessment is relative and is based on an overall assessment of the duration, physical and mental effects, as well as in some cases the age, gender and state of health of the person affected;
Muršić v. Croatia (7334/13, Grand Chamber of 20 October 2016, EMDN-2013-7334) Section 97. The purpose of the processing, the context in which it took place, and whether the person concerned was in a vulnerable situation, are also relevant; *Khlaifia and Others v. Italy* (16483/12, Grand Chamber of 15 December 2016, ECREDN-2012-16483), paragraph 160. When a person is deprived of liberty, the protection is strengthened; *Bouyid v. Belgium*, paragraph 100.

The difference between torture, inhuman and degrading treatment or punishment depends mainly on the degree of suffering inflicted, but the purpose of the treatment is also important. Based on the ECHR's case-law, the Court of Appeal assumes that the relevant alternative in this case is degrading treatment.

Treatment is considered degrading when it humiliates or degrades a person, shows a lack

of respect for or diminishes the person's human dignity, or induces feelings of fear, anxiety, or inferiority that can erode the individual's moral and physical resilience. It may be sufficient for the person to experience humiliation in their own

eyes, even if others don't. Whether there is a purpose to humiliate or degrade the person is relevant, but the absence of such a purpose does not preclude a violation of Article 3 of the ECHR. Reference is made to ECHR Grand Chamber Judge *Gäfgen v. Germany* (22978/05, 1 June 2010, ECHR-2005-22978), paragraph 89; *Ilaşcu and Others v. Moldova and Russia* (48787/99,
July 8, 2004, EMDN-1999-48787) Section 425; and *M.S.S. v. Belgium and Greece* (30696/09, 21 January 2011, EMDN-2009-30696), paragraph 220.

In the event of alleged violations of Article 3, the ECHR makes a particularly thorough assessment of the evidence, even though it does not, as a general rule, replace the national court's assessment of the evidence; *Cestaro v. Italy* (6884/11, Grand Chamber 7 April 2015) paragraph 164.

2.4.2 Particularly about interference against the will of a person deprived of liberty

In the case of medical interventions against the will of a person deprived of liberty, the ECHR imposes a duty on states to protect the person's physical health, including by providing necessary medical treatment. The authorities must ensure that a complete record is kept of the inmate's state of health and treatment during detention; *Rooman v. Belgium* (18052/11, Grand Chamber of 31 January 2019, EMDN-2011-18052) paragraph 147.

A measure that is therapeutically necessary according to recognised medical principles cannot in principle be regarded as inhuman or degrading. However, the court must ensure that medical necessity has been convincingly shown to exist; *Jalloh v. Germany* (54810/00, Grand Chamber 11 July 2006, ECHR-2000-54810) paragraph 69 with further references. See also *Herczegfalvy v. Austria* (10533/83, 24 September 1992, ECHR-1983-10533), paragraph 82, and *Spivak v. Ukraine* (21180/15, 5 June 2025), paragraph 168.

Where compulsory psychiatric treatment has taken place without documented therapeutic necessity, the ECtHR has found violation; *Gorobet v. Moldova* (30951/10, 11 October 2011) paragraph 52 and *Bataliny v. Russia* (10060/07, 23 July 2015) paragraph 88. Long-term and systematic administration of antipsychotics without a predetermined course of treatment and without medical justification has been considered to constitute degrading treatment; *Spivak v. Ukraine,* paragraphs 190–202. In *V.I. v. Moldova, the* ECtHR pointed out that the national courts had not carried out any analysis of the coercive aspect of the complainant's placement in a psychiatric hospital and psychiatric treatment. Nor had any investigation been carried out as to whether the complainant's state of health required such placement and treatment, or whether other forms of treatment would have been more appropriate, cf. paragraph 112.
Article 3, on the other hand, was not violated in *Naoumenko v. Ukraine* (42023/98, 10 February 2004). The complainant suffered from serious mental disorders, had attempted

suicide twice and was put on medication to alleviate his symptoms, see paragraphs 113–116.

Furthermore, the way in which the compulsory treatment is carried out may not exceed the threshold for seriousness pursuant to Article 3; *Nevmerzhitsky v. Ukraine* (54825/00, 5 April 2005) paragraph 94, which concerned force-feeding during hunger strikes.

The Court must also ensure that procedural guarantees for the decision exist and have been complied with ("procedural guarantees for the decision [...] exist and are complied with»). Reference is made to *Jalloh v. Germany,* paragraph 69, and *Spivak v. Ukraine,* paragraph 168, with further references. In order for the requirement for adequate procedural safeguards to be met, the mechanism must enable rapid intervention by an independent authority with the competence to intervene directly in the diagnostic process or medication, as well as to detect and prevent potential arbitrariness or misuse; *Spivak vs. Ukraine* Episode
184. There must be a realistic possibility of bringing an appeal, cf. paragraph 188. See also *V.I. v. Moldova,* paragraph 112.

Physical coercive measures against patients in psychiatric hospitals shall only be used as a last resort, and when the use is the only means available to prevent immediate or imminent harm to the patient or others; *M.S. v. Croatia (No. 2)* (75450/12, 19 February 2015) paragraph 104. Furthermore, there must be sufficient safeguards against abuse, which provide adequate procedural protection and which are suitable to document that the requirements of utmost necessity and proportionality have been met, and that all other reasonable alternatives have proven insufficient to manage the risk of harm to the patient or others. It must also be demonstrated that the coercive measure in question was not maintained beyond the period strictly necessary for this purpose, cf. paragraph 105.

The inferiority and powerlessness that are typical of patients admitted to psychiatric hospitals require increased vigilance when assessing whether the Convention has been complied with; *Herczegfalvy v. Austria* paragraph 82 and *Spivak v. Ukraine* paragraph 170.

In addition to the Member States' negative obligations – to refrain from treatment that violates Article 3 of the ECHR – the States have positive obligations. A substantive obligation is to establish a legislative and regulatory protection framework. Another is, in certain defined situations, to take operational measures to protect persons from the risk of treatment in violation of the provision. In addition, states are obliged to effectively investigate credible allegations that such processing has taken place. Reference is made to *Spivak v. Ukraine,* paragraph 171.

Allegations of ill-treatment in violation of Article 3 must be supported by "appropriate evidence", which the Court of Appeal understands as evidence appropriate to the situation. However, the location of the burden of proof depends on the facts, the nature of the arguments and the convention right in question. The principle that the person making an allegation has the burden of proof does not apply absolutely under the ECHR. When the

events at issue are largely within the scope of the

The authorities' exclusive knowledge, as in the case of deprivation of liberty, strong factual presumptions of harm during the stay arise. The burden of proof then rests with the state, which must provide a satisfactory and convincing explanation by presenting evidence that weakens the complainant's presentation. The reason is that detainees are in a vulnerable situation, and that the authorities have a duty to protect them. In the Grand Chamber case *Bouyid v. Belgium*, the ECHR has emphasised that this principle applies to all cases where a person is under the control of the police or a similar authority, see paragraphs 82–84. The same is applied in *V.I. v. Moldova* (38963/18, 26 March 2024) paragraph 140. In it, the ECHR stated that the lack of clarification of the facts is due to the authorities' failure to investigate it effectively. The Court reiterated that in all cases where it cannot establish the precise circumstances of the case for reasons objectively attributable to national authorities, it is incumbent on the State to provide a satisfactory and convincing explanation of the course of events and to adduce solid evidence capable of refuting the complainant's arguments, cf. paragraphs 139 and 141.

2.5 ECHR Article 8 and Article 17 of the ECHR: The right to privacy

Article 8 of the ECHR "Right to respect for private and family life" reads:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The right to privacy encompasses a person's physical, mental, and moral integrity, as well as privacy, identity, and autonomy. Member States have a positive obligation towards vulnerable people with mental illness. Maintaining mental stability is considered an indispensable prerequisite for the effective exercise of the right to respect for private life; *Bensaid v. United Kingdom* (44599/98, 6 February 2001, EMDN-1998-44599), paragraph 47.

However, a person's right to refuse medical treatment also falls under Article 8. The ability to live one's life in a way one chooses may include the ability to engage in activities that are perceived as physically harmful or dangerous to the person concerned; *Pretty v. United Kingdom* (2346/02, 29 April 2002) paragraphs 61 and 62.

Coercive medication, isolation and shielding constitute interference with the right to privacy under Article 8(1) of the ECHR, both in terms of physical and mental integrity and autonomy. In order for such interventions to be justified, they must have a legal basis, as well as be justified by relevant considerations and necessary in a democratic society, cf. Article 8(2). The exceptions are interpreted

restrictive. The intervention must correspond to an imperative social need, and the necessity must be convincingly demonstrated in each case.

The legal basis requirement means that there must be a legal basis in national law, which must meet certain qualitative requirements. The term "law" is understood in a substantive sense and includes case law, administrative rules and customary law, in addition to laws and regulations. The legal basis must be available, predictable, compatible with the rule of law and contain sufficient safeguards against the arbitrary exercise of authority.

Explicit requirements in national law must be complied with in order for the interference to have a sufficient legal basis, even if a similar requirement cannot be derived from the ECHR; *Reyes Jimenez v Spain* (57020/18, March 8, 2022). In the case, the complainants had given verbal consent to a procedure, where the law required written consent.

Relevant considerations for coercive measures in psychiatry may be the patient's health and the safety of others, cf. «prevention of disorder» and «protection of health», cf. ECHR Article 8 (2).

The necessity requirement means that the grounds for the intervention must be relevant and sufficient, seen in light of the case as a whole. Furthermore, the measure must be proportionate to – be proportionate to – the legitimate purpose. The proportionality assessment is the core of the necessity requirement and requires a balanced balance of conflicting considerations.

Forced administration of medicine constitutes a serious interference with a person's physical integrity pursuant to Article 8(1) of the ECHR and must therefore have a legal basis that ensures sufficient guarantees against arbitrariness. Under certain circumstances, coercive medication of a mentally ill patient may be justified to protect the patient and/or others. However, such decisions must be made on the basis of clear legal guidelines and with the possibility of judicial review; *X v. Finland* (34806/04, 3 July 2012) paragraph 220:

> The Court considers that the forced administration of medication represents a serious interference with a person's physical integrity, and must accordingly be based on a «law» that guarantees proper safeguards against arbitrariness. In the present case such safeguards were missing. The decision to confine the applicant for involuntary treatment included an automatic authorisation to proceed to forcible administration of medication if the applicant refused the treatment. The decision-making was solely in the hands of the doctors treating the patient, who could take even quite radical measures regardless of the applicant's wishes. Moreover, their decision-making was free from any kind of immediate judicial scrutiny: the applicant did not have any remedy available whereby she could require a court to rule on the lawfulness, including proportionality, of the forced administration of medication, or to have it

discontinued.

2.6 Article 14 of the ECHR and Article 26 of the ECHR: The prohibition of discrimination

Article 14 of the ECHR "Prohibition of discrimination" reads:

> The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Non-discrimination is a fundamental principle that underpins the ECHR; *S.A.S. v. France* (43835/11, Grand Chamber of 1 July 2014), paragraph 149. Article 14 does not prohibit discrimination as such, but discrimination in the exercise of the rights and freedoms enshrined in the ECHR, including Articles 3 and 8. The ancillary nature does not imply that the application is dependent on the existence of a breach of the primary provision of rights. Furthermore, the material scope of Article 14 is not strictly limited to what follows from the primary provision. *Biao v. Denmark* (38590/10, Grand Chamber 24 May 2016) paragraph 88.

The Court of Appeal assumes that long-term and serious mental illness may qualify as grounds for discrimination; *V.I. v. Moldova.*

Discrimination occurs when persons in comparable situations are treated differently without an objective and reasonable justification; *V.I. v. Moldova,* paragraph 168. Disproportionately harmful effects of a general practice that, even if formulated in neutral terms, discriminates against a group may constitute indirect discrimination. No discriminatory intent is required; *Biao v. Denmark* , paragraph 103.

The Court of Appeal assumes that if the authorities in practice give less weight to the autonomy of persons with mental disorders than to somatic patients, this may constitute indirect discrimination in the exercise of rights pursuant to Article 8 of the ECHR.

Whether there is an objective and reasonable justification for the differential treatment must be assessed in relation to the purpose and effects of the measure in question, as well as the principles that apply in democratic societies. The differential treatment must pursue a legitimate purpose. There must be proportionality between the funds used and the purpose that is sought to be achieved. There must be a reasonable balance between the considerations that the measure is intended to safeguard and respect for the complainant's rights and freedoms guaranteed by the ECHR.

Article 14 does not prohibit states from treating groups differently in order to correct factual differences between them. In certain cases, failure to attempt to correct inequality through differential treatment may in itself constitute a violation of the article. A lack of

facilitation for persons with disabilities may in itself constitute discrimination; *Enver Şahin v. Turkey,* paragraphs 67–69.

The complainant has the burden of proving that he or she has been subjected to differential treatment. In such cases, the state must prove that the different treatment is based on an objective and reasonable justification; *Biao v. Denmark* , paragraph 92.

2.7 The relationship between ECHR Articles 3, 8 and 14

The ECHR must be read as a whole, so as to ensure internal consistency and harmony between the various provisions; *Enver Şahin v. Turkey,* paragraph 59. When situations may fall under several articles of the ECHR, the ECHR may, depending on the circumstances, consider the complaint separately under each provision or together. It may also consider it unnecessary to deal with the same complaint under Articles 8 and/or 14 if it finds a violation of Article 3. As a general rule, complaints from persons who are victims of abuse or mistreatment by state actors will be assessed pursuant to Article 3. A treatment that does not meet the threshold set out in Article 3 may nevertheless be contrary to Article 8. cf. *Wainwright v. United Kingdom* (12350/04, 26 September 2006, EMDN-2004-12350), paragraphs 44–49. See the ECHR Secretariat's *Guide on Article 3 of the European Convention on Human Rights,* as of 31 August 2025, paragraphs 23–27 with references, *Guide on Article 8 of the European Convention on Human Rights*, as of 28 February 2025, paragraphs 38–41 and 148, and *Guide on Article 14 of the European Convention on Human Rights and on Article 1 of Protocol No. 12 to the Convention,* as of February 28, 2025, paragraph 133.

2.8 Interpretation of the ECHR and SP in light of the CRPD

The ECHR has stated that the ECHR should, as far as possible, be interpreted in accordance with other rules of international law of which it is a part, including the CRPD; *Enver Şahin v Turkey* Episode
60. With reference in particular to the CRPD, the ECHR has found that there is a European and global consensus on the need to protect persons with disabilities from discriminatory treatment. This includes an obligation for states to ensure reasonable facilitation to enable persons with disabilities to fully realise their rights. Failure to do so constitutes discrimination, cf. cf. CRPD Article 2. Reference is made, inter alia, to *Glor v. Switzerland* (13444/04, 30 April 2009) paragraphs 54, 80 and 84; and *Enver Şahin v. Turkey,* paragraphs 67–69.

As the ECHR has so far interpreted ECHR articles 3, 8 and 14, the Court of Appeal cannot see that interpretation in light of the CRPD entails an absolute prohibition against coercive treatment.

In *Rooman v. Belgium* , the ECHR stated in 2019 that Article 5 of the ECHR, as it had been interpreted so far, does not contain a prohibition on deprivation of liberty on the basis of disability, contrary to what is proposed by the CRPD Committee in the 2015

cf. Article 14, see paragraph 205. The case concerned a lack of adapted treatment of a Belgian citizen who had been forcibly hospitalised for many years. Thus, the ECHR does not necessarily appear to base its interpretation of the ECHR on the CRPD Committee's understanding of the CRPD.

The Court of Appeal cannot see that the ECHR applied a prohibition against coercive treatment in *Clipea et al. against Moldova* in 2024, as referred to in section 2.3, see paragraphs 64 and 97.
Spivak v. Ukraine was handed down on 5 June 2025, and the ECtHR thus had the opportunity to take into account all the statements and recommendations reviewed by the Court of Appeal in paragraph 2.3. The ECHR also referred to the above-mentioned report of 1 February 2013 by the UN Special Rapporteur on torture, see paragraph 121. interpreted in light of the CRPD, prohibits coercive medication, see paragraphs 168 and 176.

The Court of Appeal has referred to the article *The European Court of Human Rights and the Human Rights Model of Disability Convergence, Fragmentation and Future Perspectives*, by Delia Ferri and Andrea Broderick, to which the appellant has referred. However, it cannot lead to a different conclusion, see below the conclusions in section 9 of the article.

It is also noted that it is primarily the ECHR that is to develop the ECHR; *HR-2022-2329-A* Section 70.

The Court of Appeal cannot see that the UN Human Rights Committee's General Comment no. 35 on Article 9, paragraph 19 of the ECHR, which is referred to in paragraph 2.3, indicates that Articles 7, 17 and 26 of the ECHR should be interpreted in a different way than the corresponding provisions of the ECHR.

The Court of Appeal therefore assumes that neither ECHR articles 3 and 8, cf. 14, nor SP articles 7 and 17, cf. 26, prohibit all forms of coercive treatment, nor coercive medication with antipsychotics.

However, *Herczegfalvy v. Austria,* paragraph 82 and *Spivak v. Ukraine,* paragraph 170, include the premise that the patient is "entirely incapable of deciding for themselves") in connection with coercive medication. When the CRPD's rules on decision support are also taken into account, the Court of Appeal believes that the extent to which the patient is unable to make his or her own decisions must be included in the assessment of whether coercive treatment violates the rights under the ECHR and the ECHR.

With regard to physical coercive measures, the Court of Appeal refers to *M.S. v. Croatia (no. 2)* from 2015. Here, the ECHR agreed with the nation state that medical standards in

psychiatry allow for the use of coercive measures against patients in psychiatric hospitals when no other measure can achieve the desired result, namely to calm down an agitated person and prevent the person from harming himself or others, cf. paragraph 104. The Court of Appeal may:

Therefore, it does not see that ECHR Articles 3 and 8, cf. Article 14, and corresponding provisions of the SP, cf. the CRPD, exclude the use of solitary confinement and shielding.

In *Spivak v. Ukraine* , the ECHR found it necessary to first make a separate assessment of the legal and regulatory framework for coercive medical measures in psychiatric institutions, including the complaint mechanisms, and then the actual treatment of the complainant, including the authorities' handling of the objections he raised, see paragraph 177. Such an approach is also in line with how Eidsvik and the state have structured their arguments in this case. In the following, the Court of Appeal will therefore first consider the legal framework for the coercive measures, and then the specific treatment of Eidsvik.

3. The Mental Health Care Act and the Mental Health Care Regulations

3.1 Introduction

The Court of Appeal will first make some general comments on the Mental Health Care Act and the Regulations, before explaining the starting points for the interpretation of the provisions.

3.2 Overall

No. 62 of the Act relating to the Establishment and Implementation of Mental Health Care (the Mental Health Care Act) of 2 July 1999 entered into force on 1 January 2001. No. 1258 of the Regulations on the Establishment and Implementation of Mental Health Care etc. (the Mental Health Care Regulations) No. 1258 elaborates on certain provisions of the Act, including Sections 4-3, 4-4 and 4-8, to which this case applies.

The Mental Health Care Act was amended in several respects by Act No. 6 of 10 February 2017 on amendments to the Mental Health Care Act, etc. (increased self-determination and legal protection). The Mental Health Care Regulations were amended by Regulations No. 562 of 11 May 2017. The Court of Appeal reproduces and assesses the Act and the Regulations as they stood when the coercive measures took place in 2014 and 2016. Where the Court of Appeal finds it appropriate, it will comment on the changes in 2017.

The Mental Health Care Act had the following purposes during the period in question, cf. Section 1-1:

> The purpose of this Act is to ensure that the establishment and implementation of mental health care takes place in a responsible manner and in accordance with fundamental principles of due process. The purpose is also to ensure that the measures described in the Act are based on the patient's needs and respect for human dignity.

The Court of Appeal assumes that the other provisions of the Act must be interpreted in light of this.

In the amendment of the Act in 2017, the purpose provision was changed by including in the first paragraph that the purpose is also to ensure that the mental health care is "in accordance with human rights". However, this already followed from Sections 2 and 3 of the Human Rights Act. In addition, in 2017, the following was included in section 1-1, first paragraph, last sentence and second paragraph:

> One purpose of the rules is to prevent and limit the use of coercion.
>
> The healthcare must be arranged with respect for the individual's physical and mental integrity and, as far as possible, be in accordance with the patient's needs and right to self-determination and respect for human dignity.

In order for Chapter 4 of the Mental Health Care Act "Implementation of mental health care" to apply, the conditions for compulsory mental health care in Section 3-3 must be met. This means, among other things, that the patient must have "a serious mental disorder".

The Court of Appeal further agrees with the State that Sections 4-3, 4-4 and 4-8 of the Mental Health Care Act must be read in the light of Section 4-2 of the Act, which read as follows in the period in question:

> Restrictions and coercion shall be limited to what is strictly necessary, and the patient's views on such measures shall be taken into account as far as possible. Measures may only be used that have such a beneficial effect that they clearly outweigh the disadvantages of the measure.
>
> In the case of mental health care in an institution, the stay shall, as far as it is compatible with the purpose and the individual's condition, be carried out in such a way that the patient's opportunity to make decisions about himself or herself is safeguarded.
>
> With the limitations mentioned, conditions must be facilitated so that patients receive:
> a. participate in the design of the institution's daily life and other matters that affect the individual patient,
> b. the opportunity to pursue their private interests and hobbies,
> c. access to activities within the framework of the house rules,
> d. opportunity for daily outdoor activities.
>
> The individual's philosophy of life and cultural background must also be taken into account.
>
> The King may issue further regulations on house rules for institutions for mental health care.

In 2017, a new first paragraph, third sentence, second and third paragraphs were added to

> the provision: If less invasive measures are sufficient, these shall be used.
>
> Before a decision is made pursuant to Chapter 4 of the Act, the patient must be given the opportunity to comment where possible. The information must be recorded and form the basis for the decision. Particular emphasis shall be placed on the patient's

statements about previous experience of the use of coercion.

The use of the following measures should be evaluated with the patient as soon as possible after the intervention has been completed:

1. shielding that the patient opposes, cf. Section 4-3,

2. examination and treatment without one's own consent, cf. Section 4-4,
3. examination of rooms and belongings and body searches pursuant to Section 4-6, first paragraph, and examination pursuant to Section 4A-4, second and third paragraphs,
4. drug testing without the patient's consent, cf. Section 4-7a, second paragraph, and
5. use of coercive measures, cf. Section 4-8.

The patient must be offered at least one conversation about how he or she has experienced the use of coercion. The patient's view of the measures implemented must be recorded in the medical records.

Section 15 of the Regulations "Protection of personal integrity. The patient's right to participation» second paragraph read during the period in question, and still reads, as follows:

> Before measures are taken pursuant to this chapter, the patient shall be given as much influence as possible. The patient has the right to participate in the choice between different available and appropriate treatment methods, cf. Section 3-1 of the Patients' Rights Act. Attempts to establish voluntary cooperation with the patient must continue even after the measure has been implemented.

3.3 Procedural safeguards

The Mental Health Care Act provides instructions on several mechanisms for control and verification. The Control Commission is regulated by Section 6-1. The first and second paragraphs read as follows in 2014–2016:

> Where someone is under mental health care pursuant to this Act, there shall be a control commission which, in accordance with further rules laid down by the Ministry, makes the decisions specifically assigned to it.
>
> To the extent possible, the control commission shall also carry out the control it deems necessary for the welfare of the patients. It can take up cases on its own initiative or at the request of the patient, the patient's next of kin or the staff. If it finds matters it wishes to point out, it shall take the matter up with the professional responsible person and, if applicable, the County Governor.

The Control Commission consists of a lawyer who is qualified to serve as a judge, a doctor and two other members, including a person with a connection to patient interests, cf. Section 6-2 of the Mental Health Care Act. The Commission is independent in its activities, cf. Section 6-3.

Decisions on compulsory mental health care pursuant to Sections 3-3 and 3-7 of the Mental Health Care Act may be appealed to the Control Commission by the patient and

his/her next of kin. The processing is subject to special procedural rules in section 6-4. The Control Commission's decision on compulsory mental health care may be brought before the district court in accordance with the provisions of Chapter 36 of the Dispute Act, cf. Section 7-1 of the Mental Health Care Act. When assessing whether the conditions for compulsory mental health care are met, the court may examine all aspects of the case and is not bound by the parties' submissions and allegations, cf. Section 36-5, third paragraph, and Section 11-4, first paragraph, of the Dispute Act.

Decisions on *shielding* and *isolation* can be appealed to the Control Commission by the patient and his/her next of kin, cf. Section 4-3, third paragraph, and Section 4-8, fifth paragraph, of the Mental Health Care Act. A decision on *forced medication* may be appealed to the County Governor (County Governor) by the patient and their next of kin, cf. Section 4-4, seventh paragraph. In the event of an appeal, the patient has the right to be assisted by a representative, cf. Section 1-7. The special procedural rules in Section 6-4 do not apply.

The Control Commission's handling of complaints is regulated in Chapter 7 of the Mental Health Care Regulations, cf. Section 29 first paragraph. Section 55 sets out requirements for the content of the Control Commission's decision.

The County Governor's processing of appeals is governed by the Public Administration Act, cf. Section 1-6 of the Mental Health Care Act, with the addition of Section 29, third paragraph, of the Mental Health Care Regulations, which reads:

> The County Governor shall make decisions without undue delay. If deemed necessary, expert assistance shall be engaged. Personal contact must be made with the patient, unless this is clearly unnecessary. If the appeal is upheld, a decision shall be made to immediately cease any processing that has been initiated. Notification of the decision shall be sent to the complainant with a copy to the professional responsible for the decision.

Decisions on forced medication, shielding and solitary confinement cannot be brought before the courts pursuant to the provisions of Chapter 36 of the Dispute Act, but their validity may be reviewed by the courts pursuant to the general rules of procedure of the Dispute Act.

3.4 Application of law, administrative discretion and judicial review

As part of its assessment of the legal framework, the Court of Appeal considers the extent to which the legal basis for intervention provides guidance on the application of law or administrative discretion.

The State has argued that the legal basis for intervention consists entirely of administrative discretion. Eidsvik believes that they provide guidance on the application of law. She has received support for this view from the Equality and Anti-Discrimination Ombud, which supervises that Norwegian law and administrative practice correspond to Norway's obligations under the CRPD, cf. Section 5 third paragraph (c) of the Anti-Discrimination Ombud Act, and ICJ Norway, in submissions pursuant to Section 15-8 of the Dispute Act.

The courts' review of administrative discretion is normally limited. It must normally be

content to test whether the exercise of discretion is based on correct facts, and whether it otherwise lies within the limits of the competence base – interpreted in accordance with the limitations imposed by the ECHR and the ECHR, among others – and the doctrine of abuse of authority.

The courts' right of review is codified in Article 89 of the Constitution. The intensity of the review depends on an interpretation of the individual statutory provision, where the wording of the Act is the starting point; *Rt-1995-1427 (nature conservation)* on page 1436, *Rt-2007-257 (Trallfa)* paragraph 40,
Rt-2012-1985 (long-term child I) paragraph 142, *Rt-2012-18* paragraph 41 and *Rt-2015-1232*

Section 30. Since the rules on judicial review of administrative decisions are based on court-created law, case law is a key starting point; *Rt-2012-1985 Section 54*.

It is a general principle in administrative law that the courts can at least review the subsumption in the application of laws that interfere with the individual. This is considered an important part of the rule of law; *Rt-1995-1427 (nature conservation)* pages 1433 and 1436, *Rt-2007-1573 (national security)* paragraph 52 and *Rt-2015-1232 (widow's pension)* paragraph 38.

When the legislator has laid down a condition in the Act that must be fulfilled in order for the administration in the individual case to be allowed to exercise its competence, it is in principle natural to regard the condition as a substantive limitation of competence that the courts are reviewing;
Rt-2007-257 (Trallfa) paragraph 40 and *Rt-2015-1232 (widow's pension)* paragraph 31. See also
Rt-1995-1427 (nature conservation) on page 1436. However, certain "words and concepts" can be
"so vague that they provide a poor basis for a legal clarification", cf. *Rt-2007-257* episode 40. The expression 'special reasons' was here regarded as 'very general and very discretionary'. See also *Rt-2015-1232,* paragraph 31.

Furthermore, the nature of the assessment topic is relevant; *Rt-2015-1388 (internal displacement)* paragraph 225. Exceptions may be made to the general rule of full judicial review if the condition is determined on the basis of political considerations, and the area of law is characterised by difficult trade-offs of a distinctly political nature; *Rt-2012-1985 (long-term child I)* paragraphs 107–110 and *Rt-2015-1232 (widow's pension)* paragraphs 32 and 38. Exceptions may also be conceivable in cases where "the decision is based on an assessment of a distinctly professional nature in areas that the courts cannot be expected to have the necessary insight into". *Rt-2007-1573 (National Security)* paragraph 52.

However, Rt-1975-603 (swingball), Rt-1995-1427 (nature conservation) and *Rt-2015-1388 (internal flight)* are examples of the courts reviewing assessments that require special expertise.

When there are obligations under international law, there is an argument that the courts have full jurisdiction to review; *Rt-2015-1388 (internal flight)* paragraph 216. Paragraph 226 states:

> Another safe starting point is that the courts can also examine the specific subsumption where there is a question of the relationship to our human rights obligations. Against this background, it is clear that the courts have full jurisdiction to examine whether the conditions in Section 28 first paragraph (a) and (b) of the [Immigration Act] are met. For the same reason, the assessment of relevance in

section 28, fifth paragraph, is based on a discretion that can be fully reviewed. The courts' competence to test whether the internal flight alternative is safe and accessible is thus not limited.

The powers of competence must be interpreted and applied in such a way that they are in accordance with the requirements for an effective remedy in the ECHR and the ECHR, cf. Sections 2 and 3 of the Human Rights Act.

When interpreting the legal basis, it may also be of importance whether the legislator has taken a position in the preparatory works on whether the condition provides instructions for the application of law or administrative discretion; *Rt-2012-1985 (Long-Term Child I)* paragraphs 144 and 145.

The Court of Appeal has also taken into account *Rt-2012-18* and *Rt-1993-587*, which concerned a licence,
Rt-2012-1025, on the valuation assessment in section 13-1, third paragraph, of the Taxation Act, and *HR-2017-967-A*, on the determination of the tax and VAT basis, to which the state has referred in particular.

When the courts review assessments that require special expertise, there is reason to show restraint; *Rt-2015-1388 (Internal displacement)* paragraph 247.

However, in the view of the Court of Appeal, when examining allegations of breach of the Convention, the courts must ensure that the review is sufficiently intense to ensure that the overall national treatment satisfies the requirements of the ECHR.

The Court of Appeal then proceeds to assess the legal framework for coercive medication, cf. Section 4-4 of the Mental Health Care Act, solitary confinement, cf. Section 4-8 and shielding, cf. Section 4-3.

4. Forced medication pursuant to Section 4-4 of the Mental Health Care Act

4.1 Introduction

In the following, the Court of Appeal will explain the relevant provisions of the Act and Regulations in section 4.2. Subsequently, in section 4.3.1, it will review the material conditions for forced medication. The requirement that the procedure must be medically necessary according to recognised medical principles makes it necessary to take a closer look at the evidence base for medication with antipsychotics. This is what the Court of Appeal does in section 4.3.2. The Court of Appeal then reviews the procedural requirements in section 4.4. In section 4.5, the Court of Appeal considers whether the Norwegian legal framework for forced medication is in accordance with Norway's obligations under the Convention.

4.2 Section 4-4 of the Mental Health Care Act with regulatory provisions

Forced medication is regulated by Section 4-4 of the Mental Health Care Act, which read as follows:

> A patient under compulsory mental health care may, without their own consent, be subjected to such examination and treatment that is clearly in accordance with

professionally recognised psychiatric methods and sound clinical practice.

Without the patient's consent, examination and treatment that involves a serious intervention cannot be carried out, with the following exceptions:

a. The patient can be treated with drugs without their own consent. Such drug treatment can only be carried out with preparations that are

registered in this country and with commonly used doses. Drug treatment can only be carried out with drugs that have a beneficial effect that clearly outweighs the disadvantages of any side effects.

b. As part of the treatment of a patient with a severe eating disorder, nutrition may be given without one's own consent if this appears to be a strictly necessary treatment option.

Examination and processing without one's own consent can only take place when an attempt has been made to obtain consent for the examination or treatment, or it is obvious that consent cannot or will not be given. If this is not clearly impossible, consideration shall also be given to whether other voluntary measures can be offered as an alternative to examination and treatment without one's own consent.

Treatment measures that have not been consented to can only be used after the patient has been sufficiently examined to provide a basis for assessing the condition and the need for treatment. Such treatment measures can only be initiated and implemented when they are highly likely to lead to healing or significant improvement of the patient's condition, or to the patient avoiding a significant worsening of the disease.

The medical officer makes decisions about examination and treatment without their own consent.

Decisions on examination and treatment without one's own consent must be recorded without delay.

Decisions pursuant to this section may be appealed to the County Governor by the patient and his or her next of kin.

The King in Council issues regulations on examination and treatment without his own consent.

At that time, there was no condition regarding lack of capacity to consent, cf. cf. the current Mental Health Care Act, Section 4-4, first paragraph, second and third sentences.

The relevant provisions in Part III of the Mental Health Care Regulations "Examination and treatment without one's own consent" read as follows during the period in question:

§ 19. Assessment of alternative measures

Before a decision can be made pursuant to Section 4-4 of the Mental Health Care Act, it must always be considered whether other voluntary measures can be offered as an alternative to treatment without one's own consent.

§ 20. More about the survey

Before a decision is made on treatment with drugs without their own consent, the professional responsible for the decision must have personally examined the patient during the last 48 hours. The total examination time cannot be set to less than 3

days, unless the patient will suffer serious health damage in the event of postponement or through previous treatment stays is well known by the institution that adopts the treatment.

[…]

Throughout the examination period, the institution shall seek to gain the patient's trust so that treatment can be carried out with the patient's consent.

[…]

§ 21. Decisions on processing without one's own consent

When treatment without one's own consent includes several forms of treatment, a comprehensive decision can be made that includes the treatment elements that are relevant to the individual patient. However, treatment with drugs must always be decided separately.

The decision must state the planned start and duration of the treatment. The planned duration can be set to a maximum of 3 weeks. In the case of a decision to treat with drugs, the duration may be set to a maximum of 3 months. The decision must also state that the requirements for adequate investigation pursuant to section 20 are met.

The treatment can be initiated no earlier than 48 hours after the patient has been informed of the decision. Exceptions to this can only be made if the professional responsible for the decision finds that the treatment cannot be postponed for weighty reasons relating to treatment.

The reason for such immediate implementation shall be stated in the decision.

§ 22. Completion of treatment with drugs

Treatment by injection should only be given when it is not possible to get the patient to take the medicine by mouth. Depot injections should not be given in the treatment of acute mental disorders.

[…]

The patient must not be given medicines without being informed, cf. the Patients' Rights Act
§ 3-2. This includes information on the actual dosage and possible side effects. Information may be omitted to patients who, due to advanced lethargy, are unable to understand the circumstances associated with the use of the drugs.

Section 4-4, fifth paragraph, of the current Mental Health Care Act stipulates that a decision on forced medication cannot be made until the patient has been observed and attempted to be helped for at least five days from the establishment of the protection, with similar exceptions as under Section 20, first paragraph, of the Regulations.

4.3 Material terms

4.3.1 The material conditions for forced medication

It is clear from the wording of Section 4-4, second paragraph, of the Mental Health Care Act that treating a patient with drugs without their own consent entails a "serious intervention" that in principle

is prohibited. The provision provides a legal basis for making exceptions to this prohibition, and sets out several substantive conditions for such access. Certain of the conditions may overlap to some extent.

First, all processing without one's own consent must be "clear [...] in accordance with professionally recognised psychiatric methods and sound clinical practice", cf. section 4-4, first paragraph. Drug treatment can only be carried out with preparations that are registered in this country, and with commonly used doses, cf. Section 4-4 second paragraph (a), second sentence.

Second, treatment measures "may only be initiated and implemented when they are highly likely to lead to healing or significant improvement of the patient's condition, or that the patient avoids a significant worsening of the disease", cf. Section 4-4, fourth paragraph. In a letter dated 22 March 2019 (19/4832-3), the Directorate of Health stated that the requirement should be read in light of the materiality requirement in section 3-3 no. 3 (a) (the treatment condition). The condition contains a requirement for "a clear and noticeable difference in the patient's psychosis symptoms and level of functioning, respectively with and without treatment with drugs". If treatment is assumed to 'only reduce anxiety and agitation, and not psychosis symptoms, other treatment or drugs other than antipsychotics must be considered'.

Thirdly , the medicinal product must have "a beneficial effect that clearly outweighs the disadvantages" of the intervention, including adverse reactions, cf. Section 4-2, first paragraph, first sentence and Section 4-4, second paragraph, letter a, third sentence.

Fourth, coercion must be strictly necessary. As far as possible, the patient's views on such measures shall be taken into account, cf. Section 4-2, first paragraph, first sentence.

In the view of the Court of Appeal, none of these conditions are words and concepts that are so vague that they provide a poor starting point for legal assessments. None of the provisions provide instructions for political considerations or priorities.

Although the conditions refer to medical assessments, they do not preclude full review by the courts. It is not uncommon for the courts to consider medical issues. A close example is Section 3-3 of the Mental Health Care Act, where the court assesses, among other things, the conditions in paragraphs 3 and 7. In such cases, the court must "examine all aspects of the case", and the court is composed of an expert judge, cf. Sections 36-4, 36-5 third paragraph and 36-10 fourth paragraph of the Dispute Act. This makes the court particularly suitable for reviewing medical assessments in these cases.
However, the Court also considers medical issues in a number of other cases, including patient injury compensation, insurance, social security and claims for compensation under the Compensation of Injuries Act.

As stated in section 3.4, it is in principle natural to assume that when the legislator has laid down a condition in the Act, which must be met in order for the administration in the individual case to be allowed to exercise the competence conferred by the provision, the courts will review the

whether the condition is met. The wording of the heading of Section 4-4 of the Mental Health Care Act was also amended in 2017 to "clarify that the provision regulates the conditions for making decisions", cf. the special comment to the provision in Prop. 147 L (2015–2016).

However, for the Mental Health Care Act, there are statements in the preparatory works that indicate the opposite. In Ot.prp. no. 11 (1998–1999), the Ministry of Social Affairs and Health considered whether it should be opened for judicial review pursuant to Chapter 33 of the Civil Procedure Act (Chapter 36 of the Disputes Act) of intrusive decisions other than the establishment and maintenance of compulsory mental health care. The Attorney General stated that it can be "questioned whether the courts should be made to fully review professional judgement and thus perform administrative tasks". The Ministry was of the opinion that there was "uncertainty as to whether legal protection for patients would be greater as a result of an extension of the right to bring legal proceedings", and that an extension of the special rules could make prioritisation in the courts difficult. Following "an overall assessment", the Ministry decided not to submit a proposal that the right of action under what is now Chapter 36 should include "e.g. coercive treatment decisions", see section 11.4 page 140. It noted that such decisions can be brought before the courts in accordance with the ordinary rules of procedure, and further:

> Unless the Control Commission's decisions contain what must be regarded as errors according to the doctrine of abuse of power, the courts' right of review of these decisions will be limited by the Control Commission's discretionary powers. However, if there are errors in the case processing or application of the law, the courts will also be able to review these aspects of the decision.

In the consultation draft, there was a limited proposal to extend the right of action under what is now Chapter 36 of the Dispute Act to include cases concerning the establishment or maintenance of compulsory mental health care, even if the compulsory protection had ceased. The Ministry's discussion of this proposal also supports that the Ministry assumed that ordinary judicial review of decisions under the Mental Health Care Act should take place within the ordinary framework for the review of administrative discretion. It is stated that in such proceedings, the courts are "precluded from examining all aspects of the case", and that "it will be difficult for the court to subsequently review an exercise of discretion", see the proposition on page 139.

The statements in the preparatory works indicate that the legislator has assumed that the Mental Health Care Act
Section 4-4 in its entirety provides instructions on administrative discretion. This constitutes a weighty factor in the direction of this interpretation alternative.

However, the decision of the medical officer to administer forced medication is not appealed to the Control Commission, as the Ministry assumed, but to the County

Governor (County Governor). The County Governor is not an independent control body with a similar composition as the Control Commission, see section 3.3. Nor does the body have such procedural rules, which constitute special procedural guarantees, as the Control Commission has when reviewing decisions pursuant to Sections 3-3 of the Mental Health Care Act and

3-7. As will be seen from section 4.5, questions have been raised over a long period of time and from several quarters as to whether the County Governor sufficiently exercises his competence as an appeal body.

The preparatory works must also be read in light of the fact that they were written before the ECHR and SPR were incorporated into Norwegian law when the Human Rights Act entered into force, and before Norway ratified the CRPD. The existence of obligations under international law is an argument in favour of the courts having full jurisdiction to review; *Rt-2015-1388 (Internal displacement),* paragraph 216.

For the interpretation of Section 4-4 of the Mental Health Care Act, it is significant that Article 3 of the ECHR requires that it must be convincingly demonstrated that coercive medication is medically necessary, and that increased vigilance is required when assessing whether the Convention has been complied with;
2.4.2. With regard to Article 8, the ECHR has, as mentioned, assumed that there must be a possibility of immediate judicial scrutiny. In *X v. Finland* , it meant that the patient had no legal remedy available that could order a court to rule on the legality, including proportionality, of the forced medication, or to have it stopped, cf. paragraph 220.

Finally, the Court of Appeal refers to the fact that due process considerations dictate that the courts carry out an in-depth review. A decision on forced medication is particularly invasive, and it is a general principle in administrative law that the courts can at least review the subsumption in the application of laws that interfere with the individual.

The Court of Appeal has therefore concluded that the court can fully examine whether the conditions in Section 4-4 first paragraph, second paragraph (a), third paragraph and fourth paragraph of the Mental Health Care Act are met in the individual case.

For coercive medication, equal treatment considerations are not relevant. Nor are there any political considerations. However, there may be reason to be reluctant to try those parts of the Act's conditions that require special medical expertise. Whether there is a basis for such restraint must be assessed specifically in the individual case. Here, it may be important, among other things, how thoroughly and specifically the reason for the decision is.

When the conditions of the Act are met, Section 4-4 second paragraph (a) of the Mental Health Care Act provides instructions for administrative discretion as to whether the competence to make decisions is to be used: When the conditions are met, a decision "may" be made. The decision as to whether the competence is used can only be reviewed by the courts within the framework of the review of administrative discretion.

4.3.2 The evidence base for medication with antipsychotics

The requirement that coercive medication must be medically necessary according to recognised medical principles makes it necessary to take a closer look at the evidence base for medication with antipsychotics.

The assessment of whether a violation of the convention has occurred in this case must be based on the general knowledge base in the field that was available in 2014 and 2016; *O'Keeffee v. Ireland* (35810/09, 28 January 2014) para. 143. As a background for the assessment of the Mental Health Care Act, the Court of Appeal has nevertheless found it appropriate to also look at sources created after 2016. Neither party has stated that there have been significant changes since 2016, and both sides have referred to sources from after 2016 in support of their arguments.

Because all use of coercion must be necessary, research on coercive medication is both problematic in principle and difficult to carry out in practice. The evidence base therefore mainly applies to voluntary medication with antipsychotics.

The Court of Appeal has taken into account a wide range of sources, including *NOU 2011:9 Increased self-determination and legal security, The balancing act between self-determination and care responsibility in mental health care* (*Paulsrud Committee*), *NOU 2019:14 Forced Limitation Act, Proposal for common rules on coercion and interventions without consent in the health and care services (Østenstad Committee)* and the report submitted in June 2023 by *The Expert Committee on Competence to Consent*, which was appointed by the Government to evaluate the condition of lack of competence to consent for the use of coercion in mental health care.

The Court of Appeal assumes that medication with antipsychotics in general – and coercive medication in particular – is controversial in the medical community, and that several of the reports quoted above are controversial. Reference is made to the letter from the Norwegian Directorate of Health on 22 March 2019 (19/4832-3), the consultation response to *NOU 2019:14 (the Østenstad Committee) from the* Norwegian Psychiatric Association, and the summary of the debate in the report from *the Expert Committee on Competence to Consent*, point 7.2.

The Court of Appeal has placed great emphasis on the national professional guidelines and guidelines. However, they must be read in light of the fact that they apply to voluntary treatment. *The National Professional Guideline for the Assessment and Treatment of Bipolar Disorders* (IS-1925) was published in 2012, and amended most recently in 2022. The guideline was unpublished in 2024. A review of the guidelines is summarised in *Bipolar guide – updated knowledge* (2024). *The National Professional Guideline for the Assessment, Treatment and Follow-up of Persons with Psychotic Disorders* (IS-1957) was published in 2013, with amendments from 2022. When assessing the specific forced medication of Eidsvik, the Court of Appeal attaches somewhat less importance to this guideline because it is clear from the preface that it does not apply to affective psychotic disorders, which is what she suffers from. It is nevertheless part of the overall knowledge base. The psychosis guideline was published

in 2025. At the same time, the recommendation was
Psychotic disorders – drug treatment published, as a revision of the drug chapter

in the psychosis guideline. The Directorate has circulated for consultation a draft of *Psychotic disorders – treatment methods,* which is mainly from chapter 8 of the unpublished guideline.

The Court of Appeal has also placed emphasis on international sources, which are also partly cited in the Norwegian sources. In 2014, the British National Institute for Health and Care Excellence (NICE) issued guideline CG178 *Psychosis and schizophrenia in adults: prevention and management, Clinical Guideline 178* (CG178). In 2010, the WHO published the *Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders*, updated in 2023, to strengthen countries' ability to provide better and more accessible treatment for mental, neurological and substance-related disorders. The court has also taken into account, among others, the WHO and the UN High Commissioner for Human Rights*' Mental health, human rights and legislation: guidance and practiceMental Health, Human rights and legislation (2023),* and Lauren R. Mosher et al.'s article *The treatment of acute psychosis without neuroleptics: six-week psychopathology outcome data from The Soteria Project* (1995). Furthermore, the Court of Appeal has taken into account the statements of the expert witnesses: specialist in psychiatry Trond Fjetland Aarre, specialist in adult psychiatry Erik Johnsen, professor emeritus of social psychology Tor-Johan Ekeland and specialist in psychotherapy and psychiatry Martin Bernhard Zinkler. Psychiatrists Knut Drottning and Egil Jonsbu have previously treated Eidsvik, but have also spoken out about general medical issues.

Based on this knowledge base, the Court of Appeal assumes that mania can last from days to several months and can be of a mild, moderate or severe nature;
Bipolar guide – updated knowledge (2024). Manic, hypomanic and depressive episodes increase the risk of new episodes. The more severe a manic episode is, the greater the chance of a complicated course; *The guideline for bipolar disorders (2012)* (IS-1925) section 1.4.

The central mechanism of action of all antipsychotics is that they inhibit the signal transmission between brain cells that takes place with the help of dopamine; *The Paulsrud Committee (2011),* point 9.2. The Court of Appeal refers to the account of the effects in *the Østenstad Committee (2019)* item 10.1.1.2.1 page 420 et seq.

With regard to the effect of drug treatment, the Court of Appeal notes that national and international guidelines in the field recommend voluntary treatment with antipsychotic drugs for psychosis and bipolar disorder type I. The Court of Appeal assumes that highly qualified professionals have considered this issue thoroughly, including the certainty of evidence, when drafting the guidelines.

Section *4.7 of the guideline for bipolar disorders (2012) (IS-1925)* stated that drugs can shorten episodes and prevent new episodes, and that clinical experience indicates that

drugs can make new episodes less severe. It was assumed that previous

says a lot about future developments, especially in the short term. In section 6.1, it was assumed that drugs are the «cornerstone» in the treatment of mania, and that they tend to work «quickly and effectively». Section 6.1.2 stated that 'all antipsychotics that have been investigated for acute mania and mixed episodes have shown better efficacy than placebo', see also section 6.4. The *Bipolar Guide – updated knowledge (2024)* assumes that the treatment with
"The best documented effect in bipolar disorder is drug treatment and psycho-education in groups", and that phase treatment for mania has "the best effect if it is started early in order to limit duration and intensity".

Section *8.13 of the Guideline for Psychotic Disorders (2013)* (IS-1957) stated that: "Drugs with antipsychotic effect are one of the forms of treatment that have a well-documented effect on the symptoms of psychotic disorders." It was stated that, depending on the patient group, '50–80 % of patients who receive an effective drug will improve significantly, compared with 5–40 % of those who do not receive an effective drug'. Against this background, antipsychotic drug treatment was 'recommended as first-choice treatment both for acute psychotic conditions and for the prevention of relapse'.

Psychosis disorders – drug treatment (2025) states that patients with psychotic disorders should be offered treatment with antipsychotics together with a psychosocial approach and other psychosocial treatment measures. As justification, reference has been made to a study which indicated that among patients with acute exacerbation of mainly chronic schizophrenia, 51 per cent of patients treated with antipsychotics had at least a 20 per cent reduction in symptoms or 'at least minimal clinical improvement', while 23 per cent had at least a 50 per cent reduction in symptoms or 'at least a minor clinical improvement'. Among the patients who received placebo, the corresponding proportions were 30 per cent and 14 per cent.

The *WHO guidelines (2010)* provide a strong recommendation («Strength of recommendation: Strong») for oral antipsychotic medication for psychotic disorders, with careful weighing of efficacy, side effects and individual preferences. The evidence certainty is stated to be moderate («Moderate»). It states that people with psychotic disorders should be involved in the choice of medication through a supported decision-making process, without coercion and in accordance with human rights instruments. For bipolar disorder (ongoing episode mania), a strong recommendation is also given, but the certainty of evidence is low («Low»). See point 3.10 on pages 88, 89 and 96.

Guideline *CG178 (2014)* from the British National Institute for Health and Care Excellence (NICE) also recommends that oral antipsychotic treatment be offered in the event of acute exacerbation or relapse of psychosis or schizophrenia. Both *the Paulsrud Committee (2011)* and *the Østenstad Committee (2019)* have referred to a NICE report that indicated that there are 'more patients in the drug group who reach a more precisely

defined improvement goal' than with placebo for acute psychotic symptoms. The number of patients who need to be treated in order for one additional patient to achieve "improvement (Number Needed to Treat) is from 5 to 10. About the effect of

acute psychotic symptoms are stated in the report from *the Østenstad Committee (2019)* 10.1.1.2.2 page 241 that a recent pooled analysis showed that the difference in response between patients who received antipsychotics and placebo respectively indicates that six patients must be treated in order for one additional patient to experience improvement. Another meta-analysis indicated that more than ten patients must be treated for one additional patient to experience a good effect. The differences between the studies were assumed to be due to different research methods and sample of patients.

The Expert Committee on Competence to Consent (2023) has referred to a systematic review and meta-analysis from 2019, which found that antipsychotic drugs reduce psychotic symptoms and the number of hospitalisations and prevent relapse. Reference was also made to a study that indicated that an estimated one in five does not respond to antipsychotic drugs.

The Court of Appeal also notes that the evidence certainty for alternative methods, including the use of benzodiazepines, appears relatively weak – and in any case weaker than for antipsychotics. See e.g. *The guideline for psychotic disorders (2013)* (IS-1957) point 8.13.4.1 page 89, *the guideline for bipolar disorders (2012)* (IS-1925) points 4.6 and 4.8 and *the Bipolar guide – updated knowledge 2024* and the *Paulsrud Committee* chapter 11.

Against this background, the Court of Appeal assumes that the choice the responsible therapist is often faced with is between antipsychotics and letting the psychosis/mania burn out on its own.
The Court of Appeal further assumes that treatment with antipsychotics for most people will alleviate the symptoms and shorten the duration of the episode. How much and for how long, however, can vary depending on the person and situation.

The Court of Appeal has noted the research on the number of patients who need to be treated in order for one additional patient to achieve "improvement" or "good effect" («Number Needed to Treat»).
The court will return to this – and the rest of the evidence base – when assessing whether the rules for forced medication are contrary to the Convention in section 4.5.

The Court of Appeal assumes that antipsychotics can have many and sometimes serious side effects – mental, metabolic and motor, as well as tardive dyskinesias, akathisia and neuroleptic malignant syndrome. Studies show more deaths than expected in patients who use antipsychotics, but it is uncertain whether this is due to the disorders, accompanying problems or the treatment. *The Paulsrud Committee (2011)* point 9.3 page 113 et seq.

It is also assumed that a good treatment relationship is in many cases central to achieving improvement, and that it is likely that this will be damaged by the use of coercion.

Coercion can also entail a number of other «disadvantages» within the meaning of Section 4-2 of the Mental Health Care Act, including trauma, retraumatisation, violation of autonomy, integrity and dignity, psychological discomfort in the form of shame, anxiety, anger and powerlessness, as well as damage to social identity and access to one's own coping resources. Reference is made to *the Guideline for Bipolar Disorders*

(2012) (IS-1925) point 1.4, *Guideline for psychotic disorders (2013)* (IS-1957) part 1 cf. points 2, 3.2 and 8.1, and *the Paulsrud Committee (2011)* point 10.1 page 117 et seq. and point 10.4.3 page 124, as well as the majority of the Commission's comments in point 15.2.3 page 200.

Whether the conditions in Section 4-4 of the Mental Health Care Act, cf. Section 4-2 are met in the individual case, must be determined after a specific assessment, on the basis of this knowledge base.

4.4 Procedural requirements

Section 4-4 of the Mental Health Care Act and its regulations also set out a number of procedural requirements, which are supplemented by the Public Administration Act, cf. Section 1-6 of the Mental Health Care Act.

First , the patient must have been "sufficiently examined to provide a basis for assessing the condition and need for treatment", cf. Section 4-4, fourth paragraph, of the Mental Health Care Act. The medical officer must have personally examined the patient during the last 48 hours before a decision is made, cf. Section 20, first paragraph, first sentence of the Regulations. The total examination time may not be set at less than three days, unless "the patient will suffer serious damage to his health through postponement or through previous treatment stays is well known to the institution that decides on the treatment", cf. the second sentence.

Regarding the exceptions, the following is stated about current law in Proposition No. 147 L (2015–2016), section 11.1 on page 41:

> The first exception applies if the patient will suffer serious damage to his or her health in the event of postponement. This means a serious and acute risk of the patient's health condition deteriorating significantly. Serious physical damage to health, self-harm or attempted suicide is also covered. Both somatic and psychological consequences of postponement must be assessed. It is required that the risk of harm to health is predominantly probable (preponderance of probabilities).
>
> The second exception applies if the patient is well known to the institution that adopts the treatment through previous treatment stays. This exception is relevant in cases where the patient is well known after having recently undergone treatment, and the institution has reliable documentation of both the condition and the effect of treatment, and where any side effects are outweighed by this effect. It is assumed that the patient has recently been adequately assessed.

Furthermore, section 11.4 on page 43 states:

> As mentioned, the exemption for patients who, if postponed, will suffer serious damage to their health, will include cases where there is a serious and acute risk that

the patient's condition will deteriorate significantly. Even if the patient is clearly affected by symptoms of psychosis, mania or depression, this will not in itself be an independent basis for making exceptions from the examination period. Even when the patient has had a severe decline in function and considerable symptom pressure outside the institution, the framework of admission may in itself provide symptom reduction.

> Serious physical damage to health, such as serious self-harm, attempted suicide, vegetation and delusions that lead to life-threatening refusal to eat, will be covered. Furthermore, the exemption will cover psychological health damage, such as in the case of significant suffering pressure in patients with psychosis, including manic psychosis, and in the case of severe depression. If the condition causes significant suffering for the patient as a result of frightening delusions, hallucinations and significant inner turmoil, there may be grounds for exceptions. Such symptom pressure can be observed as restless wandering, repetitive self-harm, attempts to flee or other behaviour characterised by fear.

Second, there must be "an attempt to obtain consent to the examination or treatment", or it must be "obvious that consent cannot or will not be given", cf. Section 4-4, third paragraph, first sentence of the Act.

Thirdly , it will be "considered whether other voluntary measures can be offered as an alternative to [...] processing without one's own consent", provided that it is not "manifestly impossible", cf. the Act
see Section 4-4, third paragraph, second sentence and Section 19 of the Mental Health Care Regulations.

Fourthly , decisions on compulsory treatment must be recorded "without delay", cf. Section 4-4, sixth paragraph, of the Act. The decision must be justified, cf. Sections 24 and 25 of the Public Administration Act. Since coercive medication is at the core of the principle of legality, there are special requirements for clarity and clarity in the justification. It must be stated that the decision has been "made according to a factual and justifiable assessment", and that "all relevant circumstances have been considered". Deficiencies in the reasoning may indicate a failure in the decision itself and create doubt as to whether the administrative body has based its decision on a correct legal opinion; *Rt-1981-745 (Isene)* page 748.
Superficial standard formulations without any basis in research-based knowledge and the specific circumstances related to the patient are not sufficient, cf. Aage Thor Falkanger, *Mental health care and forced medication*, Lov og Rett (2017) page 258. See also Rt-2000-1066 page 1972 and e.g. SOM-2016-3672.

Fifthly, the treatment can be initiated no earlier than 48 hours after the patient has been informed of the decision. Exceptions can only be made if the medical officer finds that the treatment cannot be postponed for "weighty reasons relating to treatment", cf. Section 21, third paragraph, of the Regulations. It is stated in the Directorate of Health's circular IS-2012-9 that the reason for the blocking period is that the patient must have the opportunity to consider whether he or she wants to appeal the decision.
Appeals during these 48 hours have a suspensive effect, cf. Section 28, third paragraph, of the Regulations.

A decision on forced medication can be appealed to the County Governor (County Governor) by the patient and his/her next of kin, cf. Section 4-4, seventh paragraph, of the Mental Health Care Act. The appeal must be submitted "immediately", cf. Section 28 first paragraph i.f. of the Mental Health Care Regulations. The appeal shall be processed even if the measure has ceased, unless the complainant has expressed in writing that it is withdrawn, cf. the second paragraph. Appeal filed within 48 hours of the

The patient has been notified of the decision has a suspensive effect until the appeal has been decided, unless the patient will suffer serious damage to his health if the decision is postponed, cf. the third paragraph.

4.5 Whether the rules on forced medication are in conflict with the ECHR and SP, cf. CRPD

Reference is made to the account of the content of the relevant convention rights in section 2, and the review of the Norwegian legislation and the knowledge base in sections 3 and 4.2–4.4.

As the Court of Appeal interprets the Mental Health Care Act with its regulatory provisions, it considers the legal framework for forced medication in Norway to be in accordance with the substantive and procedural requirements of ECHR Articles 3, 8, cf. 14, as well as SP Articles 7, 17, cf. 26.

With regard to the *substantive* requirements, the Court of Appeal refers to the fact that the law requires that forced medication is medically necessary, based on recognised medical principles. Such medical necessity must be convincingly documented. It also follows from the Act that the beneficial effects must clearly outweigh all the disadvantages of the measure. In addition to side effects, it includes loss of self-determination and control over one's own thought processes, retraumatization and damage to treatment relationships.

In the view of the Court of Appeal, the evidence base does not provide a basis for concluding that coercive medication with antipsychotics can never be medically necessary, based on recognised medical principles, or that the benefits will never clearly outweigh the disadvantages.

Coercive medication with antipsychotics is very invasive, and it must be assessed specifically for the individual patient whether such coercive medication is medically necessary in the situation in question. The Court of Appeal has noted the studies which, on a group basis, indicate that a relatively large number of patients must be treated in order for one additional patient to experience varying degrees of positive effect. This is information that the individual responsible therapist must include in their assessment. However, clinical experience with the individual patient will also be central to the specific assessment. Nor do these figures give reason to rule out the possibility that forced medication with antipsychotics may be necessary.

With regard in particular to the prohibition against discrimination in Article 14 of the ECHR and Article 26 of the ECHR, cf. the CRPD, the Court of Appeal notes that permanent and serious mental illness in itself will not be sufficient to meet the conditions for forced medication, cf. also Proposition No. 106 S (2011–2012) on consent to

ratification of the CRPD, pages 16–17. It is also stated in the purpose clause in section 1 that the Mental Health Care Act shall, among other things, ensure that the measures are based on the patient's needs and respect for human dignity. Section 4-2, first paragraph, first sentence states that "as far as possible", the patient's view of coercion shall be taken into account. The second paragraph states that in the case of mental health care in an institution, the stay shall be carried out "as far as it is compatible with the purpose and the individual's condition in such a way that the patient's opportunity to make decisions about himself or herself is safeguarded". Section 15 of the Mental Health Care Regulations

The second paragraph states that the patient shall be «given as much influence as possible» before coercive measures are implemented, and that the patient has the right to participate in the choice between different available and justifiable treatment methods, cf. Section 3-1 of the Patients' Rights Act.

With regard to the *procedural* requirements, the Court of Appeal refers in particular to the review of procedural safeguards in sections 3.3 and 4.4.

As stated in paragraph 2.5, as part of the grounds for the violation of Article 8 of the ECHR, the ECHR has emphasised that the decision-making was not subject to any immediate judicial review; the person had no legal remedy available that could order a court to rule on the lawfulness, including proportionality, of the coercive medication, or to have it stopped. cf. *X v. Finland* , paragraph 220.

The County Governor (County Governor) is not sufficiently independent to meet the requirements set by the ECHR in its case law on ECHR Articles 5 and 6 in order to constitute a court or tribunal. *Campbell and Fell v. United Kingdom* (7878/77 et al., 28 June 1984), paragraphs 78–82.

Furthermore, it has been questioned whether the County Governor sufficiently exercises his competence as an appeal body. NOU 2011: 9 point 16.3 "The County Governor's review of decisions under the Mental Health Care Act" states:

> The Secretariat has sent an inquiry to all county governors with a request for psychiatric competence. […] Four county governors state that they have specialist expertise in psychiatry. Psychiatric competence is rarely obtained if the office does not have it. All county governors state that the case processing is mainly carried out by a doctor and a lawyer. Usually it is the doctor, but in some places the psychiatric nurse, who conducts the conversation with the patient.
>
> The Commission would like to point out that decisions on treatment without one's own consent are a very intrusive measure. Feedback to the Committee from users and others indicates that forced treatment with drugs is often perceived as the greatest violation that occurs in connection with compulsory mental health care. The Commission has noted that professional competence was a major reason why the complaints system was added to the county medical officers in 1984, and would point out that only a few of the county governors have such competence today. The Commission does not find it sufficient for proper review that the County Governors have medical expertise, as the Ministry assumed in Ot.prp. no. 11 (1998 – 99). The Committee cannot see that the check-up regularly entails a full examination of all aspects of the case as long as the county medical officer, according to information the Committee has received, does not always have the necessary psychiatric expertise.

Reference is also made to the Equality and Anti-Discrimination Ombud's submission pursuant

to the Dispute Act
Section 15-8 in this case:

> Every year, an ever-increasing number of decisions are made on forced medication that are carried out in relation to people who are considered to have a "serious mental disorder". In 2022, almost 10,000 decisions on treatment without personal consent were reported, distributed among 3750 patients. Decisions on compulsory treatment with drugs have almost tripled since 2017, and the geographical differences have increased. The number of appeals is also increasing, and the county governor's offices received 1600 appeals against such decisions in 2021, 89-90% of which were confirmed nationwide. [See, inter alia, Better treatment better decision, report from the expert committee on consent competence, June 2023, page 102, and the Ombud's report Incorporation of the CRPD, LDO2023 page 68.]
>
> The expert committee that submitted the report Better decisions, better treatment in 2023, also questions how the legal requirement under Section 4-4, fourth paragraph, of the Mental Health Care Act is understood in practice. The Commission writes on page 103: "With regard to decisions on processing without consent, the input the Committee has received from the County Governors also provides grounds for assuming ambiguities in the understanding of the legal basis for this area... The Commission does not rule out that such circumstances may be a partial explanation for the increase in complaints." [See, inter alia, Better Treatment, Better Decision, page 103]
>
> The system that has been established for administrative review of this type of case has documented weaknesses, and has been proposed to be changed by several public committees – without this being followed up politically [See NOU 2011:9 chapter 16 and NOU 2019: 14 chapter 28.]

Although the figures referred to are from after the period in which this case relates, the Court of Appeal believes that they also shed light on the situation in 2014 and 2016. The Parliamentary Ombudsman (the Parliamentary Ombudsman) has stated in several cases that it has been unclear whether the County Governor has applied the correct norm when interpreting Section 4-4 of the Mental Health Care Act, see, inter alia, SOM-2016-3492, SOM-2017-708, SOM-2017-543, SOM-2017-3156 and SOM-2025-752.

Furthermore, judicial review of the County Governor's (County Governor's) decision must take place through ordinary lawsuits, which are not suitable for stopping any unauthorised coercive medication. Whether an interim injunction pursuant to Chapter 34 of the Dispute Act may be used for this purpose, cf. NOU 2001: 32 A point 19.2.4.1 page 522, has not been an issue in this case.

The Court of Appeal has nevertheless concluded that the procedural safeguards provided for by Norwegian law are sufficient to satisfy the requirements of the ECHR and the ECHR, interpreted in light of the CRPD. The statement quoted above in *X v. Finland* , paragraph 220, was not included in the explanation of the general principles. It was part of the ECHR's reasoning for the specific outcome of the case, which concerned weaker procedural safeguards than the Norwegian set of rules contains. In the view of the Court of Appeal, the procedural requirements;

Section 4.4, the right of appeal to the County Governor (County Governor), cf. Section 3.3, and the right to judicial review of the decision, where the Court of Appeal considers that the courts have full power of review, in principle sufficient legal protection mechanisms. For comparison, reference is also made to *HR-2024-775-A (telephone control)* paragraphs 70–75. See also report
15 January 2024 on the incorporation of the CRPD, inter alia. Part II, point 14.5.6, pages 162–163.

However, the County Governor's (County Governor's) lack of independence and the indications that in some cases the appeals body does not sufficiently review the responsible practitioner's decision on forced medication, mean that the courts must make a particularly thorough assessment of whether the procedural safeguards are met in the specific case.

5. Isolation pursuant to Section 4-8 of the Mental Health Care Act

Solitary confinement is a means of coercion. This is regulated by Section 4-8 of the Mental Health Care Act, which in the period in question read as follows:

> Coercive measures shall only be used against the patient when this is indispensable to prevent him from harming himself or others, or to prevent significant damage to buildings, clothing, fixtures or other things. Coercive measures shall only be used when more lenient measures have proven to be manifestly futile or insufficient.
>
> Coercive measures may be used:
> a. mechanical coercive measures that impede the patient's freedom of movement, including belts and straps and injury prevention special clothing
> b. Short-term placement behind a locked or closed door without staff present.
> c. single use of short-acting drugs for sedative or anaesthetic purposes.
> d. short-term restraint.
>
> For patients under the age of 16, it is not permitted to use coercive measures as mentioned in letters a and b in the previous subsection.
>
> Patients who are subjected to coercive measures must be continuously supervised by nursing staff. When restrained in a bed or chair, nursing staff must stay in the same room as the patient unless the patient objects.
>
> Coercive measures may only be used after a decision by the professional responsible, unless otherwise stipulated in regulations. The decision must be recorded without delay. The decision can be appealed to the control commission by the patient or his or her next of kin.
>
> The King in Council issues further regulations on the use of coercive measures.

The relevant provisions in Part IV of the Mental Health Care Regulations "Coercive measures" read as follows during the period in question:

> *§ 25. Decision on the use of coercive measures*
>
> The use of coercive measures for treatment purposes is not permitted.
>
> If an acute emergency situation means that immediate contact with the professional responsible person is not possible, the person in charge of the department may make a decision to use the

mechanical coercive measures, isolation or short-term restraint. In such cases, the professional responsible person must be notified as soon as possible. If the situation makes the continued use of coercive measures necessary, the professional responsible must take a position on whether the use of coercive measures should be maintained.

§ 26. Implementation of the use of coercive measures

The use of coercive measures shall be made as short as possible and carried out in the most gentle and caring manner possible. Insulation must be used for a maximum of two hours at a time. In the case of continuous use of mechanical coercive measures for more than eight hours, it shall be ensured, as far as possible, based on the patient's condition and the circumstances in general, that the patient is given freer care for a shorter or longer period of time. If this cannot be done, the reason for this must be recorded.

The patient must be continuously supervised. In the case of restraint in a bed or chair, the personnel must stay in the same room as the patient, unless the patient wishes to be alone and this is professionally justifiable.

The use of coercive measures shall be assessed on an ongoing basis, and immediately discontinued if it proves not to have the intended effects or has unforeseen negative consequences.

The law stipulates that the coercive measure must be "indispensable to prevent him from harming himself or others, or to prevent significant damage to buildings, clothing, furniture or other things". Furthermore, coercive measures may only be used when "more lenient measures have proven to be manifestly futile or insufficient". The parties agree that the provision provides instructions on the application of law, and the Court of Appeal agrees with this.

The ECHR has stated that physical coercive measures against patients in psychiatric hospitals must be a last resort and the only means available to prevent immediate or imminent harm to the patient or others; *M.S. v. Croatia (No. 2)*, paragraph 104.

The Court of Appeal is not aware that the ECHR has ruled on whether it is permissible to use coercive measures to avert material damage, as the wording of Section 4-8, first paragraph, first sentence of the Mental Health Care Act, according to its wording. However, because none of the decisions on the isolation of Eidsvik have been justified by preventing material damage, it is not necessary to take a position on whether section 4-8 should be interpreted restrictively, or whether this part of the provision is in conflict with ECHR articles 3, 8 or 14, and corresponding provisions in the SP, which in the case take precedence. cf. Sections 2 and 3 of the Human Rights Act.

Although the special procedural rules in Section 6-4 of the Mental Health Care Act do not

apply to the Control Commission's review of decisions on solitary confinement, the Court of Appeal finds that the treatment satisfies the requirements for sufficient procedural safeguards; *M.S. v. Croatia (No. 2),* paragraph 105. The Commission is independent and makes its decisions on the

On the basis of "judicial principles", cf. *cf. Rt-2001-1123* on Article 6(1) of the ECHR and *Rt-2004-583,* paragraph 34 on Article 5(4). The decision can also be brought before the courts.

6. Shielding pursuant to Section 4-3 of the Mental Health Care Act

Shielding is regulated by Section 4-3 of the Mental Health Care Act, which in 2014 and 2016 read as follows:

> If a patient's mental state or acting out behaviour during the stay makes shielding necessary, the medical officer may decide that the patient shall be kept completely or partially separate from fellow patients and from personnel who do not participate in the examination, treatment and care of the patient for treatment reasons or out of consideration for other patients.
>
> A decision is made if shielding is maintained beyond 24 hours. If the patient is transferred to a shielded unit or similar that entails a significant change in the person's surroundings or freedom of movement, a decision must be made if shielding is maintained beyond 12 hours. Decisions on risk-free return must be recorded without undue delay. Decisions can only be made for up to two weeks at a time.
>
> Decisions on shielding and on extension of shielding can be appealed to the control commission by the patient and his or her next of kin.
>
> The King may issue further regulations on the conditions for risk-free return and its implementation.

Shielding is regulated in more detail in Sections 16 to 18 of the Mental Health Care Regulations, which read as follows:

> *§ 16. Conditions for risk-free return*
>
> Shielding must be justified by considerations of treatment or consideration for other patients, cf. Section 4-3 of the Mental Health Care Act. Treatment-related considerations may apply, for example, if it is necessary to limit the patient's sensory impressions, or in situations where the patient exhibits increasing restlessness or anxiety, and shielding is considered to be able to counteract the deterioration of the patient's condition. It is not sufficient that the patient suffers from an agitation that must be considered normal when establishing compulsory observation or compulsory mental health care.
>
> Consideration for other patients may form the basis for shielding when the patient's behaviour is very disruptive, troublesome or unfortunate for other patients. It is not required that the patient poses a danger to other patients.
>
> In the case of shielding out of consideration for the patient himself, it must be assessed whether the intervention will have a beneficial treatment effect. In the case

of shielding for the sake of others, the needs of fellow patients must be assessed against the unfortunate consequences shielding may have for the patient.

§ 17. Decisions on risk-free return that are maintained beyond 12 hours

> When assessing whether the shielding entails a significant change in the patient's surroundings or freedom of movement, cf. Section 4-3, second paragraph, second sentence of the Mental Health Care Act, a comparison must be made of the patient's situation during shielding and without such a measure. Key factors in the assessment will be the restrictions the patient will be subject to, for example whether strict restrictions are placed on access to certain items or exit options, and how the room in which the shielding is carried out is furnished.
>
> *§ 18. Implementation of risk-free return*
>
> Shielding may mean that the patient is referred to stay in his or her own room or in premises that are separate from the common areas and patient rooms in the ward (shielded unit). It is not permitted to lock or otherwise close the door to the room where the patient is located. The patient can be physically directed to where the shielding is to be carried out.
>
> The patient may be restrained if he or she tries to leave the place where the shielding is being carried out. A patient who is under voluntary mental health care cannot be detained or otherwise prevented from leaving the institution if he or she so wishes. The patient must be informed of his or her right to discharge from the institution.
>
> Healthcare personnel must be present to the extent necessary. If the patient expresses a desire to be alone, the healthcare personnel must leave the room if presence is not considered necessary.
>
> Restrictions on the patient's contact with the outside world require that a separate decision is made to this effect, cf. Section 4-5 of the Mental Health Care Act.

In the view of the Court of Appeal, Section 4-3, first paragraph, of the Mental Health Care Act contains both a rule that must be assessed according to the ECHR's norm for coercive treatment, and a rule that must be assessed according to the norm for physical coercive measures. When risk-free return is adopted "for therapeutic reasons", it is a treatment measure. However, when a patient is shielded "out of consideration for other patients", it is a control measure. The difference from insulation, cf.
Section 4-8 second paragraph (b) is that it is not permissible to close the door to the room where the patient is located. Shielding can also last longer than insulation.

Circular IS-2012-9 states about Section 16 of the Regulations that acting out can only justify shielding out of consideration for others than the patient himself if he or she is "of a qualified nature" and
"very disturbing, troublesome or unfortunate for the other patients". It is not required that the patient poses a danger. Regarding the relationship between shielding and isolation, it is stated:

> Shielding will be a less invasive measure than, for example, solitary confinement. It is therefore assumed that it will be assessed whether risk-free return will be

sufficient in a specific situation, even in situations with a certain element of danger. Key factors for whether the measure is considered shielding or isolation will be the background for the measure and its content. As an example, it is mentioned that a patient acts out and

> aggressive behaviour in the common area, and that a nurse leads the patient to the patient's room in order to shield other patients and to prevent the situation from degenerating and to calm the patient down. If this measure proves sufficient in the specific situation, it must be regarded as risk-free return. If, on the other hand, the patient is so outgoing that there is a need to have a closed door between the patient and healthcare personnel, the measure must be regarded as isolation, cf. Section 4-8 of the Act. This also applies in cases where the situation escalates after the patient has been led to the room for shielding.
>
> Risk-free return cannot be implemented out of consideration for the staff/staffing situation.

Section 4-8 of the Act stipulates that the patient's "mental state or acting out behaviour [...] makes shielding necessary". Like the rules for forced medication and solitary confinement, the Court of Appeal finds that the conditions side of Section 4-3, first paragraph, of the Mental Health Care Act is the application of law. None of the words are so vague that they provide a poor starting point for legal assessments, and none of the provisions provide instructions for political considerations or priorities. The fact that parts of the provision refer to medical assessments does not preclude the application of the law. The existence of obligations under international law also indicates that the courts have full jurisdiction to review; *Rt-2015-1388 (internal flight)* paragraph 216. However, depending on the circumstances, there may be reason to be reluctant to try those parts of the Act's conditions that require special medical expertise.

Section 4-3 of the Mental Health Care Act must be interpreted in the light of the ECHR and the ECHR, cf. Sections 2 and 3 of the Human Rights Act. The treatment rule must be interpreted in the light of the framework established by the ECHR for coercive measures, and the rule on control measures must be interpreted in light of the ECHR's opinions on coercive measures, see section 2.4.2. When the rules are interpreted in this way, the Court of Appeal cannot see that there is any conflict between the Norwegian regulations and ECHR Articles 3, 8 and 14, as well as Articles 7, 17 and 26 of the ECHR, nor when these are interpreted in the light of the CRPD.

On the same grounds as for solitary confinement, cf. point 5, the Court of Appeal finds that the Norwegian regulations meet the requirements for sufficient procedural safeguards. The Court of Appeal does not agree with the appellant that the legal basis for risk-free return is too broad and provides instructions for a discretion without sufficient limitations. Reference is made to the terms and conditions and the Mental Health Care Act with regulations, which have been reviewed above, and that the Court of Appeal assumes that the conditions provide instructions for the application of the law. When the conditions are met, the provision provides instructions on an administrative discretion as to whether the competence to decide on risk-free return is to be used, and in what form the risk-free return is to take place. However, the Control Commission has full jurisdiction to review

appeals. Furthermore, the courts have the competence to test whether the exercise of discretion is based on the correct assessment of evidence and lies within the limits that follow from, among other things, the competence base, the ECHR and the SP, as well as the doctrine of abuse of authority.

7. Treatment of Eidsvik

7.1 Introduction

The Court of Appeal will first explain the starting points for the assessment of evidence. The Court of Appeal will then decide whether the forced medication, isolation and shielding of Eidsvik violated her human rights.

According to the ECHR's method, an overall assessment must be made of whether the person's convention rights have been violated. The way Eidsvik has formulated his claim, and with the conclusions reached by the Court of Appeal, the Court of Appeal has nevertheless found no reason to make such an overall assessment in addition.

7.2 Evidentiary requirements, assessment of evidence and burden of proof

The courts' review of whether an administrative decision is invalid is usually based on the facts at the time of the decision; *Rt-2012-1985*, paragraphs 81 and 98. The Court of Appeal assumes that the same applies to claims for a declaratory judgment for violation of the Convention. In this case, it is in any case not stated that there are relevant subsequent facts.

The ECHR only assumes a sequence of events that can justify an infringement, when this is "Proof beyond reasonable doubt". This is an autonomous threshold and does not correspond to the criminal law standard of proof in Norway. The Court of Appeal assumes that the ECHR's application of this stricter standard of proof is justified by the same considerations as the margin of discretion, see section 2.2. The Supreme Court has not applied a stricter standard of proof in the cases where it has considered a claim for a declaratory judgment for violation of the Convention. Therefore, the Court of Appeal cannot see that there is a basis for making an exception from the general standard of proof in Norwegian law regarding a preponderance of probabilities.

A general assessment shall be made of what is most likely, following a free assessment of evidence in accordance with the guidelines laid down by the Supreme Court. In situations where the causal and symptom picture is unclear, the quality and weight of the evidence may vary. Records close to the time normally carry the greatest weight, especially when professionals have recorded observations to clarify a condition. From *Rt-1998-1565 (whiplash I)* it is stated on page 1570:

> Particularly important in the assessment of evidence will be records made in time close to the event or circumstance to be clarified, and in particular descriptions made by professionals precisely to clarify a condition. This will apply, among other things, to records in medical records about findings and about the symptoms the patient has during the examination or treatment. For example, information from patient to doctor will have weaker evidential value if the information relates to the patient's condition at a significantly earlier time than the time of the consultation in

question. Information from parties or witnesses with ties to the parties that has been provided after the dispute has arisen, and which contradicts or changes the picture given by more eventful and independent evidence, will usually be less important

The evidential value of the medical records and discharge summaries has become a particular topic in this case.

The Court of Appeal attaches particular importance to what appears in the medical record when professionals have recorded observations to clarify a condition. It also attaches great importance to other records of objective conditions. However, the Court of Appeal notes that the medical records and discharge summaries do not necessarily describe all relevant events neutrally and completely. They show what the doctor or nurse in question has considered to be central, and recorded.

The Court of Appeal assumes that Eidsvik has explained herself about the events in question as she remembers them. In assessing her statement, the Court of Appeal must nevertheless take into account that these episodes are far back in time, and that they occurred at times when she was under the influence of mental illness and/or medication.

The burden of proof is basically on the plaintiff. However, as stated in section 2.4.2, the burden may in certain cases fall on the state in the case of incidents that are alleged to have occurred while a person was under the control of the authorities.

In its assessment, the Court of Appeal will take as its starting point the decisions that have been made, and the reasons given, cf. *Rt-2015-1388 (Internal Flight)* paragraph 247.

All the decisions on forced medication, isolation and shielding have been made by ticking a box on a standard form. There is no specific assessment or justification for the decisions themselves. However, the Court of Appeal assumes that they must be read in the light of any specific assessment or justification that is also stated in the medical record.

7.3 Forced medication

7.3.1 Introduction

The Court of Appeal assumes that Eidsvik meets the criteria for the diagnosis of bipolar disorder type I (ICD-10 code F 31.0. – F31.7). The disorder is characterised by two or more episodes in which the patient's mood and activity level are significantly disturbed. The disorder sometimes consists of elevated mood (elation) and increased energy and activity (hypomania and mania) and other times in lowered mood (depressed mood), reduced energy and activity (depression).

The forced medication of Eidsvik that the Court of Appeal will consider took place in 2014 and 2016. However, the history is relevant for assessing whether these were in conflict with her convention rights. The Court of Appeal will therefore first give a brief account of this.

Eidsvik was born in 1964 and has a daughter. Eidsvik is a trained child welfare educator and special educator with a 2nd department (cand.mag.), with further education in guidance (SEPREP) and management/administration, and is an approved trauma therapist in several methods.

Eidsvik has been subject to compulsory mental health care eleven times in the period 1988–2016. In ten of the admissions, she was forcibly medicated with antipsychotics. On one admission, she was treated without medication. With the exception of one admission, all have been at the County Hospital in Molde, psychiatric department, Hjelset.

Eidsvik has opposed medication with antipsychotics from the first hospitalization. She has also been an outspoken opponent of medication while she has been well-functioning and working.

7.3.2 The first eight admissions

On *the first admission* (1988), a decision was made to take coercive medication three days after admission. The decision was implemented the next day. After having been 'acting out both verbally and physically', she was described after being coerced as gradually having 'clear clinical improvement'. She became "more and more collected, her delusions were faded and she became motor calm". She was discharged after a week. The last couple of days in the department, she showed
"not clear symptoms of a persistent lack of reality".

In her medical records from *her second admission* (1989), it is stated that she is "very anxious about being forcibly medicated". Five days after admission, she was forcibly medicated. After a break of about ten days, medication was restarted, with the following remark: 'Unfortunately, it is found that the drug-free treatment programme that has been attempted has unfortunately failed again'. During the forced medication, there were "punches, kicks and spitting at the staff". It appears that Eidsvik had speech difficulties. About a week later, the forced treatment was stopped. About two weeks after this, 'the clinical condition appears to have stabilised'. Furthermore, it is stated:

> The conversations with passports. has a clearly supportive function. This is due to several factors. It should be mentioned that, especially for this passport, it has seemed unfortunate that one has had to resort to the use of drug coercion and coercive treatment with drugs, so that an unfortunate polarisation and an apparent contradiction from the start, of the passport, was perceived to exist.

She was discharged five days after this, but admitted six days after that.

On *the third admission* (1989), a decision was made to administer forced medication after three days. The decision was implemented immediately, and Eidsvik "resisted a lot". The

course of events in the department was perceived to have 'clear parallels with the previous stay', and 'this time too there were aggressive outbursts and with punches and threats against the staff'. A few weeks into her stay, Eidsvik told of "strong side effects", she did not talk, only pointed and

"trying to be stiff in the body", which was perceived as "fair play". Several times it is reported that the drugs have a good effect, in that she calms down and falls asleep. It also appears that she seems to be a danger to others; Among other things, she has kicked a nurse in the stomach.
After about a month and a half, she appears to be in good recovery, she has been "for some time" without medication and does not show definite signs of psychotic delusions. It appears that on several occasions attempts have been made to get her to talk, but that she has been busy.

On *her fourth admission* (1991), Eidsvik hallucinated and was afraid; she saw reptiles in bed, she thought there was heavy water in the tap and gas in the room and that the flowers were emitting lead. She refused to take medication because she was "afraid to fall asleep, because then she might get an injection and die." Eidsvik "kept coming back to previous forced medication, which was very traumatic for her", and threatened to kill the staff in the department. A decision was made to take forced medication ten days after admission. Eidsvik was given rohypnol, which she herself wanted. She punched/kicked when confronted with medicine. Side effects were described as 'stiff jaw/throat, drool'. It was "difficult to understand what she is saying when she twists her mouth". Eidsvik was offered "antiparkinson's drug" for the side effects, while at the same time it appeared that she "controls the 'side effects'". It appeared that she kicked and "was unwilling" during the forced medication, but "at the same time it could appear that there was no reluctance". The paranoid notions faded somewhat after about the second week. The last medication took place on February 20, 1991 with Cisordinol depot 200 mg. She was discharged on 16 April 1991.

The fifth admission took place on 5 June 1991. Because this is the only admission where she was not forcibly medicated, the Court of Appeal will give a more detailed account of this.

The medical records state that the night after admission, she was "violent, both physically and verbally, [... s]punches, kicks and spitting". Five days after admission, she made death threats against a nurse, who assessed that without medical treatment, Eidsvik would "reduce the chances of recovery". Seven days after admission, on 12 June, a decision was made on forced medication. Because Eidsvik appealed, the decision was not implemented. On 14 June, it was noted:
"Are we going to move forward and get an alliance with passports. we see it as absolutely necessary that she be given medication needs." In the following days, however, she is described as gradually improving. The county medical officer spoke to Eidsvik on 19 June. Two days later, she was given two days of leave.

On 2 July 1991, Knut Drottning took over the treatment responsibility for Eidsvik. His first note states:

Inger Mari had strong experiences of being raped in connection with the forced medication. She then relived a rape about 5 years ago, and it is clear that in situations where we decide, she relives this. […] She admits that being psychotic was a very unpleasant experience, but
At the same time, it has been educational. […]

> […] She is very skeptical about the use of medication in psychiatry, but she seems to accept that I have a more positive attitude towards this. She expresses that she wants to be here on a voluntary basis for a while to come, and I give her a verbal promise that she will not be medicated if she continues to be as stable as she is at the moment.

On 10 July, Eidsvik no longer met the conditions for compulsory hospitalisation. She remained a volunteer until July 25, 1991, when she was discharged.

Prompted by the state's submissions, the Court of Appeal notes that it does not consider it likely that the recovery without antipsychotics during the fifth hospitalization was an after-effect of the medication during the fourth hospitalization. It is noted that about four months elapsed from the last prolonged-release injection was given on 20 February 1991, until she is first described as improving from mid-June. After the drug-free admission, it took a little more than three years until the next admission.

The *sixth admission* (1994) is the only one who was not at the hospital at Hjelset, but at Åsgård, University Hospital of North Norway. After four days, a decision was made on forced medication, which was implemented. She is described as having clear paranoid notions of surveillance and being very afraid. It appears that Eidsvik "has rejected all medication, now seems so run down, tired and chaotic that she obviously needs immediate treatment." The effect of the medication is described as positive; She has slept and collected her thoughts better. She was offered oral medication, but would not take it. Åsgård mapped Eidsvik's background and received, among other things, the following information about previous abuse from a psychologist, with whom Eidsvik had gone to interviews:

> Passport. has always been extremely contrarian to drug treatment. He believes this is partly ideologically conditioned as it is special. anti-drug culture in Northwest Norway when it comes to neuroleptics.
>
> Part of her intense antipathy towards drugs was that she had previously been subjected to a sexual assault in the form of rape. This happened while she was under the influence of prolonged-release neuroleptics, and she herself has come to the opinion that it would never have happened if she had not been under the influence of drugs.

After this, 11 years passed before the next admission.

The seventh admission (2005) was again at Hjelset. At first, the criteria for the use of "coercive measures" were not considered to be "met". She "often repeated that she does not want an injection". It is stated that "[t]he state of mind changes within a few minutes, from being positive and smiling she goes over to being angry and irritated (when we talk about medicine)". A note six days after admission states:

When one turns the conversation to drug treatment, she shuts down completely and does not want to talk about this. Can't justify the quirk, asks me to read her journal.

> I perceive the patient as clearly agitated, psychotic and completely without insight into the disease. She has been in similar positions, and has then recovered with the help of antipsychotic treatment. Since ho no refuses such treatment on a voluntary basis, find a basis for making a decision about treatment under duress.

It appears from the medical records that Eidsvik is perceived to have improved «a good deal after injection». On the same day, she took Zyprexa voluntarily. Eidsvik had appealed the forced medication decision prior to this, but it did not come to the knowledge of the responsible therapist until six days later. The county medical officer had therefore not received the documents, which were not sent until a week after the complaint was dated.

The journal of 18 February 2005 states:

> During drug treatment, [the patient has become] incredibly much better in just a short time. She could be moved to a closed post, is straightforward in contact, speaks in an orderly and adequate manner. A week ago, she actually started taking Zyprexa orally, and she thanks us for the help (and she doesn't mean that ironically). It is planned to send her on leave next week, when she has been on oral Zyprexa for a few days.

Eidsvik was given overnight leave a few days later and was discharged a couple of days later.

On *her eighth admission* (2007), psychosis with paranoid thoughts was described. It appears that she has auto-discontinued Zyprexa and Abilify, and is said to have "reportedly managed well without medication until recently". She had resisted hospitalization, and the police therefore used handcuffs to get her in. The next day, she was told that if she did not agree to voluntary treatment with antipsychotics, a decision would be made after the three-day examination period. However, coercive medication took place before the examination period has expired, as far as the Court of Appeal deems to be a coercive measure pursuant to Section 4-8 second paragraph (c) of the Mental Health Care Act. The next day, it was observed that Eidsvik
"seems to have difficulty speaking, dysarthria, needs to prepare before starting a conversation." There are suspected to be side effects of the injection. Eidsvik was offered Akineton tablets for the side effects, but did not want this. On the same day, a decision was made on forced medication pursuant to section 4-4. Ten days after admission, it is stated:

> I am contacted about the patient as she has now finally taken zyprexa 10 mg voluntarily. She now wants to avoid forced medication by injection tomorrow. I see from the journal that she had a stay in 2005 with the same course. She got much better after a couple of injections of cisordinol and zyprexa, started taking

medication voluntarily (zyprexa 20mg) and was discharged in good shape with zyprexa 15 mg (got a little tired of 20mg) Gradually reduced the dose until April last year when zyprexa was discontinued.

Ten days later, the decision to be involuntarily hospitalized was rescinded. It is stated in the medical records:

> She herself is only interested in taking Stesolid to calm down after discharge and otherwise believes that she should have been given a "drowsy cure" as treatment on admission. I'm very unhappy that she got Cisordinol Acutard and that she didn't get Akineton. When it is pointed out that the patient was offered this, but refused to take it, the patient says that this should have been given by force. It is not entirely unproblematic to give Akineton after a decision, and in the end it was she herself who opposed this.

After that, seven years passed until the next admission, when the first forced medication that the Court of Appeal will decide whether constitutes a violation of the convention took place.

7.3.3 Ninth admission (22 February to 19 March 2014)

Eidsvik was hospitalized on 22 February 2014 when she had a "manic episode without psychotic symptoms". It appears from the discharge summary that the 18-year-old daughter and a childhood friend of Eidsvik asked that they wait as long as possible before considering possible forced medication. They stated that it was the forced medication that had been most traumatic for Eidsvik in previous admissions, and that she had been clear that she would rather be ill for a longer period of time than be subjected to forced medication.

The discharge summary provides information about the course, assessment and treatment:

> Passports were entered under section 3-2, this was changed to section 3-3, at the same time as a risk-free return decision was made (section 4-3). It was also necessary to make a decision on coercive measures in the form of solitary confinement (Section 4-8). […]
> Pas was considered to be clearly manic and in need of drug treatment. She was offered this, but declined and was determined not to accept tablets voluntarily.
> In previous admissions, she has responded well to neuroleptics in similar phases. A decision was made on treatment without one's own consent (Section 4-4 a) the day after admission. Since her passport is well known from earlier and her mental picture is very similar to previous admissions, the requirement for three days of observation was waived. It was hoped that her condition would improve spontaneously, as this did not happen and she consistently refused to accept tablets, an inj. i.m. with Zyprexa 20 mg and Stesolid 10 mg.
> For a few days, she then took Zyprexa tbl. Due to lack of improvement, it was decided to add Cisordinol based on the fact that the combination Zyprexa/Ciordinal has had a good effect on those in the last two admissions. When the pas opposed taking Ciordinal tbl, it was prescribed on 5.3. Ciordinal Acutard inj. 50 mg im and Akineton inj 5 mg im. Injection with Cisordinol Acutard 50 mg and Akinton 5 mg im was repeated 7.3. After this, the clinical picture improved in that she appeared calm and adequate, with insight into the fact that she had been in a period of illness and what could have triggered it.
> She was moved out of the sheltered side and was given leave to go home. When this worked well, she was discharged.
> […] She is adamant that she does not want stabilizing medication to prevent new

episodes.

This is ticked on the standard form for a decision on forced medication on 23 February 2014. The medical records of the same day state:

Decisions on processing without one's own consent (section 4-4a)
Inger-Mari has a known bipolar mood disorder. She has several compulsory hospitalisations and has been forcibly medicated several times during the manic phase, most recently at the previous admission in 2007. She was admitted two days ago to Ålesund Hospital. She has appeared clearly manic upon admission and her condition has remained largely unchanged since admission. A shielding decision has been made (4-3) as well as a decision that she can be placed in her room for short periods with the door closed and without staff present (4-8). On examination today, she first sits in the smoking room and talks loudly to herself. During the examination, she walks restlessly around the room, talking incessantly.
She is partly oriented to the situation, but is springy in topics and mostly talks about things that have no relevance to the situation, she asks, among other things. if we are Jesus and make many similar statements that give suspicion great chaos of thought. She has been offered medication several times since her admission and is also offered this during the conversation. She expresses that she is determined not to accept tablets voluntarily.

Rating:
The patient is clearly manic and in need of drug treatment. In previous admissions, she has responded well to neuroleptics in similar phases. A decision is hereby made on processing without one's own consent. Since the patient is well known from previous admissions and her mental picture is very similar to previous admissions, the requirement for three days of observation is waived.

When the deadline of 48 hours before implementation had expired, it appears that Eidsvik still showed
"clear signs of a manic state, but still somewhat subdued compared to the previous days", and had slept sufficiently. Medication was awaited in the hope that the mania "within a reasonable time, will pass without the effect of the forced medication".

On 27 February 2014, Eidsvik had poorer sleep and appeared worse. She opposed a therapist conversation, and it was not possible to enter into a dialogue. She was given a one-hour deadline to take antipsychotics orally, before the coercive decision would otherwise be implemented. The nurse's medical records state that Eidsvik "had to be physically held by 4 men when she resisted". She said she was "afraid she will be raped after she falls asleep". Later that day, Eidsvik turned to a male environmental therapist.

On 5 March 2014, it appears that Eidsvik so far did not appear to be improving on the medication she had been given. An additional antipsychotic was prescribed, as well as Akineton for any side effects. The nurse's records state that she was "taken and lifted up into bed and held on to the injection that day". She was angry and crying, but eventually calmed down. Two days later, she was perceived as somewhat more subdued and had slept more.

On 10 March 2014, Eidsvik is described as "calm and adequate". She was moved out of the sheltered section to a regular, closed ward and was given leave the following day.

On 6 March 2014, Eidsvik appealed the decision to take forced medication. The complaint was received by the County Governor of Møre og Romsdal on 10 March. Two days later, the county medical officer called Hjelseth,

who on 13 March 2014 submitted the medical records and form L2 "decision on treatment with drugs without own consent", i.e. the decision on forced medication.

On 18 March 2014, Eidsvik returned from leave and was subsequently discharged.

The appeal against the decision on forced medication was not decided. In a letter to

Eidsvik on 19 March
2014, the County Governor assumed that since Eidsvik had been discharged from compulsory protection,
there was no longer any decision to review. The complaint was therefore dismissed.

When assessing *whether the forced medication constituted a violation of the Convention,* the Court of Appeal takes the decision as its starting point, supplemented by medical records and discharge summaries. Considering the long-term clinical experience the hospital had with Eidsvik, the Court of Appeal is somewhat reluctant to review the responsible therapist's assessment of medical necessity when the decision was made and implemented. The Court of Appeal considers it clear that the purpose of the medication was treatment, and that the responsible therapist believed that Eidsvik would have a shorter and milder course of medication than without. It also appears from the medical records that during previous admissions, attempts had been made to enter into a treatment alliance with Eidsvik without success, and that she had acted out, aggressive and violent on several occasions, even outside of the forced medication. Psychiatric nurse Camilla Vibeke Klunderud explained during the appeal hearing that she perceived Eidsvik as unwell when admitted, and that she did not want medication and was afraid of dying. Eventually, after the injections, she calmed down and got better. The Court of Appeal understood Klunderud to mean that she believed that Eidsvik was so ill that she needed medication with antipsychotics, even if it meant coercion.

However, the court must ensure that medical necessity is convincingly documented, and that the procedural safeguards are met. Furthermore, the manner in which the coercive treatment was carried out cannot exceed the threshold for seriousness pursuant to Article 3 of the ECHR.

The decision is made by ticking a standard form. There is neither there nor from the assessment in the medical records on the same day any specific assessment of whether the advantages of forcibly medicating Eidsvik "clearly" outweigh the "disadvantages", cf. cf. Section 4-4 second paragraph (a) third sentence of the Mental Health Care Act, cf. Section 4-2.

Appeal Judge Guro Hansson Bull and Extraordinary Appeal Judge Karen Wendel Sandaa note that even though the decision does not contain an explicit assessment of this

condition, an overall review of the medical records at the time of the decision shows that such an assessment has been made based on extensive experience with the patient's medical history, including marked resistance to medication. Read in context, it appears that Eidsvik was so ill that the advantages of forced medication clearly outweighed the disadvantages.

In the Court of Appeal's view, a decision should have been made on coercive measures in the form of
«short-term restraint» pursuant to Section 4-8 second paragraph (d) of the Mental Health Care Act before Eidsvik could be restrained as described during the forced medication. In response to the State's objection that coercive measures cannot be used for treatment, the Court of Appeal notes that the restraint itself did not constitute treatment. On the other hand, it was a coercive measure that was used to be able to carry out medication against the patient's will. Particularly in light of the information about the rape, regardless of the degree and form of physical coercion by which the medication was to be carried out if necessary, should have been considered as part of the weighing of advantages against disadvantages pursuant to Sections 4-2 and 4-4.

The Court of Appeal further points out that Eidsvik's appeal against the forced medication decision was not received by the County Governor until four days after it was submitted, and that the appeal was never decided.
This constituted a violation of the procedural rights Eidsvik had pursuant to Section 28 first paragraph i.f. and second paragraph of the Mental Health Care Regulations, and means that the procedural guarantees provided for in the Norwegian regulations were not followed.

After an overall assessment of these circumstances, the Court of Appeal has concluded that *Article 3 of the ECHR* and *Article 7 of the ECHR* were violated in that the procedural safeguards prescribed by law and regulations were not fulfilled by the forced medication. The Court of Appeal has here placed decisive emphasis on the lack of consideration of Eidsvik's complaint and the lack of a decision on restraint in connection with the medication itself.

Medical interventions without consent constitute an interference with private life pursuant to *Article 8 of the ECHR* and *Article 17 of the ECHR*, including personal autonomy. In the view of the Court of Appeal, the failure to fulfil the procedural safeguards provided for in the Norwegian regulations means that the requirement for proportionality has not been met, and that the right to privacy has been violated.

Article 14 of the ECHR and *Article 26 of the ECHR* protect against discrimination in the exercise of the rights under Articles 3 and 8 of the ECHR and Articles 7 and 17 of the ECHR, respectively.

In the view of the Court of Appeal, the lack of consideration of Eidsvik's complaint about the forced medication meant that it was not sufficiently arranged for her – who was in a limited position to safeguard her rights at the time due to her long-term and serious mental illness – to be able to fulfil her opportunity to realise these in full. The same applies to the lack of a decision on restraint in connection with the medication itself. This entails a

violation of Article 14 of the ECHR, cf. Articles 3 and 8, and Article 26 of the ECHR, cf. Articles 7 and 17, also read in the light of Articles 2, 5 and 12 of the CRPD.

7.3.4 Tenth admission (October 20 to November 25, 2014)

Eidsvik was admitted on 20 October 2014. It appears from the admission record that she is an active advocate of drug-free treatment in mental health care. When the daughter was informed of the decision to shield herself on 22 October, she stated that Eidsvik is "very afraid of being medicated" and asked to be notified if this had to happen. The next day, Eidsvik was told that a decision would be made on forced medication, and it is again stated that Eidsvik has "great resistance to drug treatment".

On 24 October, a decision was made by ticking off the standard form. The medical records of the same day state:

> -The patient has known bipolar disorder, with several forced hospitalizations, most recently in March 2014 with acute mania. She was then forcibly medicated and it was considered that this had a good effect.
> […]
> -At the examination today, the patient has a great flood of speech, she is very jumpy in the conversation, incoherent, most of what she says does not make sense, e.g. "... king and government put me on a flight here." Pas is also psychomotor restless, wanders around the room while talking, is perceived as irritable and lacks insight into her own situation. Pas has now been at Hjelset for 3 days without his condition having changed significantly. She is still considered to have a maniform psychosis.
> -Pas have repeatedly been encouraged to take medication voluntarily. Pas is opposed to medication, but previous experience indicates that the patient has had a good effect of antipsychotic medication during previous stays, and that this has previously led to a significant improvement in the patient's condition.
> Since the passport is admitted under section 3.3, and she does not wish to take medication, a decision is made
> 4.4a of the PHL on treatment without the patient's own consent. Passports are informed about the right to appeal the decision, but do not want to do so today. Daughter is informed.

A telephone note from conversations with relatives on the same day states:

> Daughter says that pas has been subjected to abuse earlier in life and that pas experiences a new trauma every time she is forcibly medicated. According to the daughter, the pas believes that it is the lack of sleep that causes her to become ill and the daughter therefore wants the pas to first and foremost get sleeping pills. Pas is also said to have said that psychosis is something that must be allowed to burn out, even if it takes 2.5 months. Pas has been offered sleeping pills/sedatives, but has not wanted this. Otherwise reported that the passport slept well last night.
> -Reported from the environmental staff that the mother of the passport wanted the patient to receive medication.

Three days later, it appears that Eidsvik was calmer and easier to talk to, but still did not want medication and was incoherent, illogical and rambling in the conversation. Furthermore, it appears that the county medical officer would probably come the next day,

as Eidsvik's daughter had appealed the treatment decision. From the county medical officer's visit on 28 October 2014, reference is made:

> The county medical officer was at the passport today. They considered that the passport did not want to appeal the decision on forced medication and is not currently processing the appeal (which came from the daughter).
> If the passport changes its mind, we must contact the county medical officer quickly, who can then process the complaint quickly.

On the same day, the decision on forced medication was implemented. The nurse's records show that Eidsvik was standing up on the sofa during the medication and was perceived to be very scared. She "strongly resisted receiving the injection and therefore had to be held by 4 men to get the injection". Two days later, it appears that Eidsvik "has her tongue out of her mouth most of the time and therefore difficult to understand what she is saying", but that she can control this by putting her tongue in her mouth and does not indicate any discomfort. She sometimes doesn't answer. This was assessed as a 'side effect or simulation of a side effect', and it appears that she was 'observed occasionally being relaxed in the face'.

Apart from the fact that Eidsvik slept well the first night after the medication, her mental state was otherwise "little changed". Another antipsychotic was prescribed. On 5 November 2014, she was given the choice between orodispersible tablet or injection. First, she threw a tablet out of the window. It is then stated: 'With 5 staff in the room, the patient finally took his
orodispersible tablet [...] Somewhat angry and afraid of dying for a little while after taking the tablet."

This drug was also not considered to have "sufficient effect". Because Eidsvik was «Very afraid of side effects», on 10 November 2014, a drug was prescribed that did not appear on the coercive medication form, as it was considered to be more gentle. Eidsvik appealed the decision to take forced medication. The County Governor rejected the appeal on the same day. A telephone note of 11 November 2014 states that the senior consultant had spoken to the assistant county medical officer on the telephone about the complaint, and that the latter had no objections to the fact that
"Xeplion/Risperdal is used if it is considered to be a professional adequacy." The medication was not stated in the forced medication form.

The next day, it is reported again that Eidsvik is not better, and that she has received four injections during the last two days. The daughter has contacted the department. She is "Frustrated and angry" because the mother constantly complains about how she is doing at the hospital, and that the day before she received three injections. After a meeting with the daughter on 13 November 2014, the journal states:

> Daughter critical of the fact that we use so much medicine. According to his daughter, Pas has previously been subjected to abuse when she was younger, and believes that forced medication causes aggravation/retraumatization. Daughter says

passport goes to psychologist due to previous forced medication. The daughter wishes (on behalf of the child) that the disease should be allowed to take its natural course, even though it may take a very long time. Therapists explain why we have treated the way we have. Agree that therapists will try to call passports about 2 times per week for general information.

On 14 November, Eidsvik is still described as "manic with increased verbal activity and periodically incoherent. She has also "been pronounced offensive (sexualised statements, descriptions of appearance and the like) towards fellow patients and staff". A few days later, she is described as calmer and more collected. However, she became angry when she was told that she was going to get another injection. According to the discharge summary, she gradually improved five to ten days before discharge.

The nurse's medical records of 21 November 2014 show that Eidsvik explained that it is primarily conversations she wants as treatment. She wanted a plan for the eventual next admission, how to proceed without medication. She understands that the treatment time can take longer without medication, but says she is willing to have to go through it.

Eidsvik was discharged on 25 November 2014.

In assessing *whether the forced medication constituted a violation of the Convention,* the Court of Appeal is also somewhat reluctant to review the responsible therapist's assessment of medical necessity. However, the Court of Appeal notes that neither the decision on forced medication nor the associated medical record contain any specific weighing of the advantages against the disadvantages, cf. cf. Section 4-4 second paragraph (a) third sentence of the Mental Health Care Act, cf. Section 4-2. Nor has an assessment been made of the form and degree of power that may be necessary to implement the decision.

Appeal Judge Guro Hansson Bull and Extraordinary Appeal Judge Karen Wendel Sandaa note similar to the special comment set out in section 7.3.3. Reference is also made here to the fact that information about Eidsvik's experience of abuse and retraumatisation was entered in the medical record on the same day as the decision was made.

The Court of Appeal further points out that Eidsvik's daughter's appeal against the decision was not processed. Next of kin have an independent right of appeal, cf. Section 4-4, seventh paragraph, of the Mental Health Care Act. A letter to Eidsvik's daughter on 28 October 2014 states that the County Governor assumed that there was no appeal under consideration because Eidsvik had expressed in a brief conversation the same day that she did not wish to appeal the decision. Thus, the legal protection guarantee that Norwegian law provides for in the form of complaint processing was not followed in this coercive medication.

In the grounds for the decision on 10 November 2014, following Eidsvik's own complaint, the County Governor pointed to the diagnosis Eidsvik had received, and then gave the following reasoning:

> The County Governor considers you to be clearly in need of treatment, and accepts

the consultant's assessment that treatment with drugs is highly likely to lead to healing or significant improvement of your condition.

> Due to a lack of insight into the disease, it seems unrealistic at present to expect voluntary, stable cooperation on further drug treatment with drugs.

In the decision, the County Governor only took a position on one of the conditions of the Act. Among other things, there is no assessment of the condition that the drug has "a beneficial effect that clearly outweighs the disadvantages" of the measure, cf. Section 4-4 second paragraph (a) third sentence of the Mental Health Care Act, cf. Section 4-2. The grounds for the decision also leave the impression that the County Governor has not sufficiently used his competence as an appeal body under the Public Administration Act § 34. It is noted that the appeal decision does not contain any specific assessments, as well as the wording that the County Governor "accepts the consultant's assessment".

Thus, the procedural safeguards prescribed by law were not followed in the case of forced medication during this stay.

An overall assessment of these factors leads the Court of Appeal to believe that *Article 3 of the ECHR* and *Article 7 of the ECHR* were also violated by this forced medication. In particular, it is pointed out that Eidsvik's daughter's complaint was not processed, as well as the errors in the County Governor's handling of Eidsvik's complaint. Prior to the retention under medication described in the medical records, a decision should have been made pursuant to Section 4-8 second paragraph (d) of the Mental Health Care Act.

On the same grounds as for forced medication during the ninth hospitalization, the Court of Appeal finds that *Article 8 of the ECHR* and *Article 17 of the ECHR* have also been violated.

On the same grounds as in section 7.3.4, the Court of Appeal has also come to the conclusion that the failure to process Eidsvik's daughter's complaint, the errors in the County Governor's handling of Eidsvik's own complaint and the lack of a decision to restraint in connection with the medication itself constitute a violation of *Article 14 of the ECHR, cf. Articles 3 and 8,* and *Article 26 of the ECHR, cf. Articles 7 and 17,* also read in light of CRPD articles 2, 5 and 12.

7.3.5 Eleventh admission (March 7 to May 31, 2016)

Eidsvik was hospitalized on March 7, 2016. It is stated in the admission record that "[t]he patient is strongly opposed to psychotropic drugs, and has therefore opposed preventive drug treatment of his or her mental disorder". On admission, she was assessed as fully awake and oriented, with clear speech, but elated and agitated, with reduced contact. The suicidal risk was assessed as low. The risk of violence was assessed as low to moderate. On one occasion, however, Eidsvik held up the coffee cup in such a way that the chief physician perceived it as a threat in the form of Eidsvik emptying the coffee cup on the senior consultant.

The discharge summary of 14 June 2016 provides information on the course, assessment and treatment:

> The patient is strongly opposed to psychotropic drugs, bordering on delusional (even when she is healthy), and it was not possible to achieve voluntary cooperation when it comes to medication. She was treated with Xeplion intramascular injections, this was due to a good antimanic effect. The first injection was given on 09.03.16 (150 mg Xeplion i.m.), she received 3 more injections of 100 mg i.m. during her hospitalization (16.03.16/13.04.16/13.05.16). Mood-stabilising treatment with Orfiril oral solution 8mlx2 was started on 20.04.16 and stepped up to 10 ml x 2 on 03.05.16.
> The patient was constantly reluctant to be treated with Orfiril, as she called "rat poison", nevertheless she accepted treatment until the last injection of Xeplion on 3.05.16. After this injection, the patient refused to take any more Orfiril, arguing that she did not want to take oral medicine if she was nevertheless receiving intramuscular treatment. The alternative to Orfiril was injections with 10mg Zyprexa, but it was decided not to expose the patient to daily stress with forced injections.

Both the day after admission and the following day, the daughter asked that medication be awaited against Eidsvik's will. It appears from a telephone note in the medical records on 9 March 2016 that the consultant stated in conversation with the daughter that 'we are shortening her suffering and discomfort in connection with previous intervention'.

The medical records of the same day, 9 March 2016, show that Eidsvik initially had a neutral mood, but became agitated and aggressive when the conversation turned to drug treatment. She came "right up in the therapist's face" and was "threatening", before she pulled back a little and said that she was "terrified". In a conversation later that day, Eidsvik tried to summon people she saw on TV to get them to kill the consultant, and pushed the consultant in the back after the conversation. The consultant assessed Eidsvik to be very ill/psychotic, and that it is «not in the interest of waiting for the start of drug treatment». The consultant made a decision to take coercive medication starting on the same day.

A decision on forced medication was made by completing a standard form on 9 March 2016. Neither the investigation period of three days before the decision nor the blocking period of 48 hours after the decision were complied with. The form does not tick any of the exemptions for deviating from the three-day examination time, but for "the 48-hour appeal period with suspensive effect to be waived as the patient will suffer serious damage to his health if postponed". The decision covered many different medications. The «Section assessment (§ 4-4a phl)» in the medical records on the same day states that the patient is well known to his or her regular treatment provider, who was involved in the assessment together with the senior consultant. Furthermore, it is stated, among other things:

> An attempt was made to inform the patient about section 4-4 a phl and about medication that must be given to her today. The patient turns up the radio then. In

any case, she is not able to get the information. At the same time, she will not take any medication in tabl form.

Assessment: the patient is very agitated, incoherent, delusional, allegedly hallucinated at times and. She lost her sleep, she is in violent (physical readiness), came with a physical attack both against u.t and against a nurse who injected today.

> Diagnosis: psychotic mania, high risk of violence.
>
> Conclusion: the patient needs medication as soon as possible. There is a great risk of significant damage to health by waiting 2 days with medication. Therefore, deviations are made
> 2 days deadline for appeals on section 4-4 a PHL today. The conditions for making the decision are considered to be met. Medications come with a rapid improvement effect. The patient has no insight into the disease.

The nurse's records show that Eidsvik, after being told about forced medication, on the morning of 9 March verbally threatened several of the male employees and hit a nurse who was sitting on the sofa and spat on him without warning. Later it appears that she was "Very anxious, threatening, and angry, it seemed like she had little control." When she was about to be given medication, she hit the nurse on the upper arm, "probably not to hurt him, but to mark a boundary."

When the decision had been made, the daughter expressed dissatisfaction with the fact that the appeal deadline had been set aside with suspensive effect, but did not file a formal appeal against the decision on forced medication.

After about five days, the medicine was considered to have a good effect. She is still described as psychotic, but that "you see a very good effect when she gets a good night's sleep". In mid-April, however, Eidsvik appeared to have deteriorated. The nurse's medical records of 14 April 2016 state:

> Is on constant alert in fear of a new injection. Says she manages to relax for 5 hours when she sleeps. The rest of the day she is afraid.

On 11 May, Eidsvik asked to postpone the injection in connection with the fact that she wanted to appeal the decision. This was accommodated. She complained to the county governor on 12 May. The county medical officer had a conversation with Eidsvik, who gave "a comprehensive account". The appeal was rejected on 13 May.

Eidsvik was discharged on 31 May 2016.

In assessing *whether the forced medication constituted a violation of the Convention,* the Court of Appeal is still somewhat reluctant to review the responsible practitioner's assessment of medical necessity. However, the Court of Appeal notes that the decision of the responsible processor does not contain any specific weighing of advantages against disadvantages.

Judge of Appeal Guro Hansson Bull and Extraordinary Judge of Appeal Karen Wendel

Sandaa note similar to the special comments set out in sections 7.3.3 and 7.3.4.

The Court of Appeal notes that this medication has not been used to assess the form and degree of force that may be necessary to implement the decision. It is not clear which of the conditions of the Act was considered to be fulfilled in order to derogate

the examination time of three days before a decision. It is also unfortunate that the grounds for the decision refer to an incident that occurred after the decision had been made and implemented, namely that Eidsvik attacked the person who injected.

In the appeal decision of 13 May 2016, the County Governor pointed out that Eidsvik had a serious mental illness. The further reason for not upholding the complaint was as follows:

> In the past two months, you have reluctantly accepted medication, and it is reported in the medical records that you have improved somewhat during your hospitalization, until you now choose to appeal the decision. In our conversation, psychotic symptoms did not emerge as clear as those described in the medical records, but the County Governor considers you to still be in need of treatment, and accepts the consultant's assessment that treatment with drugs is highly likely to lead to further improvement of your condition.

In this case, the County Governor based his decision on an incorrect understanding of the condition in the Mental Health Care Act
Section 4-4 fourth paragraph. It is not sufficient that the treatment measure is highly likely to lead to "further improvement"; It must at least be able to lead to "significant improvement". Furthermore, the County Governor – like the responsible treatment provider – has failed to take a position on the other conditions of the Act, including whether the medicinal product has "a beneficial effect that clearly outweighs the disadvantages" of the measure, cf. Section 4-2 first paragraph first sentence and Section 4-4 second paragraph (a) third sentence. The County Governor's reasoning also leaves the impression that the County Governor has not sufficiently used his competence pursuant to Section 34 of the Public Administration Act. Even though in the conversation with Eidsvik, in which she is said to have given "a comprehensive account", it did not come to light
"psychotic symptoms as clear as those described in the medical records",
"accept[the]" the County Governor's assessment without further consideration. Nor has the County Governor commented on the fact that it was clear from the decision at first instance which of the Act's conditions were considered to be fulfilled in order to deviate from the three-day investigation period.

Appeal Judge Guro Hansson Bull and Extraordinary Appeal Judge Karen Wendel Sandaa note that it appears from the decision that the County Governor refers to the journal entries, and it must be assumed that the information from there has been taken into account. However, several of these should have been discussed and assessed on an independent basis by the County Governor.

The procedural safeguards that Norwegian law provides for were thus not complied with in this forced medication. Particular attention is drawn to the errors in the County Governor's handling of complaints and the lack of a decision on restraint in connection

with the medication itself. Overall, the Court of Appeal finds that the processing entails a *violation of Article 3 of the ECHR and Article 7 of the ECHR*.

On the same grounds as for forced medication during the ninth and tenth hospitalizations, the Court of Appeal finds that *Article 8 of the ECHR* and *Article 17 of the ECHR* were also violated.

The Court of Appeal has also found that there is a violation of *Article 14 of the ECHR, cf. Articles 3 and 8*, and *Article 26 of the ECHR, cf. Articles 7 and 17*, also read in the light of Articles 2, 5 and 12 of the CRPD. Particular reference is made to the errors in the County Governor's handling of Eidsvik's complaint and the lack of a decision on restraint in connection with the medication itself.

7.4 Isolation

7.4.1 Introduction

In the following, the Court of Appeal will review the isolation and shielding that it appears from the medical records that Eidsvik was subject to in 2014 and 2016. The review must be read on the basis of what is stated about the history and forced medication in section 7.3.

The Court of Appeal will continuously consider Eidsvik's claims that the solitary confinement violated her human rights. Subsequently, in section 7.5, the Court of Appeal will consider her submissions that the shielding was carried out in an unauthorised manner.

The Court of Appeal assumes that solitary confinement may be decided when it is "indispensable" in order to, among other things, prevent the person from "harming" others, cf. Section 4-8, first paragraph, first sentence of the Mental Health Care Act. Coercive measures shall only be used when more lenient measures have proven to be manifestly futile or insufficient, cf. the second sentence of the first paragraph. Isolation must be the last resort and the only means available to prevent immediate or imminent harm to the patient or others; *M.S. v. Croatia (No. 2)*, paragraph 104.

7.4.2 Ninth admission (22 February to 19 March 2014)

When Eidsvik arrived in Hjelset on 22 February 2014, a decision was made to "transfer to a sheltered unit" for six days. In her medical records, she is described as "very agitated without being directly threatening". On the same day, she is described at the shielding unit as "verbally aggressive, shouting, threatening to staff". Shielding in a separate room is agreed at 15.40. At one point, she "pushes" staff "in an attempt to get her out of the room."

That same evening, Eidsvik was in his room. When the staff came in to check on her, she was
"verbally aggressive", stood up, was "motorically active with threatening body language" and wanted the staff out of the room. It is stated in the medical records that "[a]n person does not come for a conversation".

A decision was then made *on solitary confinement*, i.e. short-term placement behind a

locked or closed door without staff present, in order to «prevent the patient from harming others», cf. Section 4-8 of the Mental Health Care Act. The assessment that appears in the medical record of 22 February 2014 is as follows:

> One confers on the on-call duty, chief physician Jonsbu. It is agreed that a decision is made on the use of coercive measures in the form of short-term placement behind a locked door without staff present pursuant to section 4.8 of the PHL.

On the same day, Senior Consultant Jonsbu wrote the following:

> Refers to a journal note by Martin Engeland from today, where the patient is described as very restless, periodically threatening and has pushed the staff. This clinical picture is not surprising in relation to how the patient behaved in the section assessment earlier today. The undersigned makes a decision (paragraphs 4-8) that the patient can be placed in his or her room for a short time with the door closed without the staff present in the room.

The Court of Appeal notes that in a situation where the patient is threatening and violent, the conditions for solitary confinement may, depending on the circumstances, be considered met. When the decision was made, however, Eidsvik had been lying in bed in her room, where she was sheltered, but became "motorically active with threatening body language" when the staff came in, and she wanted them out.

The decision to isolate is hardly justified. It appears unexplained why it was not an option at this time to leave the room and leave Eidsvik there alone, without isolation. Restrictions and coercion shall be limited to what is «strictly necessary», cf. Section 4-2, first paragraph, first sentence of the Mental Health Care Act, and shielding one's own room out of consideration for others would have been an alternative, less intrusive measure than solitary confinement. On this basis, the Court of Appeal finds that *Article 3 of the ECHR and Article 7 of the ECHR* were violated.

For the same reasons, the requirement of proportionality was not met, so that Article 8 of the ECHR and Article 14 of the ECHR were violated.

The nurse's journal of 24 February states that in the morning Eidsvik was "referred to his own room and 'held' there, so that staff sit outside with the door ajar", so that fellow patients would not be woken up. On February 27, 2014, Eidsvik, as previously mentioned, hit a male employee. On 28 February, she was sheltered in her own room "with staff sitting outside". It appears that Eidsvik had been angry and referred to the staff and other patients in a derogatory manner.
She did not want the staff to sit inside with her. Also on the morning of 1 March, she was "sheltered in her own room with a service at the door, so that she does not wake up fellow patients".

On 4 March 20124, a new *decision was made on solitary confinement* to «prevent the patient from harming others», cf. Section 4-8 of the Mental Health Care Act. The medical records state, among other things, that she pointed and flailed her arms, became "angry and behaved threateningly". It appears from the journal that Eidsvik had to be "physically led into his

own room a couple of times by disturbance and slamming doors". The medical record states the following assessment:

> The patient is psychotic and verbally acting out, lacks insight into their own illness and behaviour, the risk of tipping over into physical acting out that can lead to violent incidents

> is assessed as high based on tonight's conversation. She refuses to cooperate in taking medication. She has a decision on compulsory medication that applies to zyprexa and cisordinol, among other things. Confer with the on-call staff about offering the patient cisordinol tbl or drops in the first instance. U.t. perceives her as very unpredictable, verbally acting out and physically threatening. Out of consideration for fellow patients and staff, she should be isolated in her room if she visits the common areas of the shielding unit in this condition. *After conferring with the on-call staff, Section 4-8 is made a decision on short-term placement behind closed doors without staff present due to the risk of injury/attack on staff or fellow patients*.

The Court of Appeal has concluded that the grounds for this decision, read in light of the other, contemporaneous entries in the medical record, are sufficient to document that the requirements of necessity and proportionality were met, and that all other reasonable alternatives had proven insufficient to manage the risk of harm to others. It is referred to that a week earlier she had hit an employee, that she was fencing her arms, was angry and behaved threateningly, and that she had been led into her room several times, but that this was not sufficient. At the time of the decision, the risk of violent incidents was considered high.

For the same reasons, the Court of Appeal finds that the conditions in Article 8(2) of the ECHR were met, so that this interference did not violate Eidsvik's right to privacy. The intervention was based on legislation that was of sufficient quality and provided instructions for adequate legal protection mechanisms, and the intervention remained within the legal basis. The procedure was justified by the legitimate purposes of «prevention of disorder» and «protection of health». The requirement for proportionality was met in that the consideration of protecting others outweighed her interest in her own autonomy and integrity. She posed a real danger to others, and there were no less invasive, suitable alternatives to protect the others. For the same reasons, Eidsvik's rights under Article 17 of the SP were not violated.

On 7 March 2014, a new decision was made to transfer Eidsvik to a sheltered unit, where Eidsvik stayed for three days.

7.4.3 Tenth admission (October 20 to November 25, 2014)

On 22 October 2014, a decision was made on shielding pursuant to Section 4 of the Mental Health Care Act.
3. All the options on the form for decision have been ticked: «transfer to a shielded unit», «limitation of impressions», «shielding in rooms» and «shielded from fellow patients». It appears from the nurse's medical records that that night the night watchman was sitting "outside the patient's own shielding room, when, after several recommendations, she continued to walk over to the fellow patient's room door and talk in a loud voice". It appears from the nurse's records that Eidsvik's behaviour had a negative effect on a fellow

patient.

On 7 November 2014, a new, similar risk-free return decision was made. It appears that at times she was "a considerable nuisance to fellow patients and must then be shielded in her own room".

The nursing records for 9 November 2014 show that Eidsvik had been awake for most of the night and "talked all the time". It appears that she showed no ability to take into account the fact that other patients were asleep, that she was angry and coped very poorly with setting boundaries.

On 10 November 2014, a *decision was made on solitary confinement*, cf. the Mental Health Care Act
§ 4-8. The medical records state:

> The patient has not slept, is loud, verbally active, does not take guidance from the staff. An attempt was made to shield the room with staff present, to no effect. Then isolated in the room without the staff. A decision is made pursuant to section 4-8 b to prevent the patient from harming himself or others.

The nursing records state about 10 November 2014:

> No sleep tonight. Restless and verbally active. Didn't set boundaries and became angry and loud. An attempt was made to shelter in the room with staff present. This provoked her and she was, with the doctor on duty's approval, isolated in her room from 01.30, with staff just outside the door. When the patient believed that it was one of the staff who was responsible for the isolation, this was subjected to massive harassment by the patient and accused of being a rapist, child abuser, etc. When the patient demonstrated by putting his radio on full power, it was felt necessary to confiscate it.

Under doubt, the Court of Appeal has come to the conclusion that the grounds for the solitary confinement decision
10 November 2014, in conjunction with the information recorded in the medical records at the time of the decision, provides sufficient evidence that solitary confinement was "indispensable" to prevent Eidsvik from "harming" others, cf. Section 4-8, first paragraph, first sentence of the Mental Health Care Act. Several other methods, including shielding, had been tried to prevent Eidsvik from keeping the other patients awake at night. The Court of Appeal assumes that keeping other patients who are admitted to a psychiatric ward awake for several nights may cause them sufficient harm so that a very short period of isolation to prevent this does not constitute a violation of Article 3 of the ECHR and Article 7 of the ECHR.

For the same reasons, the Court of Appeal has concluded that the requirement for proportionality pursuant to Article 8(2) of the ECHR was met, so that Article 8 and Article 14 of the ECHR were not violated.
The legal basis requirement is fulfilled by the statutory provision, which the decision remained within, and the interference was justified by the health of others, cf. «protection of health» in Article 8(2) of the ECHR.

7.4.4 Eleventh admission (March 7 to May 31, 2016)

During the last admission, no decision was made on isolation. Risk-free return decisions were made on 8 March, 22 March, 5 April, 19 April, 14 May and 18 May 2016. The decisions

8 March, 14 May and 18 May did not include "shielding in rooms". Apart from that, all the risk-free return options were ticked off on all the decision forms.

Although the decision of 8 March 2016 did not include "shielding in the room", the following night Eidsvik was shielded in his "own living room" with the staff sitting outside.

7.5 Shielding

Eidsvik has not argued that there was no basis for shielding her when she was admitted. It appears from both the medical records and her statement that she wanted shielding at times. However, Eidsvik believes that the shielding on several occasions was carried out in such a way that it violated her convention rights.

The Court of Appeal notes that the decision of 22 February 2014 only covered "transfer to a sheltered unit", not "shielding in a room". Eidsvik was nevertheless on 24 and 28 February, as well as
1 March, "held"/"sheltered" in their own room. Nor was the decision of 8 March 2016 covered
"shielding in a room", but Eidsvik was nevertheless shielded the following night in his "own living room" with the staff sitting outside.

This raises the question of whether the risk-free return had a sufficient basis in the decision, cf. *Rt-2001-428* page 445. However, at the time, Section 4-3, second paragraph, of the Mental Health Care Act only required that a decision be made if shielding is maintained beyond 24 hours or "entails a significant change" to the patient's "surroundings or freedom of movement", which is maintained beyond 12 hours. The Court of Appeal has not found sufficient evidence that the shielding in one's own room affected these limits in any of these cases.

Eidsvik has explained that the door to her room was kept closed from the outside several times during shielding by staff holding one foot or putting an armchair against the door. It is agreed that such closure is not authorised by the rules on shielding, which do not permit the closing of the door, cf. Section 18, first paragraph, second sentence of the Mental Health Care Regulations.

The questions are thus whether Eidsvik has provided evidence appropriate to the situation, for this to happen, cf. *Bouyid v. Belgium,* paragraphs 82-84 and *V.I. v. Moldova*, paragraphs 139-141, whether the burden of proof has shifted to the State, and if so, whether the State has fulfilled it.

It appears from the medical records that on some occasions the staff sat outside while

Eidsvik was sheltered in his rooms, but it does not appear that the door was closed.

Eidsvik has explained that when she was shielded in her room, the door was very often closed, sometimes ajar. When she was alone in the room, the nurse sat outside the door on several occasions in 2014 and 2016 in a Stressless chair. Either the armchair was with its back to the door leaf, or the nurse put his foot on the door leaf, in both cases so that the door was closed. Whether this

happened depended on which nurse was at work and their tolerance for frustration. Usually scrolled on the mobile phone, read or knitted while sitting like this. She could see what they were doing through an oblong window in the door. In 2014, a nurse sat like this with his foot on the door, during the second shielding. In 2016, it happened both at night and during the day. One night watchman often sat with the back of his chair against the door and read the Bible. Two others used to keep the door closed all night. During the appeal hearing, Eidsvik described the appearance of two of these nurses. The State's counsel pointed out that if Eidsvik had described these people earlier, an attempt could have been made to identify them and bring them as witnesses.

Eidsvik further explained that she was "in isolation" without access to fresh air from Friday 13 May to Thursday 19 May 2016, when she was allowed to go out for 20 minutes in the garden. Based on the medical records, the Court of Appeal assumes that this was a case of shielding without exit, but that she was not kept in her own room during this entire period.

Psychiatric nurse Klunderud had a lot to do with Eidsvik when she was in a sheltered ward in 2014 and 2016. She explained that she has not experienced the door being held shut during shielding, but that she could not ignore the possibility that it has happened. She did not work at night, as Eidsvik has explained that this happened most often. Eidsvik has not explained that Klunderud closed the door, but Klunderud believed that if such a thing had happened, it would have been written in the medical records.

An article from NRK on 6 December 2016 states that patients at the psychiatric wards in Ålesund and Hjelset in Molde are exposed to more extensive and prolonged use of restraints and restraints than at all other hospitals in Norway. It appears that notifications and demands for changes to routines were made in 2007, 2009, 2012, 2013, 2014, 2015 and 2016, without these being sufficiently followed up.

The 2017 annual report from the Parliamentary Ombudsman states that a key finding from the visits to several hospitals was that shielding measures in mental health care were implemented in ways that meant that the intervention had "a clear character of isolation or had to be regarded as isolation". In some places, written routines or informal practices were found suggesting that 'a few minutes of short-term blocking of patients' doors was considered 'part of the
the risk-free return decision'". During the Ombudsman's visit to Ålesund Hospital, Department of Hospital Psychiatry from 19 to 21 September 2017, information emerged indicating that 'patients were briefly confined behind a locked or closed door without the decision-maker being informed, even afterwards', cf. section 8.5 of the visit report. This seemed to be partly due to the fact that some of the staff had misunderstood how risk-free return decisions can be legally implemented. The Parliamentary Ombudsman was of the opinion that such a lack of knowledge among the employees creates a risk of unauthorised

practice. Hjelset is not specifically mentioned in the report.

In 2018, the Parliamentary Ombudsman submitted the thematic report *Shielding in mental health care – risk of inhumane treatment*. He believed that several aspects of the practice of shielding entailed a risk of inhuman or degrading treatment. It appears that there are statistically large regional differences, cf. section 3.2.2. Section 8.4.1 states:

> In several places, the Ombudsman has found that the shielding had a clear character of isolation. In some cases, the shielding was in reality isolation pursuant to Section 4-8 (b) of the Mental Health Care Act. At some hospitals, written routines and informal practices were found that indicated that a few minutes of blocking patients' doors was considered to be
> "part of the risk-free return decision". For example, it was found that patients were told to hold the room for a certain period of time, and that the door was blocked from the outside if the patient tried to come out before this time had elapsed. Such coercive measures constitute solitary confinement pursuant to Section 4-8 (b) of the Mental Health Care Act, and can only be implemented in situations similar to emergency law.

The information is not disputed, and the Court of Appeal takes it as its basis. The Court of Appeal assumes that this is general information that can be included in the assessment of whether Eidsvik has sufficiently substantiated his allegation of a breach of the Convention.

The Court of Appeal has found the assessment difficult. Eidsvik has explained himself in relatively detail about the conditions. She also has support in general information, including from the Parliamentary Ombudsman (the Parliamentary Ombudsman). However, it appears from the medical records that Eidsvik occasionally hallucinated when she was hospitalized. In this situation, the Court of Appeal attaches decisive importance to the fact that the state has tried to shed as much light on this issue as possible, including offering witness evidence. Eidsvik did not appeal any of the decisions on isolation or shielding to the county governor.
The Court of Appeal further assumes that Eidsvik did not provide sufficiently detailed descriptions of the staff who she believes blocked her door before the appeal hearing to make it possible for the state to find out who this may be. There is therefore no basis for concluding that the difficulties in providing sufficient information about the case are due to the authorities' failure to investigate it effectively.

Under some doubt, the Court of Appeal has subsequently concluded that there has not been sufficient evidence that the door was kept closed during shielding.

The Court of Appeal has therefore concluded that there is no basis for finding that Eidsvik's rights under ECHR articles 3, 8 and 14, or SP articles 7, 17 and 26 have been violated by the implementation of the risk-free return decisions in 2014 and 2016

8. Subject of internal law liability

The State has argued that it has not been properly sued with regard to the declaratory judgment that the coercion itself against Eidsvik constitutes a breach of the Convention. It has referred to the fact that the coercion was carried out by a health trust, which is a separate legal entity, cf. Section 6 of the Health Trust Act. The Supreme Court has not taken

position on this question as the submission was only made by the state after the Supreme Court had ruled on other questions of inadmissibility in HR-2024-826-A.

Pursuant to Article 1 of the ECHR and Article 2(1) of the ECHR, it is incumbent on the States to guarantee everyone within their jurisdiction the rights and freedoms arising from the Conventions.

The question is who is the right person to be sued under domestic Norwegian law in the event of a declaratory judgment for a violation of the ECHR and the ECHR when the actions are carried out by a legal entity other than the state.

Pursuant to Section 1-3 of the Dispute Act, a case may be brought against a person who has a sufficient connection to the claim. The second paragraph of the provision reads as follows:

> The person bringing the case must demonstrate a genuine need to have the claim settled in relation to the defendant. This is decided on the basis of an overall assessment of the topicality of the claim and the parties' connection to it.

The connecting condition states that the plaintiff "must direct the lawsuit against the person against whom he or she believes he or she has a claim", cf. the special comments to section 1-3 of Ot.prp.nr.51 (2004–2005) on page 366.

The Court of Appeal cannot see that the preparatory works have taken a position on who is the right defendant in a claim for a declaratory judgment for breach of the Convention, see Ot.prp. no. 51 (2004–2005) item
11.8. The Dispute Resolution Committee assumed that "most lawsuits will be directed against the state as the obligated party under the conventions", but the statement was only part of an assessment of whether a rule on screening should be introduced, cf. NOU A, Part II, chapter 5.4.6, page 201. The Court of Appeal reads the statement in section 4.4.1 on page 168 as a reference to the fact that the state is the liable party under international law in the event of violations, while public bodies are obligated parties that must comply with the Convention in practice – not as a position on the question of who is the right person to be sued under domestic law in the event of an allegation of a breach of the Convention.

In *Rt-2011-1666 (Vestre Viken),* the Supreme Court held that the state must be made a defendant in a declaratory action for a declaration of breach of the Convention, cf. also Rt-2009-1350, paragraph 24. The reason was that only the states are "obligated parties under the ECHR", and that a judgment against a health trust will not have the force of res judicata against the state. Nor can such a judgment ensure the legal clarification that may be necessary for legislative changes. The plaintiff had no legal interest in obtaining a judgment that a health trust had violated the ECHR, and the case was dismissed, cf. paragraphs 36–39.

HR-2022-401-A (Tolga) did not concern a declaratory judgment for breach of the Convention, but whether a municipality could be sued with a claim for compensation for non-economic loss based on Article 13 of the ECHR, cf. Articles 3 and 8. In this case, the Supreme Court found that a claim for damages shall be directed against the legal entity that is presumed to be liable under Norwegian law. In that case, it was the municipality.

The Court of Appeal cannot see that *the Tolga judgment* changes what follows from *the Vestre Viken judgment*. In *the Tolga judgment*, the relationship to *the Vestre Viken judgment* is expressly discussed. Most of the arguments put forward by the state in support of its view in the case now before the Court of Appeal were also considered in *the Tolga judgment*. Both similarities and differences between declaratory actions for a declaration of violation of the convention and actions for damages are discussed. It was also taken into account that "if both the municipality and the state can be sued as a result of the same ECHR violation, two decisions may be made with different results", see paragraph 49.

In the view of the Court of Appeal, there is therefore no basis for the Court of Appeal to depart from the first express conclusion in *paragraph 39 of* the Vestre Viken judgment:

> My conclusion is therefore that the state through the Ministry of Health and Care Services must be sued if the plaintiff is to have a legal interest in obtaining a judgment that a health trust has violated an incorporated human rights convention.

The state has the overall responsibility for compliance with the convention protection and cannot organise itself away from this through the enterprise model. Eidsvik's claim concerns a determination that the state has not fulfilled its obligations under Article 1 of the ECHR to safeguard her rights under Articles 3, 8 and 14, cf. Sections 2 and 3 of the Human Rights Act, cf. Ot.prp. no. 51 (2004–2005) on page 366. Correspondingly, the state's duty to provide security pursuant to Article 2(1) of the SP applies, cf. Articles 7, 17 and 26. The Court of Appeal therefore believes that she can sue the state for violation of the ECHR and SP even where any violations are due to actions carried out by a health trust.

9. Costs

None of the parties has been "fully or substantially successful", cf. Section 20-2, second paragraph, of the Dispute Act. The clear general rule when none of the parties has been successful in full or in essence is that the parties must bear their own costs, cf. Ot.prp. no. 51 (2004–2005) pages 278 and 446. The threshold for being awarded legal costs pursuant to section 20-3 is relatively high, cf. inter alia HR-2018-267-U, paragraph 26 with further references. Particular emphasis shall be placed on how much the party has been successful, the proportion of the legal costs associated with this part of the case, as well as the elements in Section 20-2, third paragraph, second sentence.

In the view of the Court of Appeal, Eidsvik's claim has been upheld of significance, cf. Section 20-3 of the Dispute Act. She has been successful in her claim that her convention rights were violated on several occasions while she was subject to compulsory mental health care, in that the procedural safeguards stipulated in the Act and the Regulations

were not met. The fact that she was not successful in her claim that shielding and two instances of solitary confinement constituted violations does not change the assessment. Nor does it mean that she has not been successful in the principle of her claim, which is that the legal framework for forced medication, isolation and shielding in Norway is contrary to the ECHR and the ECHR.

Eidsvik has undoubtedly achieved so much that it would not be reasonable to demand that she accept the opposing party's position in the dispute; Ot.prp. no. 51 (2004–2005) page 446. In the view of the Court of Appeal, there are "weighty reasons" for awarding Eidsvik legal costs pursuant to section 20-3. The case is a matter of principle and has been conducted as a pilot case to clarify the framework for coercion under compulsory mental health care. There was "good reason to have the case tried because it was doubtful", cf. Section 20-2 third paragraph (a). The case is of great importance «welfare significance», and «the balance of power between the parties» indicates that Eidsvik should be awarded coverage for his costs, cf. letter c.

Eidsvik has claimed compensation of NOK 1,406,301.50 in fees for the proceedings in the Court of Appeal. Of this, NOK 1,340,767 is to cover fees incl. VAT, and NOK 39,420 is court fees. The rest is travel, accommodation and lost earnings for Eidsvik and two witnesses. The state has argued that the number of hours is too high and that lost earnings for parties and witnesses should not be covered. The Court of Appeal agrees with the state that the number of hours appears somewhat high, even though the case is legally complicated and based on an extensive factual basis. After a discretionary assessment, taking into account the extent to which the appellant has been successful and on what basis, as well as what the Court of Appeal considers to be necessary costs that it has been reasonable to incur in view of the importance of the case, the Court of Appeal sets the coverage of costs for the appeal proceedings at NOK 1,000,000, cf. Section 20-5 of the Dispute Act.

The Court of Appeal shall base its decision on its claim for costs before the District Court, cf. Section 20-9, second paragraph, of the Dispute Act. Eidsvik has claimed reimbursement of NOK 1,525,367 in fees for the proceedings in the district court. Of this, NOK 1,492,500 is to cover fees incl. VAT, and NOK 13,189 is court fees. The rest is travel, accommodation and lost earnings for the party and witnesses. On the same grounds as for the appeal proceedings, the Court of Appeal determines the discretionary coverage of the claim at NOK 1,200,000, cf. Section 20-5.

The verdict is unanimous.

Due to the scope of the case, the judgment has not been pronounced within the statutory deadline.

For the sake of order, it is stated that Eidsvik has wanted the judgment not to be subject to any restrictions with regard to publicity, and this has not been done either.

D O M S S L U T N I N G

1. Inger-Mari Eidsvik's rights under Article 3 of the European Convention on Human Rights and Article 7 of the UN Covenant on Civil and Political Rights were violated on several occasions in connection with her forced medication while she was subject to compulsory mental health care in the periods 22 February 2014 to 19 March 2014, 21 October 2014 to 25 November 2014 and 7 March 2016 to 8 June 2016.

2. Inger-Mari Eidsvik's rights under Article 14 of the European Convention on Human Rights, cf. Article 3, and Article 26 of the UN Covenant on Civil and Political Rights, cf. Article 7, were violated on several occasions in connection with her forced medication while she was subject to compulsory mental health care in the periods 22 February 2014 to 19 March 2014, 21 October 2014 to 25 November 2014
2014 and 7 March 2016 to 8 June 2016.

3. Inger-Mari Eidsvik's rights under Article 8 of the European Convention on Human Rights and Article 17 of the UN Covenant on Civil and Political Rights were violated on several occasions in connection with her forced medication while she was subject to compulsory mental health care in the periods 22 February 2014 to 19 March 2014, 21 October 2014 to 25 November 2014 and 7 March 2016 to 8 June 2016.

4. Inger-Mari Eidsvik's rights under Article 14 of the European Convention on Human Rights, cf. Article 8, and the UN Covenant on Civil and Political Rights. Article 26 of her rights, cf. Article 17, was violated on several occasions in connection with her forced medication while she was subject to compulsory mental health care in the periods 22 February 2014 to 19 March 2014, 21 October 2014 to 25 November 2014
2014 and 7 March 2016 to 8 June 2016.

5. The use of solitary confinement for Inger-Mari Eidsvik on 22 February 2014 violated her rights under Article 3 of the European Convention on Human Rights and Article 7 of the UN Covenant on Civil and Political Rights.

6. The use of solitary confinement for Inger-Mari Eidsvik on 22 February 2014 violated her rights under Article 8 of the European Convention on Human Rights and Article 17 of the UN Covenant on Civil and Political Rights.

7. In legal costs before the Court of Appeal, the State, represented by the Ministry of

Health and Care Services, will pay Inger-Mari Eidsvik NOK 1,000,000 – one million – within two weeks of service of this judgment.

8. In the case costs before the district court, the state, represented by the Ministry of Health and Care Services, will pay Inger-Mari Eidsvik NOK 1,200,000 – one million two hundred thousand – within two weeks of service of this judgment.

9. The remainder of the appeal is dismissed.

Lisa Vogt-Lorentzen Guro Hansson Bull Karen Wendel Sandaa

Document in accordance with original,
Aurora Aubert Sætre